Mental Health Parity

in the TennCare and CoverKids Programs

Tennessee Department of Finance & Administration | Division of TennCare

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Key Abbreviations

CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
MCO	Managed care organization
MH/SUD	Mental health / substance use disorder
M/S	Medical / surgical
NQTL	Non-quantitative treatment limitation
PAC	Pharmacy Advisory Committee
PAHP	Prepaid ambulatory health plan
PBM	Pharmacy benefit manager
PDL	Preferred drug list
QTL	Quantitative treatment limitation

Mental Health Parity in the TennCare and CoverKids Programs

Introduction

Tennessee's Medicaid and CHIP programs are operated by the Division of TennCare. Since 1994, Tennessee's Medicaid program, TennCare, has operated as a 100 percent managed care program under the authority of an 1115 demonstration waiver. The state's separate CHIP program is called CoverKids.

On March 30, 2016, the Centers for Medicare and Medicaid Services (CMS) issued regulations governing the application of mental health parity requirements to Medicaid managed care programs and CHIP programs. (See 42 CFR Part 438, Subpart K and 42 CFR §457.496.) These regulations and subsequent CMS guidance recommended processes for states to use in order to demonstrate compliance with parity requirements, and specified documentation requirements related to parity. This report details Tennessee's compliance with these requirements.

Process Overview

In analyzing and documenting its compliance with parity requirements, Tennessee relied heavily on the process recommended by CMS. The primary steps in this process are outlined below.

1. Identify all benefits packages to which parity requirements apply.
2. Define mental health and substance use disorder (MH/SUD) benefits.
3. Classify benefits by benefit type (e.g., inpatient, outpatient).
4. For each benefit type, identify and analyze aggregate lifetime and annual dollar limits.
5. For each benefit type, identify and analyze other quantitative treatment limitations and financial requirements.
6. For each benefit type, identify and analyze non-quantitative treatment limitations.
7. Document the results of the parity analysis and make any changes needed to comply with parity requirements.

The remainder of this report is organized according to this framework, in order to illustrate the state's approach to each step of the parity analysis process.

Identifying Benefits Packages and Determining the Scope of the Analysis

Tennessee's Medicaid program, TennCare, operates as a 100 percent managed care program, in which all program participants are enrolled in managed care. With a limited number of specific exceptions (e.g., Medicare cost sharing), enrollees receive all services, including all MH/SUD services, from managed care contractors.

The TennCare program has two primary components. Individuals who are eligible for Medicaid under the authority of the Medicaid State Plan are enrolled in *TennCare Medicaid*. Non-Medicaid eligibles who are eligible under the authority of the state's 1115 demonstration waiver are enrolled in *TennCare Standard*. All TennCare enrollees (both TennCare Medicaid and TennCare Standard enrollees) have access to the same package of covered benefits in the same amount, duration, and scope. However, children enrolled in TennCare Standard have cost sharing obligations for MH/SUD services that are not applicable to individuals enrolled in TennCare Medicaid. (Unless specifically noted otherwise, references to "TennCare" in this report apply to both TennCare Medicaid and TennCare Standard.)

The state's separate CHIP program, CoverKids, has a benefits package that is separate and distinct from the TennCare benefits package.

Based on the design of the TennCare and CoverKids programs as described above, the state determined that three parity analyses were needed:

- TennCare Medicaid,
- TennCare Standard children, and
- CoverKids.

The discussion below will address each of these program components.

Defining Mental Health and Substance Use Disorder Benefits

In order to evaluate parity between MH/SUD benefits and medical/surgical (M/S) benefits, it is necessary to have a consistent definition of MH/SUD benefits. The parity rule defines mental health benefits as items or services for mental health conditions, as defined by the state and in accordance with applicable federal and state law. Similarly, substance use disorder benefits are defined as items or services for substance use disorders, as defined by the state and in accordance with applicable federal and state law. State definitions of mental health conditions

and substance use disorders are required to be consistent with generally recognized independent standards of current medical practice. (See 42 CFR §438.900 and 42 CFR §457.496(a).)

The parity rule defines medical/surgical benefits as items or services for medical conditions or surgical procedures, as defined by the state and in accordance with applicable federal and state law, but which do not include mental health or substance use disorder benefits.

In its parity analyses, Tennessee used the current version of the International Classification of Diseases (ICD-10-CM) as its basis for distinguishing between MH/SUD benefits and M/S benefits. For purposes of the state's analysis, claims for which the primary diagnosis code was an MH/SUD diagnosis code[1] were considered to be MH/SUD services. Codes related to intellectual disabilities or developmental disorders were excluded from the definition of MH/SUD condition for purposes of this analysis. All ICD-10-CM codes that did not fall within the state's definition of MH/SUD condition were considered M/S conditions for purpose of this analysis.

The state's definitions of MH/SUD and M/S services are presented below:

Service Type	Definition
MH/SUD services	Items or services for MH conditions and SUDs. All services for which the ICD-10-CM primary diagnosis code is an MH/SUD diagnosis are MH/SUD services, except codes related to intellectual disabilities and developmental disorders.
M/S services	All items or services that are not MH/SUD services.

The state's analysis and the discussion that follows reflect these definitions.

Classifying Benefits into Benefit Types

The parity rule directs states to conduct their parity analyses across four benefit classifications: (1) inpatient, (2) outpatient, (3) prescription drugs, and (4) emergency care. Each M/S and MH/SUD benefit must be mapped to one of these four classifications. Grouping benefits into

[1] See ICD-10-CM Chapter 5 – "Mental, Behavioral and Neurodevelopmental Disorders (F01-F99)."

these classifications allows for the comparison of financial requirements and treatment limitations among similar services (e.g., comparing the financial requirements applied to inpatient MH/SUD services with those applied to inpatient M/S services).

In defining what benefits are included in each classification, states must apply the same reasonable standard to both M/S and MH/SUD benefits. For purposes of this analysis, the state applied the following definitions to classify M/S and MH/SUD benefits.

Classification	Description
Inpatient	All covered services delivered by a provider or institution at a 24-hour facility, including those at an inpatient hospital, residential, and or skilled nursing facility setting, with a corresponding place of service code.
Outpatient	All covered services delivered by at an outpatient office, clinic, or community setting, with a corresponding outpatient place of service code.
Emergency	All covered services or items delivered in an emergency department setting to stabilize an emergency/crisis, other than an inpatient or outpatient setting, with a corresponding place of service code. Includes emergency transportation to an emergency department.
Prescription Drugs	Covered medications and drugs requiring a prescription.

Appended to this report is a benefit map that illustrates how covered TennCare's benefits were grouped for analysis purposes based on the state's definition of MH/SUD and M/S services and these benefit classifications.

Based on the state's definition of MH/SUD and M/S services described above and these benefit classifications, the state's parity analysis proceeded as outlined below.

Aggregate Lifetime and Annual Dollar Limits

The parity rule requires states to identify any aggregate lifetime or annual dollar limits imposed on MH/SUD services in each benefit classification, and to evaluate whether those limits are more restrictive than the aggregate lifetime and annual dollar limits imposed on M/S services in the same classification.

The TennCare and CoverKids programs do not impose aggregate lifetime or annual dollar limits on MH/SUD services in any benefit classification. Given that aggregate lifetime or annual dollar limits are not imposed on MH/SUD services, the state determined that the TennCare and CoverKids programs satisfy parity requirements governing these types of treatment limitations.

Quantitative Treatment Limitations

Quantitative treatment limitations are limits on the scope or duration of a benefit that are expressed numerically, including limits on the number of days or visits. The parity rule requires states to identify the quantitative treatment limits imposed on MH/SUD services in each benefit classification, and to evaluate whether those limits are more restrictive than the limits imposed on M/S services in the same classification.

The TennCare program does not impose quantitative treatment limitations on MH/SUD services in the inpatient, outpatient, or emergency classifications. In the prescription drug classification, certain TennCare enrollees are subject to a limit of five prescription drugs per month.[2] This limitation is applied uniformly to all prescription drugs without regard to whether a drug is generally prescribed for MH/SUD or M/S conditions. Upon review, the state determined that this limit, on its face, is no more restrictive with respect to MH/SUD services than it is to M/S services, because the limit is applied uniformly to all prescription drugs. Given the outcome of this review, the state determined that the TennCare program satisfies parity requirements regarding quantitative treatment limitations.

The CoverKids program does not impose quantitative treatment limitations on MH/SUD services in any benefit classification. Given that quantitative treatment limitations are not imposed on any MH/SUD services, the state determined that the CoverKids program satisfies parity requirements governing these types of treatment limitations.

Financial Requirements

Financial requirements are amounts charged to enrollees when accessing covered benefits, including copayments, coinsurance, and deductibles. The parity rule requires states to identify

[2] This limitation applies to adults age 21 and older, other than those who meet the state's level of care criteria for institutional care. TennCare maintains procedures for enrollees to exceed this limit in instances when a qualified provider attests to an urgent need for a medication.

the financial requirements imposed on MH/SUD services in each benefit classification, and to evaluate whether those requirements are more restrictive than the financial requirements imposed on M/S services in the same classification.

TennCare Medicaid, TennCare Standard, and CoverKids impose financial requirements in the form of copays on certain MH/SUD services. A discussion of the copays applied in each of these benefits packages, and the state's determination related to parity compliance in each benefits package, follow.

TennCare Medicaid

TennCare Medicaid does not charge copays on any inpatient, outpatient, or emergency services. TennCare Medicaid charges copays on prescription drugs for non-exempt enrollees[3] as follows:

Drug Type	Copay
Generic prescription drugs	$1.50
Brand name prescription drugs	$3.00

These copay tiers for prescription drugs are based on reasonable factors (i.e., generic versus brand name), and are applied uniformly to all drugs without regard to whether a drug is generally prescribed for MH/SUD or M/S conditions. Upon review, the state determined that these copays, on their face, are no more restrictive with respect to MH/SUD services than they are to M/S services, because they are based on reasonable factors and applied uniformly to all prescription drugs. Given the outcome of this review, the state determined that the copays imposed in TennCare Medicaid satisfy parity requirements.

TennCare Standard

Children enrolled in TennCare Standard have copays on inpatient services, outpatient services, and prescription drugs. There are no copays on emergency services. TennCare Standard copays vary based on the child's household income, as follows:

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[3] Federal regulations mandate that certain populations are exempt from cost sharing (e.g., individuals receiving care in institutions, individuals receiving hospice care).

Benefit	Copay For Enrollees with Incomes 100%-199% of Federal Poverty Level	Copay For Enrollees with Incomes 200% of Federal Poverty Level or Higher
INPATIENT SERVICES		
Inpatient admission	$5	$100
OUTPATIENT SERVICES		
Primary care provider and community mental health agency services[4]	$5	$15
Physician specialists and dentists	$5	$20
Non-emergency services received at a hospital emergency room	$10	$50
PRESCRIPTION DRUGS		
Prescription drugs	$1.50 for generics $3.00 for brands	$1.50 for generics $3.00 for brands

TennCare Standard copays are applied uniformly for all services, without regard to whether the services are MH/SUD services or M/S services. Copays are applied to all inpatient and outpatient M/S and MH/SUD services, other than preventive services. Copay tiers in the prescription drug classification are based on reasonable factors (i.e., brand name versus generic) and applied uniformly on all prescription drugs. Upon review, the state determined that these copays, on their face, are no more restrictive with respect to MH/SUD services than they are to M/S services, because these copays are applied uniformly to all services. Given the outcome of this review, the state determined that the copays imposed in TennCare Standard satisfy parity requirements.

[4] No copays are charged for preventive care.

CoverKids

Individuals enrolled in CoverKids have copays on inpatient services, outpatient services, and prescription drugs. There are no copays on emergency services. CoverKids copays vary based on the enrollee's household income, as follows:

Benefit	Copay For Enrollees with Incomes Less than 200% of Federal Poverty Level	Copay For Enrollees with Incomes 200% of Federal Poverty Level or Higher
INPATIENT SERVICES		
Hospitalizations and other inpatient admissions	$5	$100
Inpatient mental health and substance abuse treatment	$5	$100
OUTPATIENT SERVICES		
Physician office visit	$5 (primary care) $5 (specialist)	$15 (primary care) $20 (specialist)
Chiropractic care	$5	$15
Dental services	$5	$15
Vision services	$5	$15
Physical, speech, and occupational therapy	$5	$15
Outpatient mental health and substance abuse treatment services	$5	$15
Non-emergency services received at hospital emergency room	$10	$50
PRESCRIPTION DRUGS		
Prescription drugs	$1 for generics $3 for preferred brands $5 for non-preferred brands	$5 for generics $20 for preferred brands $40 for non-preferred brands

For prescription drugs, the copay tiers in CoverKids are based on reasonable factors (i.e., brand name versus generic, preferred versus non-preferred status) and applied uniformly on all prescription drugs, without regard to whether the drugs are generally prescribed for MH/SUD services or M/S services. For inpatient and outpatient services, copays are applied uniformly such that the copays applied to MH/SUD services (e.g., $100 for an inpatient admission) are the same as those applied to M/S services in the same benefit classification (e.g., $100 for a hospital or other inpatient admission). Upon review, the state determined that these copays, on their face, are no more restrictive with respect to MH/SUD services than they are to M/S services, because these copays are applied uniformly to all services. Given the outcome of this review, the state determined that the copays imposed in CoverKids satisfy parity requirements.

Non-Quantitative Treatment Limitations

Non-quantitative treatment limitations (NQTLs) are limits on the scope or duration of benefits that generally cannot be expressed numerically. An illustrative list of NQTLs is provided at 42 CFR §438.910(d)(2). The parity rule prohibits states and managed care contractors from imposing an NQTL on MH/SUD services unless, under the policies and procedures of the state or managed care contractor, as written and in operation, any processes, strategies, and evidentiary standards used in applying the NQTL to MH/SUD benefits are comparable to, and applied no more stringently than, the processes, strategies, and evidentiary standards used in applying the NQTL to M/S benefits.

Tennessee currently contracts with three managed care organizations (MCOs) to provide inpatient, outpatient, and emergency services to individuals enrolled in the TennCare program. Tennessee contracts with a third party plan administrator to administer the CoverKids program. TennCare's current MCOs are Amerigroup, BlueCare[5], and UnitedHealthcare Community Plan[6]. BlueCross BlueShield of Tennessee currently serves as the CoverKids plan administrator. In this discussion, the TennCare MCOs and CHIP plan administrator are referred to collectively as "health plans."

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[5] BlueCare is operated by Volunteer State Health Plan, Inc. (VSHP), which is an independent licensee of the BlueCross BlueShield Association and a licensed HMO affiliate of its parent company, BlueCross BlueShield of Tennessee.
[6] UnitedHealthcare Community Plan is operated by UnitedHealthcare Plan of the River Valley, Inc.

In order to evaluate the application of NQTLs in the TennCare and CoverKids programs, the state provided training and other information to the health plans on the parity rule generally, and on requirements concerning NQTLs specifically. In discussion with the health plans, the state identified the following NQTLs in use in the TennCare and CoverKids programs:

NQTL Type	Description
Medical necessity criteria	Criteria used by the plan to determine whether treatment or services are medically necessary.
Prior authorization	The plan reviews requests for care for medical necessity before treatment begins.
Concurrent review	The plan reviews care being provided on a periodic basis to assess continued medical necessity.
"Fail first" policies and/or step therapy protocols	The plan requires the enrollee to try one level of treatment before another level of treatment is approved.
Network standards	Standards for admitting providers to the plan's network, including restrictions based on geographic location, facility type, or provider specialty.

Once these NQTLs were identified, the state developed modules for the health plans to complete relative to each NQTL. Each module was designed to determine which MH/SUD services were subject to each NQTL type, and to assess whether the processes, strategies, and evidentiary standards used to apply the NQTL to MH/SUD services, as written and in operation, were comparable to and not more stringent than those used to apply the NQTL to M/S services in each benefit classification. The health plans were instructed to provide relevant policies and supporting documentation, where applicable. Upon receipt, the state reviewed the information submitted by each health plan to evaluate whether the information provided indicated that the plan was applying NQTLs in a manner that complied with parity requirements.

The results of the state's NQTL assessment process are summarized below. The modules submitted by each health plan are included as an attachment to this report.

Medical Necessity

For this NQTL, all health plans referred to using criteria for medical necessity determinations as specified in Tennessee state law and administrative rule chapter 1200-13-16. This rule defines medical necessity for the TennCare and CoverKids programs and specifies a set of criteria for health plans and providers to use in determining whether a particular service is medically necessary. This definition and accompanying medical necessity criteria apply uniformly to all services in the TennCare and CoverKids programs and do not differentiate between MH/SUD services and M/S services.

In their operationalization of Tennessee's medical necessity guidelines, the health plans reported using recognized independent standards of practice, such as MCG[7] care guidelines and ASAM[8] criteria, as well as plan-specific policies and guidelines. In describing the evidentiary standards used to support the medical necessity process, each health plan referred to periodic review of processes and criteria by qualified professionals, as well as adhering to generally accepted standards of clinical practice. In all cases, the processes, strategies, and evidentiary standards used to apply medical necessity criteria to MH/SUD services were comparable to, and not more stringently applied than, the processes, strategies, and evidentiary standards used to apply medical necessity criteria to M/S services.

Prior Authorization

All health plans reported requiring prior authorization for some MH/SUD services and some M/S services in the inpatient and outpatient benefit classifications. When asked why certain MH/SUD and M/S services were selected for prior authorization, the health plans indicated that the goals of the prior authorization process were to ensure timely and appropriate access to medically necessary covered services, to ensure that care is delivered in accordance with generally accepted standards of medical practice, to ensure that care is delivered in the most appropriate setting, and to prevent inappropriate utilization. These reasons did not vary for MH/SUD and M/S services. The prior authorization processes described by each health plan were also consistent for both MH/SUD and M/S services. For each health plan, the processes, strategies, and evidentiary standards used to apply prior authorization to MH/SUD services were comparable to, and not more stringently applied than, the processes, strategies, and evidentiary standards used to apply prior authorization to M/S services.

[7] Formerly called the Milliman Care Guidelines.
[8] American Society of Addiction Medicine.

Concurrent Review

All health plans reported requiring concurrent review for some MH/SUD services and some M/S services in the inpatient and outpatient benefit classifications. Within each plan, the reasons for applying concurrent review requirements were the same for MH/SUD services and M/S services, and generally included ensuring that continued services are delivered in the most appropriate setting, monitoring for transition of care, identifying potentially long-term or complex cases for care management programs, and identifying potential quality of care issues. For each health plan, the processes, strategies, and evidentiary standards used to apply concurrent review to MH/SUD services were comparable to, and not more stringently applied than, the processes, strategies, and evidentiary standards used to apply concurrent review to M/S services.

Fail First Policies and Step Therapy Protocols

One health plan reported applying fail first policies or step therapy protocols to selected MH/SUD and M/S services in the inpatient and outpatient classifications. (One health plan reported applying fail first policies only to selected M/S services, and two health plans reported that they did not use fail first policies or step therapy protocols.) The health plan that reported using step therapy protocols for MH/SUD services reported that it applied this NQTL to selected MH/SUD and M/S services in order to ensure that the safest and most cost effective therapy that would treat the member's condition is utilized first. The processes and evidentiary standards described to implement the step therapy protocols were comparable for MH/SUD services and M/S services, and not more stringently applied to MH/SUD services than to M/S services.

Network Standards

All health plans reported basing their provider network admission standards on state licensing or other credentialing requirements for both MH/SUD and M/S services. Health plans generally referred to assessments of network adequacy/service availability to determine when their networks were "closed" or "open" to additional MH/SUD and M/S providers. The process for provider credentialing and enrollment for all plans entailed completion of the Council for Affordable Quality Healthcare (CAQH) provider enrollment process.

Two health plans reported having no limitations on enrolling out-of-state providers for MH/SUD or M/S services. One health plan indicated that it generally did not contract with providers located outside the state, other than those located in counties contiguous to the state; this limitation was applied comparably for both MH/SUD and M/S providers. For all health plans,

enrollee access to out-of-network providers was limited to circumstances in which no in-network providers were available to provide needed care, and subject to approval by the plan. This limitation was applied comparably for both MH/SUD services and M/S services. For each health plan, the processes, strategies, and evidentiary standards used to implement network standards for MH/SUD services were comparable to, and not more stringently applied than, the processes, strategies, and evidentiary standards used to implement network standards for M/S services.

Application of NQTLs to Pharmacy Services

Pharmacy services within the TennCare program are delivered by a prepaid ambulatory health plan (PAHP) that serves as TennCare's pharmacy benefit manager (PBM). TennCare's current PBM is Magellan Health Services. The PBM works with TennCare's Pharmacy Advisory Committee (PAC) to implement the TennCare prescription drug benefit. The PAC meets periodically throughout the year to review current clinical evidence and to make recommendations regarding TennCare's preferred drug list (PDL) and prior authorization requirements. The PAC relies on high-quality, systematic reviews and evidence-based guidelines in recommending drugs for preferred or non-preferred status, as well as recommending when prior authorization criteria are appropriate. The state modifies its PDL and prior authorization criteria based on PAC recommendations, and these modifications are then implemented by the PBM. The clinical review process used to determine each drug's preferred/non-preferred status and prior authorization requirements (if any) are the same for all drugs, regardless of whether a specific drug is generally prescribed for MH/SUD or M/S conditions.

In its analysis, the state determined that it applies the following NQTLs to pharmacy services—medical necessity, prior authorization, and step therapy protocols. For each of these NQTLs, the processes, strategies, and evidentiary standards applied for MH/SUD services were comparable to, and not more stringently applied than, the processes, strategies, and evidentiary standards applied for M/S services. The state has attached a corresponding NQTL analysis regarding its pharmacy benefit.

Summary and Findings

Based on the analyses described above, Tennessee determined that the TennCare and CoverKids programs comply with federal parity requirements. Key findings of the analysis include:

- ***Aggregate Lifetime and Annual Dollar Limits.*** TennCare and CoverKids do not apply aggregate lifetime or annual dollar limits on MH/SUD services. Given that MH/SUD benefits are not subject to aggregate lifetime or annual dollar limits, it was determined that both programs complied with parity requirements for these types of treatment limitations.
- ***Quantitative Treatment Limits.*** TennCare does not impose quantitative benefit limits on MH/SUD services in the inpatient, outpatient, or emergency classification. Certain TennCare enrollees are subject to a limit of five prescriptions per month in the prescription drug classification. This limit is uniformly applied to all prescription drugs without regard to whether a drug is generally prescribed for MH/SUD or M/S conditions. Given that this limit is applied uniformly to all prescription drugs, the state determined that this limit was no more restrictive with regard to MH/SUD services than it was to M/S services. The CoverKids program does not impose quantitative benefit limits on MH/SUD services in any classification. It was determined that both programs complied with parity requirements for these types of treatment limitations.
- ***Financial Requirements.*** TennCare Medicaid, TennCare Standard, and CoverKids impose financial requirements on MH/SUD services in certain benefits classifications. Within each program, copays are uniformly applied to broad benefit types (e.g., inpatient admissions) without regard to whether the services are for MH/SUD conditions or M/S conditions. Upon review, the state determined that these copays, on their face, are not more restrictive with regard to MH/SUD services than with regard to M/S services. The state determined that both the TennCare and CoverKids programs complied with parity requirements for these types of financial requirements.
- ***Non-Quantitative Treatment Limits.*** The health plans contracted with the state to administer the TennCare and CoverKids program use a variety of non-quantitative treatment limitations for both MH/SUD and M/S benefits. These are medical necessity criteria, prior authorization, concurrent review, fail first policies and step therapy protocols, and network standards. The state required each health plan to provide information about its use of these NQTLs in a standardized format. Upon review of the information provided by the health plans, it was determined that these NQTLs are applied to MH/SUD services in a manner that is comparable to, and no more stringent than, their application to M/S services. The state determined that the TennCare and CoverKids programs complied with parity requirements for these types of treatment limitations.

Based on the outcome of its analyses, the state has determined that the TennCare and CoverKids programs comply with federal parity requirements. The state will update its analysis as needed to reflect changes to TennCare or CoverKids benefits that may impact mental health parity.

Appendix:

Benefit Map of TennCare-Covered Benefit

Mental Health Parity Analysis
TennCare Services Categorization and Classification

Medical/Surgical Benefits			
Inpatient	**Outpatient**	**Prescription Drugs**	**Emergency Care**
• Inpatient Hospital Services • Intermediate Care Facility for Individuals with Intellectual Disabilities • Nursing Facility Care • Organ and Tissue Transplant Services • Physician Inpatient Services	• Bariatric Surgery • Chiropractic Services (ages 21 and under) • Community Health Clinic Services • Dental Services (ages 21 and under) • Durable Medical Equipment • EPSDT Services (ages 21 and under) • Home and Community Based Services as alternative to institutional care • Home Health Care • Hospice Care • Lab and X-ray Services • Medical Supplies • Non-Emergency Transportation • Occupational Therapy • Outpatient Hospital Services • Physical Therapy • Physician Outpatient Services • Private Duty Nursing • Reconstructive Breast Surgery • Renal Dialysis Clinic Services • Speech Therapy • Vision Services	• Outpatient Prescription Drugs	• Emergency Transportation Services • Emergency Department Services

Mental Health/Substance Use Disorder Benefits			
Inpatient	**Outpatient**	**Prescription Drugs**	**Emergency Care**
• Inpatient and Residential Substance Abuse Services • Psychiatric Inpatient Facility Services • Psychiatric Physician Inpatient Services • Psychiatric Residential Treatment Services	• Behavioral Crisis Prevention, Intervention, and Stabilization Services for Members with Intellectual or Developmental Disabilities • Behavioral Health Crisis Services • Health Home Services for Persons with Serious and Persistent Behavioral Health Conditions • Intensive Community Based Treatment Services (e.g., Continuous Treatment Team, Comprehensive Child and Family Treatment, Program of Assertive and Community Treatment) • Lab and X-ray Services • Methadone Clinic Services (ages 21 and under) • Non-Emergency Transportation • Outpatient Mental Health Services (including physician services) • Outpatient Substance Abuse Services • Psychiatric Physician Outpatient Services • Psychiatric Rehabilitation Services (e.g., Psychosocial Rehabilitation, Supported Employment, Peer Recovery Services, Family Support Services, Illness Management & Recovery, Supported Housing)	• Outpatient Prescription Drugs	• Emergency Transportation Services • Emergency Department Services

Attachments:

NQTL Modules Completed by Health Plans

Amerigroup, TN

NQTL Analysis Module 1: Prior Authorization – INPATIENT SERVICES

<table>
<tr><th>PRIOR AUTHORIZATION REQUIREMENTS – INPATIENT SERVICES</th><th colspan="3">Mental Health/Substance Use Disorder Services</th><th colspan="3">Medical/Surgical Services</th></tr>
<tr><td>List all inpatient benefits requiring prior authorization.</td><td colspan="3">Mental Health (MH) Services
• Psychiatric Acute Inpatient
• Psychiatric Residential Treatment Center Services
• Psychiatric Sub-acute Care

Substance Use Disorder (SUD) Services
• Substance Abuse Inpatient or Residential Level Detoxification</td><td colspan="3">Medical/Surgical (M/S) inpatient admissions require prior authorization. Examples include:
• Acute Inpatient surgeries (Joint replacement, Spinal, and Bariatric)
• Organ/Tissue Transplant surgeries
• Sub-acute hospitalizations</td></tr>
<tr><td rowspan="2">Processes, Strategies, and Evidentiary Standards</td><td>Processes:
Explain the process, both in writing and in practice, for prior authorization that your MCO uses.</td><td>Strategies:
WHY does your MCO require prior authorization for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?</td><td>Evidentiary Standards:
What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.</td><td>Processes:
Explain the process, both in writing and in practice, for prior authorization that your MCO uses.</td><td>Strategies:
WHY does your MCO require prior authorization for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?</td><td>Evidentiary Standards:
What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.</td></tr>
<tr><td>All MH/SUD inpatient benefits that require prior authorization are:

1) Submitted by the provider to Amerigroup (AGP) through an online portal, fax or verbally.
2) AGP licensed clinician reviews submitted clinical to determine medical necessity using</td><td>Amerigroup's approach to precertification promotes appropriate care. Established procedures are followed for applying criteria based on individual member's medical necessity and community standards of care, minimizing administrative</td><td>See attachment, "Amerigroup Evidentiary Standards"</td><td>All M/S inpatient benefits that require prior authorization are:

1) Submitted by the provider to AGP through an online portal, fax or verbally
2) AGP licensed clinician reviews submitted clinical to determine medical necessity using InterQual® Level of</td><td>Amerigroup's approach to precertification promotes appropriate care. Established procedures are followed for applying criteria based on individual member's medical necessity and community standards of care, minimizing administrative</td><td>See attachment, "Amerigroup Evidentiary Standards"</td></tr>
</table>

PRIOR AUTHORIZATION REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	Amerigroup Medical Policy and Amerigroup Clinical UM guidelines. - The authorization is completed in accordance with NCQA timeframes. 3) If the reviewing clinician determines medical necessity is met, requestor is notified and provided a reference number. 4) If the reviewing clinician determines medical necessity criteria is NOT met, outreach is made to the requestor for additional supporting clinical information. 5) If the reviewing clinician determines medical necessity criteria is still NOT met, the request is sent to Medical Director review to determine if medical necessity is met. 6) The reviewing clinician notifies the requestor of the	barriers for physicians and other providers while promoting appropriate care. We utilize this process to enhance consistency in reviewing cases by providing a framework for clinical decision making. This process ensures compliance with local, state, and federal requirements, as well as accreditation bodies, i.e., NCQA. The goals of the prior authorization review process are to ensure adequacy of service availability and accessibility to eligible members; to maximize appropriate medical and behavioral health care; and to minimize/eliminate over-and/or under-		Care, Amerigroup Medical Policy, and Amerigroup Clinical UM guidelines. - The authorization is completed in accordance with NCQA timeframes. 3) If the reviewing clinician determines medical necessity is met, requestor is notified and provided a reference number. 4) If the reviewing clinician determines medical necessity criteria is NOT met, outreach is made to the requestor for additional supporting clinical information. 5) If the reviewing clinician determines medical necessity criteria is still NOT met, the request is sent to Medical Director review to determine if medical necessity is met. 6) The reviewing clinician notifies the requestor of the	barriers for physicians and other providers while promoting appropriate care. We utilize this process to enhance consistency in reviewing cases by providing a framework for clinical decision making. This process ensures compliance with local, state, and federal requirements, as well as accreditation bodies, i.e., NCQA. The goals of the prior authorization review process are to ensure adequacy of service availability and accessibility to eligible members; to maximize appropriate medical and behavioral health care; and to minimize/eliminate over-and/or under-	

PRIOR AUTHORIZATION REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	determination following Medical Director Review. 7) Upon final determination of the request, member and/or provider notification is provided based on State and Federal Requirements as well as NCQA requirements. After initial inpatient admission is approved, concurrent reviews will occur as applicable. For involuntary hospitalization, medical necessity is not applied for the first twenty-four (24) hours. (Certificate of Need for Emergency Involuntary Admission Title 33, Chapter 6, Part 4, Tennessee Code Annotated)	utilization of medical and behavioral health care. The Precertification Committee (PCC) serves as the official precertification rule decision-making body for Amerigroup, TN. The committee reviews current rules periodically for potential changes and reviews/makes decisions on requests to add, delete or change precertification rules for the organization. Changes to the precertification rules are not to be operationalized via system changes or manual processes without PCC approval. 1) The PCC is responsible for reviewing all		determination following Medical Director Review. 7) Upon final determination of the request, member and/or provider notification is provided based on State and Federal Requirements as well as NCQA requirements. After initial inpatient admission is approved, concurrent reviews will occur as applicable. There is no corollary to the involuntary hospitalization process for M/S.	utilization of medical and behavioral health care. The Precertification Committee (PCC) serves as the official precertification rule decision-making body for Amerigroup, TN. The committee reviews current rules periodically for potential changes and reviews/makes decisions on requests to add, delete or change precertification rules for the organization. Changes to the precertification rules are not to be operationalized via system changes or manual processes without PCC approval. 1) The PCC is responsible for reviewing all	

PRIOR AUTHORIZATION REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
		requests for the addition of new precertification rules and/or revisions to existing rules. This includes authorization waivers and managing Provider status. 2) PCC decisions are evidence based. The requestor is required to submit an analysis to demonstrate the effects on the business operations, and provide a summary on how the change will impact the health plan/division. Refer to Amerigroup Precertification Committee policy			requests for the addition of new precertification rules and/or revisions to existing rules. This includes authorization waivers and managing Provider status. 2) PCC decisions are evidence based. The requestor is required to submit an analysis to demonstrate the effects on the business operations, and provide a summary on how the change will impact the health plan/division. Refer to Amerigroup Precertification Committee policy	

PRIOR AUTHORIZATION REQUIREMENTS – INPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**	**Medical/Surgical Services**
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	Comparability: The processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable to M/S benefits as applicable to the prior authorization process. Stringency: There is a less stringent admission requirement for MH involuntary hospitalization which removes the application of medical necessity for the first twenty-four hours.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If prior authorization requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of prior authorization is in parity. No additional information is needed.** **If prior authorization requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of prior authorization is not in parity. Proceed to the following row.**	
Modifications Explain how prior authorization processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A	

NQTL Analysis Module 1: Prior Authorization – OUTPATIENT SERVICES

<table>
<tr><th>PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES</th><th colspan="3">Mental Health/Substance Use Disorder Services</th><th colspan="3">Medical/Surgical Services</th></tr>
<tr><td>List all outpatient benefits requiring prior authorization.</td><td colspan="3">Mental Health (MH) Services
Applied Behavioral Analysis (ABA)
Electroconvulsive Therapy (ECT)
Intensive Community Based Treatment
Intensive Outpatient (IOP)
Partial Hospitalization (PHP)
Psychological Testing
Supported Housing
Transcranial Magnetic Stimulation (TMS)
Substance Use Disorder (SUD) Services
Partial Hospitalization
Intensive Outpatient
Ambulatory Detoxification</td><td colspan="3">Auditory Surgery
Cardiac Rehab- outpatient
Dental Services (under age of 21)
ENT (Otolaryngology) Surgery
Genetic Testing
Gynecology Surgery
Hematology
Home Health Aide
Home Health Skilled Nursing
Home Health Therapy
Home Infusion
Hospice
Interventional Cardiology
LTSS services
Medical Injectable
Nephrology
Neurology
OON services
Ophthalmology Surgery
Oral Maxillofacial
Organ/Tissue Transplant and Donor Organ
Pain Management
Plastic/Cosmetic/Reconstructive Surgery
Private Duty Nursing
Prosthetics/Orthotics
Radiation Therapy
Radiology/Imaging
Rehab Therapy (PT/ST/OT)
Sleep Study
Urology Services
Vision Services (under age of 21)</td></tr>
<tr><td>Processes, Strategies, and Evidentiary Standards</td><td>Processes:
Explain the process, both in writing and in practice, for prior authorization that your MCO uses.</td><td>Strategies:
WHY does your MCO require prior authorization for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?</td><td>Evidentiary Standards:
What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.</td><td>Processes:
Explain the process, both in writing and in practice, for prior authorization that your MCO uses.</td><td>Strategies:
WHY does your MCO require prior authorization for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?</td><td>Evidentiary Standards:
What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.</td></tr>
</table>

PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	All MH/SUD outpatient benefits that require prior authorization are: 1) Submitted by the provider to AGP through an online portal, fax or verbally. 2) AGP licensed clinician reviews submitted clinical to determine medical necessity using TennCare Rules, Amerigroup Medical Policy, and Amerigroup Clinical UM guidelines. - The authorization is completed in accordance with NCQA timeframes. 3) If the reviewing clinician determines medical necessity is met, requestor is notified and provided a reference number. 4) If the reviewing clinician determines medical necessity criteria is NOT met, outreach is made to the requestor for additional supporting clinical information.	Amerigroup's approach to precertification promotes appropriate care. Established procedures are followed for applying criteria based on individual member's medical necessity and community standards of care, minimizing administrative barriers for physicians and other providers while promoting appropriate care. We utilize this process to enhance consistency in reviewing cases by providing a framework for clinical decision making. This process ensures compliance with local, state, and federal requirements, as	See attachment, "Amerigroup Evidentiary Standards"	All M/S outpatient benefits that require prior authorization are: 1) Submitted by the provider to AGP through an online portal, fax or verbally. 2) AGP licensed clinician reviews submitted clinical to determine medical necessity using TennCare Rules, Amerigroup Medical Policy, and Amerigroup Clinical UM guidelines. - The authorization is completed in accordance with NCQA timeframes. 3) If the reviewing clinician determines medical necessity is met, requestor is notified and provided a reference number. 4) If the reviewing clinician determines medical necessity criteria is NOT met, outreach is made to the requestor for additional supporting clinical information. 5) If the reviewing clinician determines medical necessity criteria is still NOT met, the request is sent to Medical Director review to determine if medical necessity is met. 6) The reviewing clinician	Amerigroup's approach to precertification promotes appropriate care. Established procedures are followed for applying criteria based on individual member's medical necessity and community standards of care, minimizing administrative barriers for physicians and other providers while promoting appropriate care. We utilize this process to enhance consistency in reviewing cases by providing a framework for clinical decision making. This process ensures compliance with local, state, and federal requirements, as well as accreditation bodies, i.e., NCQA.	See attachment, "Amerigroup Evidentiary Standards"

PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	5) If the reviewing clinician determines medical necessity criteria is still NOT met, the request is sent to Medical Director review to determine if medical necessity is met. 6) The reviewing clinician notifies the requestor of the determination following Medical Director Review. 7) Upon final determination of the request, member and/or provider notification is provided based on State and Federal Requirements as well as NCQA requirements.	well as accreditation bodies, i.e., NCQA. The goals of the prior authorization review process are to ensure adequacy of service availability and accessibility to eligible members; to maximize appropriate medical and behavioral health care; and to minimize/eliminate over-and/or under-utilization of medical and behavioral health care. The Precertification Committee (PCC) serves as the official precertification rule decision-making body for Amerigroup, TN. The committee reviews current rules periodically for potential changes and reviews/makes decisions on		notifies the requestor of the determination following Medical Director Review. 7) Upon final determination of the request, member and/or provider notification is provided based on State and Federal Requirements as well as NCQA requirements.	The goals of the prior authorization review process are to ensure adequacy of service availability and accessibility to eligible members; to maximize appropriate medical and behavioral health care; and to minimize/eliminate over-and/or under-utilization of medical and behavioral health care. *LTSS services are delivered in accordance with TennCare program requirements, member's qualifying need, and Person Centered Support Plan. The Precertification Committee (PCC) serves as the official precertification rule decision-making body for Amerigroup, TN. The committee reviews	

PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
		requests to add, delete or change precertification rules for the organization. Changes to the precertification rules are not to be operationalized via system changes or manual processes without PCC approval. 1) The PCC is responsible for reviewing all requests for the addition of new precertification rules and/or revisions to existing rules. This includes authorization waivers and managing Provider status. 2) PCC decisions are evidence based. The requestor is required to submit an analysis to demonstrate the effects on the			current rules periodically for potential changes and reviews/makes decisions on requests to add, delete or change precertification rules for the organization. Changes to the precertification rules are not to be operationalized via system changes or manual processes without PCC approval. 1) The PCC is responsible for reviewing all requests for the addition of new precertification rules and/or revisions to existing rules. This includes authorization waivers and managing Provider status. 2) PCC decisions are evidence based. The requestor is required	

PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
		business operations, and provide a summary on how the change will impact the health plan/division. Refer to Amerigroup Precertification Committee policy			to submit an analysis to demonstrate the effects on the business operations, and provide a summary on how the change will impact the health plan/division. Refer to Amerigroup Precertification Committee policy	
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	Comparability: The processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable to M/S benefits as applicable to the prior authorization process. Stringency: The processes, strategies, and evidentiary standards applied to M/S benefits are not more stringently applied to MH/SUD benefits.					

PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**	**Medical/Surgical Services**
Evaluation of Processes, Strategies, and Evidentiary Standards	**If prior authorization requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of prior authorization is in parity. No additional information is needed.** **If prior authorization requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of prior authorization is not in parity. Proceed to the following row.**	
Modifications Explain how prior authorization processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A	

NQTL Analysis Module 1: Prior Authorization – EMERGENCY SERVICES

PRIOR AUTHORIZATION REQUIREMENTS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
List all emergency benefits requiring prior authorization.	N/A – Prior authorization is not required for emergency services.			N/A – Prior authorization is not required for emergency services.		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for prior authorization that your MCO uses.	**Strategies:** WHY does your MCO require prior authorization for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for prior authorization that your MCO uses.	**Strategies:** WHY does your MCO require prior authorization for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.
	Authorization is not required for Emergency Services.	N/A	See attachment, “Amerigroup Evidentiary Standards”	Authorization is not required for Emergency Services.	N/A	See attachment, “Amerigroup Evidentiary Standards”

PRIOR AUTHORIZATION REQUIREMENTS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	Comparability: The processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable to M/S benefits as applicable to emergency services. Stringency: The processes, strategies, and evidentiary standards applied to M/S benefits are not more stringently applied to MH/SUD benefits.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If prior authorization requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of prior authorization is in parity. No additional information is needed.** **If prior authorization requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of prior authorization is not in parity. Proceed to the following row.**	
Modifications Explain how prior authorization processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A	

NQTL Analysis Module 2: Concurrent Review – INPATIENT SERVICES

CONCURRENT REVIEW REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
List all inpatient benefits requiring concurrent review.	Mental Health (MH) Services • Psychiatric Acute Inpatient • Psychiatric Residential Treatment Center Services • Psychiatric Sub-acute Care Substance Use Disorders (SUD) Services • Substance Abuse Inpatient or Residential Level Detoxification			• Acute Inpatient Hospital Services • Long Term Acute Care (LTAC) • Inpatient Rehab (under 21) • Skilled Nursing Facility (CEA)		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for concurrent review that your MCO uses.	**Strategies:** WHY does your MCO require concurrent review for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of concurrent review for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for concurrent review that your MCO uses.	**Strategies:** WHY does your MCO require concurrent review for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of concurrent review for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.
	All MH/SUD inpatient benefits that require concurrent review are: 1) Submitted by the provider to AGP through an online portal, fax or verbally. 2) AGP licensed clinician reviews submitted clinical to	The purpose of the concurrent review process is to assist the Health Plan in ensuring that eligible members continue to receive the most clinically appropriate care and services in the most efficient manner possible. We utilize this	See attachment, "Amerigroup Evidentiary Standards"	All M/S inpatient benefits that require concurrent review are: 1) Submitted by the provider to AGP through an online portal, fax or verbally. 2) AGP licensed clinician reviews submitted clinical to determine medical	The purpose of the concurrent review process is to assist the Health Plan in ensuring that eligible members continue to receive the most clinically appropriate care and services in the most efficient manner possible. We utilize this	See attachment, "Amerigroup Evidentiary Standards"

CONCURRENT REVIEW REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	determine medical necessity using Amerigroup Medical Policy and Amerigroup Clinical UM guidelines. - The authorization is completed in accordance with NCQA timeframes. 3) If the reviewing clinician determines medical necessity is met, requestor is notified and provided a reference number. 4) If the reviewing clinician determines medical necessity criteria is NOT met, outreach is made to the requestor for additional supporting clinical information. 5) If the reviewing clinician determines medical necessity criteria is still NOT met, the request is sent to Medical Director review to determine if medical necessity is	process to enhance consistency in reviewing cases by providing a framework for clinical decision making. This process ensures compliance with local, state, and federal requirements, as well as accreditation bodies, i.e., NCQA. The goals of the concurrent review process are to ensure adequacy of service availability and accessibility to eligible members; to maximize appropriate medical and behavioral health care; and to minimize/eliminate over-and/or under-utilization of medical and behavioral health care. See Precertification		necessity using InterQual® Level of Care, Amerigroup Medical Policy, and Amerigroup Clinical UM guidelines. - The authorization is completed in accordance with NCQA timeframes. 3) If the reviewing clinician determines medical necessity is met, requestor is notified and provided a reference number. 4) If the reviewing clinician determines medical necessity criteria is NOT met, outreach is made to the requestor for additional supporting clinical information. 5) If the reviewing clinician determines medical necessity criteria is still NOT met, the request is sent to Medical Director review to determine if medical necessity is	process to enhance consistency in reviewing cases by providing a framework for clinical decision making. This process ensures compliance with local, state, and federal requirements, as well as accreditation bodies, i.e., NCQA. The goals of the concurrent review process are to ensure adequacy of service availability and accessibility to eligible members; to maximize appropriate medical and behavioral health care; and to minimize/eliminate over-and/or under-utilization of medical and behavioral health care. See Precertification	

CONCURRENT REVIEW REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	met. 6) The reviewing clinician notifies the requestor of the determination following Medical Director Review. 7) Upon final determination of the request, member and/or provider notification is provided based on State and Federal Requirements as well as NCQA requirements.	Committee policy		met. 6) The reviewing clinician notifies the requestor of the determination following Medical Director Review. 7) Upon final determination of the request, member and/or provider notification is provided based on State and Federal Requirements as well as NCQA requirements.	Committee policy	
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	Comparability: The processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable to M/S benefits as applicable to the concurrent review process. Stringency: The processes, strategies, and evidentiary standards applied to M/S benefits are not more stringently applied to MH/SUD benefits.					

CONCURRENT REVIEW REQUIREMENTS – INPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**	**Medical/Surgical Services**
Evaluation of Processes, Strategies, and Evidentiary Standards	**If concurrent review requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of concurrent review is in parity. No additional information is needed.** **If concurrent review requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of concurrent review is not in parity. Proceed to the following row.**	
Modifications Explain how concurrent review processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A	

NQTL Analysis Module 2: Concurrent Review – OUTPATIENT SERVICES

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<tr><th>CONCURRENT REVIEW REQUIREMENTS – OUTPATIENT SERVICES</th><th colspan="3">Mental Health/Substance Use Disorder Services</th><th colspan="3">Medical/Surgical Services</th></tr>
<tr><td>List all outpatient benefits requiring concurrent review.</td><td colspan="3">Mental Health (MH) Services
• Applied Behavioral Analysis (ABA)
• Electroconvulsive Therapy (ECT)
• Intensive Community Based Treatment
• Intensive Outpatient (IOP)
• Partial Hospitalization (PHP)
• Psychological Testing
• Supported Housing
• Transcranial Magnetic Stimulation (TMS)

Substance Use Disorders (SUD) Services
• Ambulatory Detoxification
• Intensive Outpatient
• Partial Hospitalization</td><td colspan="3">• Auditory Surgery
• Cardiac Rehab- outpatient
• Dental Services (under age of 21)
• ENT (Otolaryngology) Surgery
• Genetic Testing
• Gynecology Surgery
• Hematology
• Home Health Aide
• Home Health Skilled Nursing
• Home Health Therapy
• Home Infusion
• Hospice
• Interventional Cardiology
• LTSS services
• Medical Injectables
• Nephrology
• Neurology
• OON services
• Ophthalmology Surgery
• Oral Maxillofacial
• Organ/Tissue Transplant and Donor Organ
• Pain Management
• Plastic/Cosmetic/Reconstructive Surgery
• Private Duty Nursing
• Prosthetics/Orthotics
• Radiation Therapy
• Radiology/Imaging
• Rehab Therapy (PT/ST/OT)
• Sleep Study
• Urology Services
• Vision Services (under age of 21)</td></tr>
<tr><td>Processes, Strategies, and Evidentiary Standards</td><td>Processes:
Explain the process, both in writing and in practice, for concurrent review that your MCO uses.</td><td>Strategies:
WHY does your MCO require concurrent review for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?</td><td>Evidentiary Standards:
What evidence supports the use of concurrent review for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.</td><td>Processes:
Explain the process, both in writing and in practice, for concurrent review that your MCO uses.</td><td>Strategies:
WHY does your MCO require concurrent review for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?</td><td>Evidentiary Standards:
What evidence supports the use of concurrent review for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.</td></tr>
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CONCURRENT REVIEW REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	All MH/SUD outpatient benefits that require concurrent review are: 1) Submitted by the provider to AGP through an online portal, fax or verbally. 2) AGP licensed clinician reviews submitted clinical to determine medical necessity using Amerigroup Medical Policy and Amerigroup Clinical UM guidelines. The authorization is completed in accordance with NCQA timeframes. 3) If the reviewing clinician determines medical necessity is met, requestor is notified and provided a reference number. 4) If the reviewing clinician	The purpose of the concurrent review process is to assist the Health Plan in ensuring that eligible members continue to receive the most clinically appropriate care and services in the most efficient manner possible. We utilize this process to enhance consistency in reviewing cases by providing a framework for clinical decision making. This process ensures compliance with local, state, and federal requirements, as well as accreditation bodies, i.e., NCQA. The goals of the concurrent review process are to ensure adequacy of service availability	See attachment, "Amerigroup Evidentiary Standards"	All M/S outpatient benefits that require concurrent review are: 1) Submitted by the provider to AGP through an online portal, fax or verbally. 2) AGP licensed clinician reviews submitted clinical to determine medical necessity using TennCare Rules, InterQual® Level of Care, Amerigroup Medical Policy, and Amerigroup Clinical UM guidelines. The authorization is completed in accordance with NCQA timeframes. 3) If the reviewing clinician determines medical necessity is met, requestor is notified and provided a reference number. 4) If the reviewing	The purpose of the concurrent review process is to assist the Health Plan in ensuring that eligible members continue to receive the most clinically appropriate care and services in the most efficient manner possible. We utilize this process to enhance consistency in reviewing cases by providing a framework for clinical decision making. This process ensures compliance with local, state, and federal requirements, as well as accreditation bodies, i.e., NCQA. The goals of the concurrent review process are to ensure adequacy of service availability	See attachment, "Amerigroup Evidentiary Standards"

CONCURRENT REVIEW REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	determines medical necessity criteria is NOT met, outreach is made to the requestor for additional supporting clinical information. 5) If the reviewing clinician determines medical necessity criteria is still NOT met, the request is sent to Medical Director review to determine if medical necessity is met. 6) The reviewing clinician notifies the requestor of the determination following Medical Director Review. 7) Upon final determination of the request, member and/or provider notification is provided based on State and Federal Requirements as well as NCQA	and accessibility to eligible members; to maximize appropriate medical and behavioral health care; and to minimize/eliminate over-and/or under-utilization of medical and behavioral health care. See Precertification Committee policy		clinician determines medical necessity criteria is NOT met, outreach is made to the requestor for additional supporting clinical information. 5) If the reviewing clinician determines medical necessity criteria is still NOT met, the request is sent to Medical Director review to determine if medical necessity is met. 6) The reviewing clinician notifies the requestor of the determination following Medical Director Review. 7) Upon final determination of the request, member and/or provider notification is provided based on State and Federal Requirements as	and accessibility to eligible members; to maximize appropriate medical and behavioral health care; and to minimize/eliminate over-and/or under-utilization of medical and behavioral health care *LTSS services are delivered in accordance with TennCare program requirements, member's qualifying need, and Person Centered Support Plan. See Precertification Committee policy	

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<tr><th>CONCURRENT REVIEW REQUIREMENTS – OUTPATIENT SERVICES</th><th colspan="3">Mental Health/Substance Use Disorder Services</th><th colspan="3">Medical/Surgical Services</th></tr>
<tr><td></td><td>requirements.</td><td></td><td></td><td>well as NCQA requirements.</td><td></td><td></td></tr>
<tr><td>Comparability and Stringency

Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied to M/S benefits.</td><td colspan="6">Comparability:
The processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable to M/S benefits as applicable to the concurrent review process.

Stringency:
The processes, strategies, and evidentiary standards applied to M/S benefits are not more stringently applied to MH/SUD benefits.</td></tr>
<tr><td>Evaluation of Processes, Strategies, and Evidentiary Standards</td><td colspan="6">If concurrent review requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of concurrent review is in parity. No additional information is needed.

If concurrent review requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of concurrent review is not in parity. Proceed to the following row.</td></tr>
</table>

CONCURRENT REVIEW REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Modifications Explain how concurrent review processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A	

NQTL Analysis Module 2: Concurrent Review – EMERGENCY SERVICES

CONCURRENT REVIEW REQUIREMENTS – EMERGENCY SERVICES	**Mental Health/Substance Use Disorder Services**			**Medical/Surgical Services**		
List all emergency benefits requiring concurrent review.	N/A – Prior authorization is not required for emergency services.			N/A – Prior authorization is not required for emergency services.		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for concurrent review that your MCO uses.	**Strategies:** WHY does your MCO require concurrent review for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of concurrent review for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for concurrent review that your MCO uses.	**Strategies:** WHY does your MCO require concurrent review for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of concurrent review for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.
	Authorization is not required for Emergency Services	N/A	See attachment, "Amerigroup Evidentiary Standards"	Authorization is not required for Emergency Services	N/A	See attachment, "Amerigroup Evidentiary Standards"

CONCURRENT REVIEW REQUIREMENTS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	Comparability: The processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable to M/S benefits as applicable emergency services. Stringency: The processes, strategies, and evidentiary standards applied to M/S benefits are not more stringently applied to MH/SUD benefits.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If concurrent review requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of concurrent review is in parity. No additional information is needed.** **If concurrent review requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of concurrent review is not in parity. Proceed to the following row.**	
Modifications Explain how concurrent review processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A	

NQTL Analysis Module 3: Medical Necessity – INPATIENT SERVICES

MEDICAL NECESSITY REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
What criteria are applied to make medical necessity/ appropriateness determinations for inpatient services?	The Behavioral Health Utilization Management (UM) Program primarily utilizes TennCare medical necessity rules 1200-13-16, Amerigroup Medical Policies, and Amerigroup Clinical Utilization Management Guidelines for behavioral health services.			Amerigroup, Tennessee primarily utilizes TennCare medical necessity rules 1200-13-16, current editions of InterQual® Level of Care criteria, Amerigroup Medical Policies, and Amerigroup Clinical Utilization Management Guidelines to review the medical necessity and appropriateness of physical health services.		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process your MCO uses, both in writing and in practice, for determining medical necessity.	**Strategies:** WHY does your MCO use the process described?	**Evidentiary Standards:** What evidence supports your MCO's MN criteria and processes for determining MN? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process your MCO uses, both in writing and in practice, for determining medical necessity.	**Strategies:** WHY does your MCO use the process described?	**Evidentiary Standards:** What evidence supports your MCO's MN criteria and processes for determining MN? Evidence may include practice guidelines and internal health plan utilization data.

MEDICAL NECESSITY REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	Amerigroup, TN utilizes the TennCare medical necessity rules 1200-13-16 and criteria in Tennessee Code Annotated (TCA) 71-5-144 in making medical necessity decisions in addition to the use of nationally recognized medical criteria to help ensure medically necessary health services are available to members. These include services that are: 1) Reasonable and necessary to prevent illnesses or medical conditions or provide early screening, interventions or treatments for conditions that cause suffering or pain, physical deformity or limitations in function, threaten	Medical Necessity criteria utilized by Amerigroup, TN provide a rules-based system for screening proposed medical/behavioral health care based on patient-specific, best health care processes and consistently match medical/behavioral services to patient needs, based upon clinical appropriateness.	Annually, the Anthem Medical Policy & Technology Assessment Committee (MPTAC) reviews all criteria used to determine medical necessity coverage decisions. The committee reviews the criteria more frequently if a new version of the criteria is published before the annual review date. Once the criteria are approved by the Corporate MPTAC, the criteria are reviewed, discussed and approved by the Amerigroup Medical Advisory Committee (MAC), which includes members who are actively practicing clinicians with relevant professional knowledge and clinical expertise: 1) In the event the Amerigroup, TN MAC identifies	Amerigroup, TN utilizes the TennCare medical necessity rules 1200-13-16 and criteria in Tennessee Code Annotated (TCA) 71-5-144 in making medical necessity decisions in addition to the use of nationally recognized medical criteria to help ensure medically necessary health services are available to members. These include services that are: 1) Reasonable and necessary to prevent illnesses or medical conditions or provide early screening, interventions or treatments for conditions that cause suffering or pain, physical deformity or limitations in function, threaten	Medical Necessity criteria utilized by Amerigroup, TN provide a rules-based system for screening proposed medical/behavioral health care based on patient-specific, best health care processes and consistently match medical/behavioral services to patient needs, based upon clinical appropriateness.	Annually, the Anthem Medical Policy & Technology Assessment Committee (MPTAC) reviews all criteria used to determine medical necessity coverage decisions. The committee reviews the criteria more frequently if a new version of the criteria is published before the annual review date. Once the criteria are approved by the Corporate MPTAC, the criteria are reviewed, discussed and approved by the Amerigroup Medical Advisory Committee (MAC), which includes members who are actively practicing clinicians with relevant professional knowledge and clinical expertise. 1) In the event the Amerigroup, TN MAC identifies

MEDICAL NECESSITY REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	to cause or worsen handicap, cause illness or infirmity of a member or endanger life. 2) Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's medical condition. 3) Consistent with health care practice guidelines and standards that are issued by professionally recognized health care organizations or governmental agencies. 4) Consistent with the diagnoses of the conditions. 5) No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness and efficiency. The Behavioral Health UM Program		issue(s) with the criteria, to the extent that approval of the criteria is deferred until clarification is obtained, the Regional Vice President Medical Director (RVPMD) or designee communicates the identified issue(s) to the Chair of the Corporate MPTAC. 2) Once the identified issue(s) is addressed by the MPTAC, the resolution of the issue is communicated to the Amerigroup TN MAC members and a vote occurs.	to cause or worsen handicap, cause illness or infirmity of a member or endanger life. 2) Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's medical condition. 3) Consistent with health care practice guidelines and standards that are issued by professionally recognized health care organizations or governmental agencies. 4) Consistent with the diagnoses of the conditions. 5) No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness and efficiency. Amerigroup utilizes InterQual® Level of Care criteria along		issue(s) with the criteria, to the extent that approval of the criteria is deferred until clarification is obtained, the Regional Vice President Medical Director (RVPMD) or designee communicates the identified issue(s) to the Chair of the Corporate MPTAC. 2) Once the identified issue(s) is addressed by the MPTAC, the resolution of the issue is communicated to the Amerigroup TN MAC members and a vote occurs.

MEDICAL NECESSITY REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	primarily utilizes Amerigroup Medical Policies and Amerigroup Clinical Utilization Management Guidelines for behavioral health services unless superseded by state requirements or regulatory guidance. Amerigroup, TN follows established procedures for applying medical necessity criteria based on individual member needs and standards of care for medical and behavioral health services. These procedures apply to prior authorization, concurrent and retrospective reviews.			with Amerigroup Medical Policies and Amerigroup Clinical Utilization Management Guidelines to review the medical necessity and appropriateness of physical health services, unless superseded by state requirements or regulatory guidance. Amerigroup, TN follows established procedures for applying medical necessity criteria based on individual member needs and standards of care for medical and behavioral health services. These procedures apply to prior authorization, concurrent and retrospective reviews.		

MEDICAL NECESSITY REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	Comparability: The processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable to M/S benefits as applicable to medical necessity. Stringency: The processes, strategies, and evidentiary standards applied to M/S benefits are not more stringently applied to MH/SUD benefits.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If medical necessity requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of medical necessity is in parity. No additional information is needed.** **If medical necessity requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of medical necessity is not in parity. Proceed to the following row.**	
Modifications Explain how medical necessity processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A	

NQTL Analysis Module 3: Medical Necessity – OUTPATIENT SERVICES

MEDICAL NECESSITY REQUIREMENTS – OUTPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**			**Medical/Surgical Services**		
What criteria are applied to make medical necessity/ appropriateness determinations for outpatient services?	The Behavioral Health Utilization Management (UM) Program primarily utilizes TennCare medical necessity rules 1200-13-16, Amerigroup Medical Policies, and Amerigroup Clinical Utilization Management (UM) Guidelines for behavioral health services.			Amerigroup, Tennessee primarily utilizes TennCare medical necessity rules 1200-13-16, Amerigroup Medical Policies, and Amerigroup Clinical Utilization Management (UM) Guidelines to review the medical necessity and appropriateness of physical health services		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process your MCO uses, both in writing and in practice, for determining medical necessity.	**Strategies:** WHY does your MCO use the process described?	**Evidentiary Standards:** What evidence supports your MCO's MN criteria and processes for determining MN? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process your MCO uses, both in writing and in practice, for determining medical necessity.	**Strategies:** WHY does your MCO use the process described?	**Evidentiary Standards:** What evidence supports your MCO's MN criteria and processes for determining MN? Evidence may include practice guidelines and internal health plan utilization data.

MEDICAL NECESSITY REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	Amerigroup, TN utilizes the TennCare medical necessity rules 1200-13-16 and criteria in Tennessee Code Annotated (TCA) 71-5-144 in making medical necessity decisions in addition to the use of nationally recognized medical criteria to help ensure medically necessary health services are available to members. These include services that are: 1) Reasonable and necessary to prevent illnesses or medical conditions or provide early screening, interventions or treatments for conditions that cause suffering or pain, physical deformity or limitations in function, threaten to	Medical Necessity criteria utilized by Amerigroup, TN provide a rules-based system for screening proposed medical/behavioral health care based on patient-specific, best health care processes and consistently match medical/behavioral services to patient needs, based upon clinical appropriateness.	Annually, the Anthem Medical Policy & Technology Assessment Committee (MPTAC) reviews all criteria used to determine medical necessity coverage decisions. The committee reviews the criteria more frequently if a new version of the criteria is published before the annual review date. Once the criteria are approved by the Corporate MPTAC, the criteria are reviewed, discussed and approved by the Amerigroup Medical Advisory Committee (MAC), which includes members who are actively practicing clinicians with relevant professional knowledge and clinical expertise. 1) In the event the Amerigroup, TN MAC identifies	Amerigroup, TN utilizes the TennCare medical necessity rules 1200-13-16 and criteria in Tennessee Code Annotated (TCA) 71-5-144 in making medical necessity decisions in addition to the use of nationally recognized medical criteria to help ensure medically necessary health services are available to members. These include services that are: 1) Reasonable and necessary to prevent illnesses or medical conditions or provide early screening, interventions or treatments for conditions that cause suffering or pain, physical deformity or limitations in function, threaten to	Medical Necessity criteria utilized by Amerigroup, TN provide a rules-based system for screening proposed medical/behavioral health care based on patient-specific, best health care processes and consistently match medical/behavioral services to patient needs, based upon clinical appropriateness.	Annually, the Anthem Medical Policy & Technology Assessment Committee (MPTAC) reviews all criteria used to determine medical necessity coverage decisions. The committee reviews the criteria more frequently if a new version of the criteria is published before the annual review date. Once the criteria are approved by the Corporate MPTAC, the criteria are reviewed, discussed and approved by the Amerigroup Medical Advisory Committee (MAC), which includes members who are actively practicing clinicians with relevant professional knowledge and clinical expertise. 1) In the event the Amerigroup, TN MAC identifies

MEDICAL NECESSITY REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	cause or worsen handicap, cause illness or infirmity of a member or endanger life. 2) Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's medical condition. 3) Consistent with health care practice guidelines and standards that are issued by professionally recognized health care organizations or governmental agencies. 4) Consistent with the diagnoses of the conditions. 5) No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness and efficiency. The Behavioral Health UM Program		issue(s) with the criteria, to the extent that approval of the criteria is deferred until clarification is obtained, the Regional Vice President Medical Director (RVPMD) or designee communicates the identified issue(s) to the Chair of the Corporate MPTAC. 2) Once the identified issue(s) is addressed by the MPTAC, the resolution of the issue is communicated to the Amerigroup TN MAC members and a vote occurs.	cause or worsen handicap, cause illness or infirmity of a member or endanger life. 2) Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's medical condition. 3) Consistent with health care practice guidelines and standards that are issued by professionally recognized health care organizations or governmental agencies. 4) Consistent with the diagnoses of the conditions. 5) No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness and efficiency. Amerigroup utilizes InterQual® Level of		issue(s) with the criteria, to the extent that approval of the criteria is deferred until clarification is obtained, the Regional Vice President Medical Director (RVPMD) or designee communicates the identified issue(s) to the Chair of the Corporate MPTAC. 2) Once the identified issue(s) is addressed by the MPTAC, the resolution of the issue is communicated to the Amerigroup TN MAC members and a vote occurs.

MEDICAL NECESSITY REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	primarily utilizes Amerigroup Medical Policies and Amerigroup Clinical Utilization Management Guidelines for behavioral health services unless superseded by state requirements or regulatory guidance. Amerigroup, TN follows established procedures for applying medical necessity criteria based on individual member needs and standards of care for medical and behavioral health services. These procedures apply to prior authorization, concurrent and retrospective reviews.			Care criteria along with Amerigroup Medical Policies and Amerigroup Clinical Utilization Management Guidelines to review the medical necessity and appropriateness of physical health services, unless superseded by state requirements or regulatory guidance. Amerigroup, TN follows established procedures for applying medical necessity criteria based on individual member needs and standards of care for medical and behavioral health services. These procedures apply to prior authorization, concurrent and retrospective reviews.		

MEDICAL NECESSITY REQUIREMENTS – OUTPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**	**Medical/Surgical Services**
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	Comparability: The processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable to M/S benefits as applicable to medical necessity. Stringency: The processes, strategies, and evidentiary standards applied to M/S benefits are not more stringently applied to MH/SUD benefits.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If medical necessity requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of medical necessity is in parity. No additional information is needed.** **If medical necessity requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of medical necessity is not in parity. Proceed to the following row.**	
Modifications Explain how medical necessity processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A	

NQTL Analysis Module 3: Medical Necessity – EMERGENCY SERVICES

MEDICAL NECESSITY REQUIREMENTS – EMERGENCY SERVICES	**Mental Health/Substance Use Disorder Services**			**Medical/Surgical Services**		
What criteria are applied to make medical necessity/ appropriateness determinations for emergency services?	No authorization/ medical necessity criteria application occurs for MH/SUD emergency services.			No authorization/ medical necessity criteria application occurs for M/S emergency services.		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process your MCO uses, both in writing and in practice, for determining medical necessity.	**Strategies:** WHY does your MCO use the process described?	**Evidentiary Standards:** What evidence supports your MCO's MN criteria and processes for determining MN? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process your MCO uses, both in writing and in practice, for determining medical necessity.	**Strategies:** WHY does your MCO use the process described?	**Evidentiary Standards:** What evidence supports your MCO's MN criteria and processes for determining MN? Evidence may include practice guidelines and internal health plan utilization data.
	Medical Necessity Review is not required for Emergencies.	Medical Necessity Review is not required for Emergencies.	Medical Necessity Review is not required for Emergencies.	Medical Necessity Review is not required for Emergencies.	Medical Necessity Review is not required for Emergencies.	Medical Necessity Review is not required for Emergencies.

MEDICAL NECESSITY REQUIREMENTS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	Comparability: The processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable to M/S benefits as applicable to emergency services. Stringency: The processes, strategies, and evidentiary standards applied to M/S benefits are not more stringently applied to MH/SUD benefits.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If medical necessity requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of medical necessity is in parity. No additional information is needed.** **If medical necessity requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of medical necessity is not in parity. Proceed to the following row.**	
Modifications Explain how medical necessity processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A	

NQTL Analysis Module 4: Fail First and Step Therapy Protocols – INPATIENT SERVICES

<table>
<tr><th>FAIL FIRST AND STEP THERAPY PROTOCOLS – INPATIENT SERVICES</th><th colspan="3">Mental Health/Substance Use Disorder Services</th><th colspan="3">Medical/Surgical Services</th></tr>
<tr><td>Does the plan apply “fail first” requirements or step therapy protocols? List the inpatient services to which these requirements apply.</td><td colspan="3">Yes, but not obligatory.

• Electroconvulsive Therapy (ECT)</td><td colspan="3">Yes.

• Abdominal Hysterectomy
• Bariatric Surgery
• Hip Joint Replacement
• Laminectomy
• Orthopedic Joint Replacement
• Orthopedic Joint Arthroscopy
• Panniculectomy & Abdominoplasty
• Reduction Mammoplasty
• Spinal Surgery</td></tr>
<tr><td>Processes, Strategies, and Evidentiary Standards</td><td>Processes:
Explain the process, both in writing and in practice, for fail first and/or step therapy protocols that your MCO uses.</td><td>Strategies:
WHY does your MCO use fail first or step therapy requirements f or these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?</td><td>Evidentiary Standards:
What evidence supports the use of fail first or step therapy for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.</td><td>Processes:
Explain the process, both in writing and in practice, for fail first and/or step therapy protocols that your MCO uses.</td><td>Strategies:
WHY does your MCO use fail first or step therapy requirements f or these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?</td><td>Evidentiary Standards:
What evidence supports the use of fail first or step therapy for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.</td></tr>
</table>

FAIL FIRST AND STEP THERAPY PROTOCOLS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	Prior authorization request process for ECT is the following: 1) Submitted by the provider to AGP through an online portal, fax or verbally. 2) AGP licensed clinician reviews submitted clinical to determine medical necessity using Amerigroup Medical Policy and Amerigroup Clinical UM guidelines. The authorization is completed in accordance with NCQA timeframes. 3) If the reviewing clinician determines medical necessity is met, requestor is notified and provided a reference number. 4) If the reviewing clinician determines medical necessity criteria is NOT met, outreach is made to the	Amerigroup applies fail first methodology to ensure the safest and most cost effective therapy that will treat the member's condition is utilized first. Progression to other more risky and costly treatments is used only if necessary.	Amerigroup Clinical UM Guideline CG-BEH-03.	Prior authorization request process for specific planned M/S inpatient services incorporating fail first criteria: 1) Submitted by the provider to AGP through an online portal, fax or verbally. 2) AGP licensed clinician reviews submitted clinical to include fail first criteria to determine medical necessity using Amerigroup Medical Policy and Amerigroup Clinical UM guidelines. The authorization is completed in accordance with NCQA timeframes. 3) If the reviewing clinician determined medical necessity is met, requestor is notified and provided a reference number. 4) If the reviewing	Amerigroup applies fail first methodology to ensure the safest and most cost effective therapy that will treat the member's condition is utilized first. Progression to other more risky and costly treatments is used only if necessary	Amerigroup maintains Amerigroup Medical Policies and Amerigroup Clinical UM Guidelines to address the above listed services. See attachment, Amerigroup Medical Policies and Amerigroup UM Clinical Guidelines, for complete listing of specific Amerigroup Medical Policies and Amerigroup UM Clinical Guidelines.

FAIL FIRST AND STEP THERAPY PROTOCOLS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	requestor for additional supporting clinical information. 5) If the reviewing clinician determines medical necessity criteria is still NOT met, the request is sent to Medical Director Review to determine if medical necessity is met. 6) The reviewing clinician notifies the requestor of the determination following Medical Director Review. 7) Upon final determination of the request, member and/or provider notification is provided based on State and Federal Requirements as well as NCQA requirements. After initial inpatient admission is approved,			clinician determines medical necessity criteria is NOT met, outreach is made to the requestor for additional supporting clinical information. 5) If the reviewing clinician determines medical necessity criteria is still NOT met, the request is sent to Medical Director Review to determine if medical necessity is met. 6) The reviewing clinician notifies the requestor of the determination following Medical Director Review. 7) Upon final determination of the request, member and/or provider notification is provided based on State and Federal Requirements as well as NCQA requirements.		

FAIL FIRST AND STEP THERAPY PROTOCOLS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	concurrent reviews will occur as applicable. For involuntary hospitalization, medical necessity is not applied for the first twenty-four (24) hours. (Certificate of Need for Emergency Involuntary Admission Title 33, Chapter 6, Part 4, Tennessee Code Annotated)			After initial inpatient admission is approved, concurrent reviews will occur as applicable.		
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	Comparability: The processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable to M/S benefits as applicable to the fail first/step therapy. There is a higher volume of M/S benefits for which we apply fail first/step therapy criteria. Stringency: The processes, strategies, and evidentiary standards applied to M/S benefits are not more stringently applied to MH/SUD benefits.					
Evaluation of Processes, Strategies, and Evidentiary Standards	**If fail first/step therapy requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of these requirements is in parity. No additional information is needed.** **If fail first/step therapy requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of these requirements is not in parity. Proceed to the following row.**					

FAIL FIRST AND STEP THERAPY PROTOCOLS – INPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**	**Medical/Surgical Services**
Modifications Explain how fail first or step therapy requirements for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A	

NQTL Analysis Module 4: Fail First and Step Therapy Protocols – OUTPATIENT SERVICES

FAIL FIRST AND STEP THERAPY PROTOCOLS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
Does the plan apply "fail first" requirements or step therapy protocols? List the outpatient services to which these requirements apply.	Yes. • Electroconvulsive Therapy (ECT) • Transcranial Magnetic Stimulation (TMS)			Yes. • Automatic Internal Cardiac Defibrillator • Cardiac Rehab • Cochlear Implants • Electromyography and Nerve Conduction Study • Endovascular Procedures • ENT • Genitourinary – Sacral Nerve Stimulator Implant • GYN Surgery (Endometrial ablation) • Home Enteral Nutrition • Neurological/Seizure Disorder – Vagus Nerve • Pain Management • Stimulator Implant • Temporomandibular Disorders • Vascular Sclerotherapy		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for fail first and/or step therapy protocols that your MCO uses.	**Strategies:** WHY does your MCO use fail first or step therapy requirements f or these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of fail first or step therapy for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for fail first and/or step therapy protocols that your MCO uses.	**Strategies:** WHY does your MCO use fail first or step therapy requirements f or these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of fail first or step therapy for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.
	Prior authorization request process for ECT is the following: 1) Submitted by the provider to AGP through an online portal, fax or	Amerigroup applies fail first methodology to ensure the safest and most cost effective therapy that will treat the member's condition	ECT: Amerigroup Clinical UM Guideline CG-BEH-03. TMS: Amerigroup Medical Policy BEH.00002	Prior authorization request process for specific M/S outpatient services incorporating fail first criteria: 1) Submitted by the	Amerigroup applies fail first methodology to ensure the safest and most cost effective therapy that will treat the member's condition	Amerigroup maintains Amerigroup Medical Policies and Amerigroup Clinical UM Guidelines to address the above

FAIL FIRST AND STEP THERAPY PROTOCOLS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	verbally. 2) AGP licensed clinician reviews submitted clinical to determine medical necessity using Amerigroup Medical Policy and Amerigroup Clinical UM guidelines. The authorization is completed in accordance with NCQA timeframes. 3) If the reviewing clinician determines medical necessity is met, requestor is notified and provided a reference number. 4) If the reviewing clinician determines medical necessity criteria is NOT met, outreach is made to the requestor for additional supporting clinical information. 5) If the reviewing clinician determines medical necessity criteria is still NOT met, the request is sent to Medical Director Review to	is utilized first. Progression to other more risky and costly treatments is used only if necessary.		provider to AGP through an online portal, fax or verbally. 2) AGP licensed clinician reviews submitted clinical to include fail first criteria to determine medical necessity using Amerigroup Medical Policy and Amerigroup Clinical UM guidelines. The authorization is completed in accordance with NCQA timeframes. 3) If the reviewing clinician determines medical necessity is met, requestor is notified and provided a reference number. 4) If the reviewing clinician determines medical necessity criteria is NOT met, outreach is made to the	is utilized first. Progression to other more risky and costly treatments is used only if necessary.	listed services. See attachment, Amerigroup Medical Policies and Amerigroup UM Clinical Guidelines, for complete listing of specific Amerigroup Medical Policies and Amerigroup UM Clinical Guidelines.

FAIL FIRST AND STEP THERAPY PROTOCOLS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	determine if medical necessity is met. 6) The reviewing clinician notifies the requestor of the determination following Medical Director Review. 7) Upon final determination of the request, member and/or provider notification is provided based on State and Federal Requirements as well as NCQA requirements.			requestor for additional supporting clinical information. 5) If the reviewing clinician determines medical necessity criteria is still NOT met, the request is sent to Medical Director Review to determine if medical necessity is met. 6) The reviewing clinician notifies the requestor of the determination following Medical Director Review. 7) Upon final determination of the request, member and/or provider notification is provided based on State and Federal Requirements as well as NCQA requirements.		

FAIL FIRST AND STEP THERAPY PROTOCOLS – OUTPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**	**Medical/Surgical Services**
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	Comparability: The processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable to M/S benefits as applicable to the fail first/step therapy. There is a higher volume of M/S benefits for which we apply fail first/step therapy criteria. Stringency: The processes, strategies, and evidentiary standards applied to M/S benefits are not more stringently applied to MH/SUD benefits.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If fail first/step therapy requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of these requirements is in parity. No additional information is needed.** **If fail first/step therapy requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of these requirements is not in parity. Proceed to the following row.**	
Modifications Explain how fail first or step therapy requirements for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A	

NQTL Analysis Module 4: Fail First and Step Therapy Protocols – EMERGENCY SERVICES

FAIL FIRST AND STEP THERAPY PROTOCOLS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
Does the plan apply "fail first" requirements or step therapy protocols? List the emergency services to which these requirements apply.	No. Prior authorization is not required for emergency services.			No. Prior authorization is not required for emergency services.		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for fail first and/or step therapy protocols that your MCO uses.	**Strategies:** WHY does your MCO use fail first or step therapy requirements f or these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of fail first or step therapy for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for fail first and/or step therapy protocols that your MCO uses.	**Strategies:** WHY does your MCO use fail first or step therapy requirements f or these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of fail first or step therapy for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.
	Authorization is not required for emergency services.	N/A	See attachment, "Amerigroup Evidentiary Standards"	Authorization is not required for emergency services.	N/A	See attachment, "Amerigroup Evidentiary Standards"

FAIL FIRST AND STEP THERAPY PROTOCOLS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	Comparability: The processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable to M/S benefits as applicable to the fail first/step therapy. Stringency: The processes, strategies, and evidentiary standards applied to M/S benefits are not more stringently applied to MH/SUD benefits.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If fail first/step therapy requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of these requirements is in parity. No additional information is needed.** **If fail first/step therapy requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of these requirements is not in parity. Proceed to the following row.**	
Modifications Explain how fail first or step therapy requirements for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A	

NQTL Analysis Module 5: Network Standards – INPATIENT SERVICES

NETWORK STANDARDS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
What are the plan's network admission requirements for inpatient providers?	Monthly the health plan reviews OPEN/CLOSED specialties (facility/non-facility) per county. If the health plan receives an application (via webportal) request from an Out-of-Network (OON) inpatient provider for a county in which it is OPEN, then our Provider Relations Team will send an application/contract package to begin the in-network process. Provider must meet all credentialing requirements (in accordance with NCQA and state/TennCare requirements), and sign a contract agreeing to all Amerigroup/TennCare policies/regulations and rates.	Monthly the health plan reviews OPEN/CLOSED specialties (facility/non-facility) per county. If the health plan receives an application (via webportal) request from an Out-of-Network (OON) inpatient provider for a county in which it is OPEN, then our Provider Relations Team will send an application/contract package to begin the in-network process. Provider must meet all credentialing requirements (in accordance with NCQA and state/TennCare requirements), and sign a contract agreeing to all Amerigroup/TennCare policies/regulations and rates.
Are there any geographic limitations on provider inclusion in the network (e.g., requirements for accessing out-of-state providers)? If so, describe these limitations.	There are no geographic limitations to add a non-participating provider to our network. We allow Out-of-State providers (OOS) to join our network that are located in states conjoining Tennessee borders.	There are no geographic limitations to add a non-participating provider to our network. We allow Out-of-State providers (OOS) to join our network that are located in states conjoining Tennessee borders.
Describe the criteria applied in determining standards for access to out-of-network providers.	If no in-network provider is available to provide the medically appropriate care or if the member meets continuity of care criteria, Amerigroup will enter an authorization to approve out of network care.	If no in-network provider is available to provide the medically appropriate care or if the member meets continuity of care criteria, Amerigroup will enter an authorization to approve out of network care.

NETWORK STANDARDS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
What methods are used to determine usual, customary, and reasonable charges?	Amerigroup uses the following methods that are in compliance with the TennCare Contract Risk Agreement (CRA) A.2.13.2 as follows: We do not reimburse a percentage of billed charges unless there is no Medicare (CMS) reimbursement methodology. Therefore we use CMS methodologies (with no auto escalators) as primary source. Other methodology options are per diem, case rates and state mandated rates.			Amerigroup uses the following methods that are in compliance with the TennCare Contract Risk Agreement (CRA) A.2.13.2 as follows: We do not reimburse a percentage of billed charges unless there is no Medicare (CMS) reimbursement methodology. Therefore we use CMS methodologies (with no auto escalators) as primary source. Other methodology options are per diem, case rates and state mandated rates.		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for setting and implementing network admission standards.	**Strategies:** WHY does your MCO use these processes and standards? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of these processes and standards? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for setting and implementing network admission standards.	**Strategies:** WHY does your MCO use these processes and standards? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of these processes and standards? Evidence may include practice guidelines and internal health plan utilization data.
	Out-of-Network (OON) providers must submit a request to join the network via Amerigroup webportal. Provider Relations Team must check the “Network Grid” to see if we are accepting the inpatient providers in the county that is being requested. If yes, then the Provider Relations Team sends the OON provider an application and contract package to	The reason we require OON providers to submit a request via webportal is because it gives us the ability/flexibility to track our responses to ensure we’re responding to all requests timely and it’s easier to track (online data base) all requests for future recruitment efforts if we need to add providers to the network at a later date to meet	1) Network Grid is based on network adequacy and clinical needs. 2) Rates are based primarily in accordance with CMS methodologies, state mandates and/or other industry standard methodologies, i.e. case rates or per diems. 3) The credentialing is in accordance with NCQA and state requirements.	Out-of-Network (OON) providers must submit a request to join the network via Amerigroup webportal. Provider Relations Team must check the “Network Grid” to see if we are accepting the inpatient providers in the county that is being requested. If yes, then the Provider Relations Team sends the OON provider an application and contract package to	The reason we require OON providers to submit a request via webportal is because it gives us the ability/flexibility to track our responses to ensure we’re responding to all requests timely and it’s easier to track (online data base) all requests for future recruitment efforts if we need to add providers to the network at a later date to meet	1) Network Grid is based on network adequacy and clinical needs. 2) Rates are based primarily in accordance with CMS methodologies, state mandates and/or other industry standard methodologies, i.e. case rates or per diems. 3) The credentialing is in accordance with NCQA and state requirements.

NETWORK STANDARDS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	complete. Provider must complete package in its entirety. Provider must meet all credentialing requirements (i.e. licensures, accreditations, certifications, attestations, Disclosures, liability coverage, sanctions, etc.) in accordance to NCQA and state/TennCare requirements). Provider must sign a contract agreeing to comply with state, federal and health plan regulations, policies/procedures and rates. If an inpatient provider successfully meets all requirements then they are allowed admission in the network.	geographical or clinical need. The purpose of the Network Grid is to have a one source document that shows which specialties are open/closed in every county in TN. It's an easy to read document that clearly shows the Provider Relations Team if the network is OPEN and if they should send an application/contract package. The Network Grid is based on Geographical market/network adequacy and clinical need.		complete. Provider must complete package in its entirety. Provider must meet all credentialing requirements (i.e. licensures, accreditations, certifications, attestations, Disclosures, liability coverage, sanctions, etc.) in accordance to NCQA and state/TennCare requirements). Provider must sign a contract agreeing to comply with state, federal and health plan regulations, policies/procedures and rates. If an inpatient provider successfully meets all requirements then they are allowed admission in the network.	geographical or clinical need. The purpose of the Network Grid is to have a one source document that shows which specialties are open/closed in every county in TN. It's an easy to read document that clearly shows the Provider Relations Team if the network is OPEN and if they should send an application/contract package. The Network Grid is based on Geographical market/network adequacy and clinical need.	

NETWORK STANDARDS – INPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**	**Medical/Surgical Services**
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	The application of standards are the same for Network Standards for Inpatient Services.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If network standards are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of these standards is in parity. No additional information is needed.** **If network standards are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of these standards is not in parity. Proceed to the following row.**	
Modifications Explain how network standards for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A	

NQTL Analysis Module 5: Network Standards – OUTPATIENT SERVICES

NETWORK STANDARDS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
What are the plan's network admission requirements for outpatient providers?	Monthly the health plan reviews OPEN/CLOSED specialties (facility/non-facility) per county. If the health plan receives an application (via webportal) request from an Out-of-Network (OON) outpatient provider for a county in which it is OPEN, then our Provider Relations Team will send an application/contract package to begin in-network process. Provider must meet all credentialing requirements (in accordance with NCQA and state/TennCare requirements), and sign a contract agreeing to all Amerigroup/TennCare policies/regulations and rates.	Monthly the health plan reviews OPEN/CLOSED specialties (facility/non-facility) per county. If the health plan receives an application (via webportal) request from an Out-of-Network (OON) outpatient provider for a county in which it is OPEN, then our Provider Relations Team will send an application/contract package to begin in-network process. Provider must meet all credentialing requirements (in accordance with NCQA and state/TennCare requirements), and sign a contract agreeing to all Amerigroup/TennCare policies/regulations and rates.
Are there any geographic limitations on provider inclusion in the network (e.g., requirements for accessing out-of-state providers)? If so, describe these limitations.	There are no geographic limitations to add a non-participating provider to our network. We allow Out-of-State providers (OOS) to join our network that are located in states conjoining Tennessee borders.	There are no geographic limitations to add a non-participating provider to our network. We allow Out-of-State providers (OOS) to join our network that are located in states conjoining Tennessee borders.
Describe the criteria applied in determining standards for access to out-of-network providers.	If no in-network provider is available to provide the medically appropriate care or if the member meets continuity of care criteria, Amerigroup will enter an authorization to approve out of network care.	If no in-network provider is available to provide the medically appropriate care or if the member meets continuity of care criteria, Amerigroup will enter an authorization to approve out of network care.

NETWORK STANDARDS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
What methods are used to determine usual, customary, and reasonable charges?	Amerigroup uses the following methods that are in compliance with the TennCare contract CRA A.2.13.2 as follows: We do not reimburse a percentage of billed charges unless there is no Medicare (CMS) reimbursement methodology. Therefore we use CMS methodology (with no auto escalators) as primary source. Other methodology options may include, per diem, case rates and/or state mandated rates.			Amerigroup uses the following methods that are in compliance with the TennCare contract CRA A.2.13.2 as follows: We do not reimburse a percentage of billed charges unless there is no Medicare (CMS) reimbursement methodology. Therefore we use CMS methodology (with no auto escalators) as primary source. Other methodology options may include, per diem, case rates and/or state mandated rates.		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for setting and implementing network admission standards.	**Strategies:** WHY does your MCO use these processes and standards? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of these processes and standards? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for setting and implementing network admission standards.	**Strategies:** WHY does your MCO use these processes and standards? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of these processes and standards? Evidence may include practice guidelines and internal health plan utilization data.
	Out-of-Network (OON) providers must submit a request to join the network via Amerigroup webportal. Provider Relations Team must check the “Network Grid” to see if we are accepting outpatient providers in the county that is being requested. If yes, then the Provider Relations Team sends the OON provider an application and contract package to	The reason we require OON providers to submit a request via webportal is because it gives us the ability/flexibility to track our responses to ensure we’re responding to all requests timely and it’s easier to track (online data base) all requests for future recruitment efforts if we need to add providers to the network at a later date to meet	1) Network Grid is based on network adequacy and clinical needs. 2) Rates are based primarily in accordance with CMS methodologies, state mandates and/or other industry standard methodologies, i.e. case rates or per diems. 3) The credentialing is in accordance with NCQA and state requirements.	Out-of-Network (OON) providers must submit a request to join the network via Amerigroup webportal. Provider Relations Team must check the “Network Grid” to see if we are accepting outpatient providers in the county that is being requested. If yes, then the Provider Relations Team sends the OON provider an application and contract package to	The reason we require OON providers to submit a request via webportal is because it gives us the ability/flexibility to track our responses to ensure we’re responding to all requests timely and it’s easier to track (online data base) all requests for future recruitment efforts if we need to add providers to the network at a later date to meet	1) Network Grid is based on network adequacy and clinical needs. 2) Rates are based primarily in accordance with CMS methodologies, state mandates and/or other industry standard methodologies, i.e. case rates or per diems. 3) The credentialing is in accordance with NCQA and state requirements.

NETWORK STANDARDS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	complete. Provider must complete package in its entirety. Provider must meet all credentialing requirements (i.e. licensures, accreditations, certifications, attestations, Disclosures, liability coverage, sanctions, etc.) in accordance to NCQA and state/TennCare requirements). Provider must sign a contract agreeing to comply with state, federal and health plan regulations, policies/procedures and rates. If an outpatient provider successfully meets all requirements then they are allowed admission in the network.	geographical or clinical need. The purpose of the Network Grid is to have a one source document that shows which specialties are open/closed in every county in TN. It's an easy to read document that clearly shows the Provider Relations Team if the network is OPEN and if they should send an application/contract package. The Network Grid is based on Geographical market/network adequacy and clinical need.		complete. Provider must complete package in its entirety. Provider must meet all credentialing requirements (i.e. licensures, accreditations, certifications, attestations, Disclosures, liability coverage, sanctions, etc.) in accordance to NCQA and state/TennCare requirements). Provider must sign a contract agreeing to comply with state, federal and health plan regulations, policies/procedures and rates. If an outpatient provider successfully meets all requirements then they are allowed admission in the network.	geographical or clinical need. The purpose of the Network Grid is to have a one source document that shows which specialties are open/closed in every county in TN. It's an easy to read document that clearly shows the Provider Relations Team if the network is OPEN and if they should send an application/contract package. The Network Grid is based on Geographical market/network adequacy and clinical need.	

NETWORK STANDARDS – OUTPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**	**Medical/Surgical Services**
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.?	The application of the Network Standards for Outpatient Services are the same.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If network standards are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of these standards is in parity. No additional information is needed.** **If network standards are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of these standards is not in parity. Proceed to the following row.**	
Modifications Explain how network standards for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A	

NQTL Analysis Module 5: Network Standards – EMERGENCY SERVICES

NETWORK STANDARDS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
What are the plan's network admission requirements for emergency providers?	Monthly the health plan reviews OPEN/CLOSED specialties (facility/non-facility) per county. If the health plan receives an application (via webportal) request from an Out-of-Network (OON) emergency provider for a county in which it is OPEN, then our Provider Relations Team will send an application/contract package to begin in-network process. Provider must meet all credentialing requirements (in accordance with NCQA and state/TennCare requirements), and sign a contract agreeing to all Amerigroup/TennCare policies/regulations and rates.	Monthly the health plan reviews OPEN/CLOSED specialties (facility/non-facility) per county. If the health plan receives an application (via webportal) request from an Out-of-Network (OON) emergency provider for a county in which it is OPEN, then our Provider Relations Team will send an application/contract package to begin in-network process. Provider must meet all credentialing requirements (in accordance with NCQA and state/TennCare requirements), and sign a contract agreeing to all Amerigroup/TennCare policies/regulations and rates.
Are there any geographic limitations on provider inclusion in the network (e.g., requirements for accessing out-of-state providers)? If so, describe these limitations.	There are no geographic limitations to add a non-participating provider to our network. We allow Out-of-State providers (OOS) to join our network that are located in states conjoining Tennessee borders. All emergency care is immediate, at the nearest facility available, regardless of contract. – According to our contract with TennCare.	There are no geographic limitations to add a non-participating provider to our network. We allow Out-of-State providers (OOS) to join our network that are located in states conjoining Tennessee borders. All emergency care is immediate, at the nearest facility available, regardless of contract. – According to our contract with TennCare.
Describe the criteria applied in determining standards for access to out-of-network providers.	If no in-network provider is available to provide the medically appropriate care or if the member meets continuity of care criteria, Amerigroup will enter an authorization to approve out of network care.	If no in-network provider is available to provide the medically appropriate care or if the member meets continuity of care criteria, Amerigroup will enter an authorization to approve out of network care.

NETWORK STANDARDS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
What methods are used to determine usual, customary, and reasonable charges?	Amerigroup uses the following methods that are in compliance with TennCare's contract, CRA A.2.13.2 as follows: We do not reimburse a percentage of billed charges unless there is no Medicare (CMS) reimbursement methodology. Therefore we use CMS methodology (with no auto escalators) as primary source. Other methodology options may include, per diem, case rates and/or state mandated rates.			Amerigroup uses the following methods that are in compliance with the TennCare contract CRA A.2.13.2 as follows: We do not reimburse a percentage of billed charges unless there is no Medicare (CMS) reimbursement methodology. Therefore we use CMS methodology (with no auto escalators) as primary source. Other methodology options may include per diem, case rates and/or state mandated rates.		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for setting and implementing network admission standards.	**Strategies:** WHY does your MCO use these processes and standards? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of these processes and standards? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for setting and implementing network admission standards.	**Strategies:** WHY does your MCO use these processes and standards? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of these processes and standards? Evidence may include practice guidelines and internal health plan utilization data.
	Out-of-Network (OON) providers must submit a request to join the network via Amerigroup webportal. Provider Relations Team must check the "Network Grid" to see if we are accepting the emergency providers in the county that is being requested. If yes, then the Provider Relations Team sends the OON provider an application and contract package to	The reason we require OON providers to submit a request via webportal is because it gives us the ability/flexibility to track our responses to ensure we're responding to all requests timely and it's easier to track (online data base) all requests for future recruitment efforts if we need to add providers to the network at a later date to meet	1) Network Grid is based on network adequacy and clinical needs. 2) Rates are based primarily in accordance with CMS methodologies, state mandates and/or other industry standard methodologies, i.e. case rates or per diems. 3) The credentialing is in accordance with NCQA and state requirements.	Out-of-Network (OON) providers must submit a request to join the network via Amerigroup webportal. Provider Relations Team must check the "Network Grid" to see if we are accepting the emergency providers in the county that is being requested. If yes, then the Provider Relations Team sends the OON provider an application and contract package to	The reason we require OON providers to submit a request via webportal is because it gives us the ability/flexibility to track our responses to ensure we're responding to all requests timely and it's easier to track (online data base) all requests for future recruitment efforts if we need to add providers to the network at a later date to meet	1) Network Grid is based on network adequacy and clinical needs. 2) Rates are based primarily in accordance with CMS methodologies, state mandates and/or other industry standard methodologies, i.e. case rates or per diems. 3) The credentialing is in accordance with NCQA and state requirements.

NETWORK STANDARDS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	complete. Provider must complete package in its entirety. Provider must meet all credentialing requirements (i.e. licensures, accreditations, certifications, attestations, Disclosures, liability coverage, sanctions, etc.) in accordance to NCQA and state/TennCare requirements). Provider must sign a contract agreeing to comply with state, federal and health plan regulations, policies/procedures and rates. If an emergency provider successfully meets all requirements then they are allowed admission in the network.	geographical or clinical need. The purpose of the Network Grid is to have a one source document that shows which specialties are open/closed in every county in TN. It's an easy to read document that clearly shows the Provider Relations Team if the network is OPEN and if they should send an application/contract package. The Network Grid is based on Geographical market/network adequacy and clinical need.		complete. Provider must complete package in its entirety. Provider must meet all credentialing requirements (i.e. licensures, accreditations, certifications, attestations, Disclosures, liability coverage, sanctions, etc.) in accordance to NCQA and state/TennCare requirements). Provider must sign a contract agreeing to comply with state, federal and health plan regulations, policies/procedures and rates. If an emergency provider successfully meets all requirements then they are allowed admission in the network.	geographical or clinical need. The purpose of the Network Grid is to have a one source document that shows which specialties are open/closed in every county in TN. It's an easy to read document that clearly shows the Provider Relations Team if the network is OPEN and if they should send an application/contract package. The Network Grid is based on Geographical market/network adequacy and clinical need.	

NETWORK STANDARDS – EMERGENCY SERVICES	**Mental Health/Substance Use Disorder Services**	**Medical/Surgical Services**
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	The application of Network Standards for Emergency Services are the same.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If network standards are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of these standards is in parity. No additional information is needed.** **If network standards are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of these standards is not in parity. Proceed to the following row.**	
Modifications Explain how network standards for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A	

BlueCross BlueShield of Tennessee

(for BlueCare and CoverKids)

NQTL Analysis Module 1: Prior Authorization – INPATIENT SERVICES

PRIOR AUTHORIZATION REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
List all inpatient benefits requiring prior authorization.	Inpatient Psychiatric Care Inpatient Detoxification Subacute Hospitalization Inpatient - Residential Treatment			Inpatient Medical (except maternity) Inpatient Surgical Transplant NICU		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for prior authorization that your MCO uses.	**Strategies:** WHY does your MCO require prior authorization for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for prior authorization that your MCO uses.	**Strategies:** WHY does your MCO require prior authorization for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.
	Prior authorization is a utilization management (UM) process which is conducted, except in emergency situations, prior to a patient's admission, stay, or other service or course of treatment. Prior authorization approval must be obtained for services to be covered under the member's plan. The prior	Our prior authorization process is designed to place members first by ensuring timely and appropriate access to medically necessary covered services as well as the appropriateness of the setting in the most effective manner. The prior authorization list is under the oversight of	We use a comprehensive monitoring and oversight process to identify the inappropriate utilization and cost of services to determine our prior authorization requirements. We conduct monthly monitoring of health care cost trends and the clinical policies and payment	Prior authorization is a utilization management (UM) process which is conducted, except in emergency situations, prior to a patient's admission, stay, or other service or course of treatment. Prior authorization approval must be obtained for services to be covered under the member's plan. The prior	Our prior authorization process is designed to place members first by ensuring timely and appropriate access to medically necessary covered services as well as the appropriateness of the setting in the most effective manner. The prior authorization list is under the oversight of	We use a comprehensive monitoring and oversight process to identify the inappropriate utilization and cost of services to determine our prior authorization requirements. We conduct monthly monitoring of health care cost trends and the clinical policies and payment

PRIOR AUTHORIZATION REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	authorization review process is performed telephonically, by web authorization, fax, and/or mail. A prior authorization review focuses on the clinical assessment of the member's physical and behavioral health needs and the practitioner's plan of treatment including the appropriateness of care, procedure and setting. The review is based on the prior authorization list requirements, thereby allowing the member and practitioner an opportunity to review alternative methods of treatment. The reviews are performed on an individualized basis for each member. Elements such as the patient's age, co-morbidities, complications, progress with treatment, psychosocial situation, and the member's home	the Chief Medical Officer (CMO). The CMO, or a designee, reviews the list, at a minimum annually, or more frequently if necessary. The review includes an analysis of the current services, rate of approvals, denials, appeals and overturns. Services that have a denial rate of less than 2% should be further evaluated to determine if the service should remain on the list. The following criteria are considerations for services on the prior authorization list: • benefit management; o services that may not be appropriate after a number have been done or to control out of network services; o benefits that potentially may not be covered e.g. investigational; • high cost services that would require coordination; • prevention	methods that contribute to these trends through collaborative workgroups. The collaborative groups include a wide range of representatives, including Actuarial, Medical Informatics, Utilization Management, Network Strategy, Finance, and Population Health departments. Key agenda topics that affect our utilization management program include analysis of disparities between utilization and dollars paid; payment policy changes, UM policy changes, and claims data analysis. Another key agenda item is presented by our Actuarial department of a detailed cost and utilization analysis called the Surveillance Report. The Surveillance Report is refreshed monthly to reflect the most recent data and the	authorization review process is performed telephonically, by web authorization, fax, and/or mail. A prior authorization review focuses on the clinical assessment of the member's physical and behavioral health needs and the practitioner's plan of treatment including the appropriateness of care, procedure and setting. The review is based on the prior authorization list requirements, thereby allowing the member and practitioner an opportunity to review alternative methods of treatment. The reviews are performed on an individualized basis for each member. Elements such as the patient's age, co-morbidities, complications, progress with treatment, psychosocial situation, and the member's home	the Chief Medical Officer (CMO). The CMO, or a designee, reviews the list, at a minimum annually, or more frequently if necessary. The review includes an analysis of the current services, rate of approvals, denials, appeals and overturns. Services that have a denial rate of less than 2% should be further evaluated to determine if the service should remain on the list. The following criteria are considerations for services on the prior authorization list: • benefit management; o services that may not be appropriate after a number have been done or to control out of network services; o benefits that potentially may not be covered (e.g., cosmetic or investigational); • high cost services that would require coordination;	methods that contribute to these trends through collaborative workgroups. The collaborative groups include a wide range of representatives, including Actuarial, Medical Informatics, Utilization Management, Network Strategy, Finance, and Population Health departments. Key agenda topics that affect our utilization management program include analysis of disparities between utilization and dollars paid; payment policy changes, UM policy changes, and claims data analysis. Another key agenda item is presented by our Actuarial department of a detailed cost and utilization analysis called the Surveillance Report. The Surveillance Report is refreshed monthly to reflect the most recent data and the

PRIOR AUTHORIZATION REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	environment are considered. Prior authorizations are performed exclusively by a licensed practical nurse (LPN) or RN with an active license and a minimum of three (3) years clinical experience or, for Behavioral Health (BH) requests, licensed mental health clinicians such as Licensed Clinical Social Workers and Licensed Professional Counselors. RNs, LPNs, and licensed mental health clinicians receive orientation and extensive training in the principles and procedures of UM. Clinical reviewers may approve requests and assign lengths of stay based on guidelines. During the review process, as needed, the clinical reviewer has access to consultation with a licensed doctor of medicine or osteopathic medicine. Clinical reviewers and	of inappropriate utilization; • assure appropriate in network providers are used for appropriate service; • prevent off-label experimental utilization of services (e.g. EMDR, Equine Therapy); identification of members needing management; • and management by a delegated entity to ensure all requests are submitted to, and managed by, the delegate. Any change to the prior authorization list is communicated to providers through the appropriate channels, such as provider newsletters, phone calls, and electronic alerts. The communication is done a minimum of thirty (30) days prior to the effective date of the change.	latest rolling 12-month trends related to 25 cost categories. Included in the data are unit cost, utilization, and total per member per month (PMPM) trends. Unit cost and utilization trends are reviewed by cost category and overall to identify where further analysis is required. The Medical Informatics department conducts detailed analysis over the selected time period using DRG, Revenue Code, or CPT-level analytics down to the provider level. In addition, this information is reviewed monthly by the business owners and presented to the medical directors and utilization managers for discussion and evaluation, as necessary, to recommend appropriate action and follow-up. This team discusses both over- and under-	environment are considered. Prior authorizations are performed exclusively by a licensed practical nurse (LPN) or RN with an active license and a minimum of three (3) years clinical experience or, for Behavioral Health (BH) requests, licensed mental health clinicians such as Licensed Clinical Social Workers and Licensed Professional Counselors. RNs, LPNs, and licensed mental health clinicians receive orientation and extensive training in the principles and procedures of UM. Clinical reviewers may approve requests and assign lengths of stay based on guidelines. During the review process, as needed, the clinical reviewer has access to consultation with a licensed doctor of medicine or osteopathic medicine. Clinical reviewers and	• prevention of inappropriate utilization; • assure appropriate in network providers are used for appropriate service; • prevent off-label experimental utilization of services (e.g., hyperbaric oxygen, Botox); identification of members needing management (e.g., transplant, maternity, admissions); • and management by a delegated entity to ensure all requests are submitted to, and managed by, the delegate. Any change to the prior authorization list is communicated to providers through the appropriate channels, such as provider newsletters, phone calls, and electronic alerts. The communication is done a minimum of thirty (30) days prior	latest rolling 12-month trends related to 25 cost categories. Included in the data are unit cost, utilization, and total per member per month (PMPM) trends. Unit cost and utilization trends are reviewed by cost category and overall to identify where further analysis is required. The Medical Informatics department conducts detailed analysis over the selected time period using DRG, Revenue Code, or CPT-level analytics down to the provider level. In addition, this information is reviewed monthly by the business owners and presented to the medical directors and utilization managers for discussion and evaluation, as necessary, to recommend appropriate action and follow-up. This team discusses both over- and under-

PRIOR AUTHORIZATION REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	licensed mental health clinicians do not deny cases for medical necessity; physicians render all medical necessity denials. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested and cannot be approved by the nurse reviewer are referred to internal physicians who have received orientation and extensive training in the principles and procedures of UM and hold a current, active non-restricted license of Doctor of Medicine or Doctor of Osteopathic Medicine in the State of Tennessee. Board certified physicians, psychiatrists and psychologists are available as needed to assist with medical necessity determinations. The physician reviewer evaluates all referred		utilization occurrences and develops plans to address them as needed. Members identified as inappropriately using services are referred to the appropriate Care Coordination Program for management.	licensed mental health clinicians do not deny cases for medical necessity; physicians render all medical necessity denials. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested and cannot be approved by the nurse reviewer are referred to internal physicians who have received orientation and extensive training in the principles and procedures of UM and hold a current, active non-restricted license of Doctor of Medicine or Doctor of Osteopathic Medicine in the State of Tennessee. Board certified physicians, psychiatrists and psychologists are available as needed to assist with medical necessity determinations. The physician reviewer evaluates all referred	to the effective date of the change.	utilization occurrences and develops plans to address them as needed. Members identified as inappropriately using services are referred to the appropriate Care Coordination Program for management.

PRIOR AUTHORIZATION REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	case documentation to determine if coverage for the care is medically necessary for the diagnosis and/or if care is being performed in the appropriate setting. If the request is received via telephone, the approval is provided verbally and by written notification to the attending physician or other ordering provider, the facility rendering service, and member. If the request is received via fax or web, written notification is mailed to the attending physician or other ordering provider, the facility rendering service, and member.			case documentation to determine if coverage for the care is medically necessary for the diagnosis and/or if care is being performed in the appropriate setting. If the request is received via telephone, the approval is provided verbally and by written notification to the attending physician or other ordering provider, the facility rendering service, and member. If the request is received via fax or web, written notification is mailed to the attending physician or other ordering provider, the facility rendering service, and member.		

PRIOR AUTHORIZATION REQUIREMENTS – INPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**	**Medical/Surgical Services**
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	While the lists of inpatient services requiring prior authorization vary between MH/SUD and M/S; prior authorization is required for both MH/SUD and M/S inpatient benefits. Policies and Procedures for inpatient prior authorization are the same for both MH/SUD and M/S benefits. Processes, strategies and evidentiary standards are the same for MH/SUD and M/S. Therefore, it has been determined that inpatient prior authorization processes, strategies and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied than inpatient prior authorization processes, strategies and evidentiary standards applied to M/S benefits.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If prior authorization requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of prior authorization is in parity. No additional information is needed.** **If prior authorization requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of prior authorization is not in parity. Proceed to the following row.**	
Modifications Explain how prior authorization processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A – No modifications required to comply with parity.	

NQTL Analysis Module 1: Prior Authorization – OUTPATIENT SERVICES

<table>
<tr><th>PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES</th><th colspan="3">Mental Health/Substance Use Disorder Services</th><th colspan="3">Medical/Surgical Services</th></tr>
<tr><td>List all outpatient benefits requiring prior authorization.</td><td colspan="3">Outpatient Therapy (Out of Network Providers Only)

Transcranial Magnetic Stimulation

Partial Hospitalization Program

Intensive Outpatient Program

BH Psych Testing

BH Psych Consult

BH ECT Outpatient</td><td colspan="3">All out of network Outpatient services

Outpatient Therapies over 21 years of age (Physical, occupational, and speech)

Selected elective Outpatient Procedures
- Arthroscopy
- Endoscopy
- Laparoscopic Cholecystectomy
- Nerve Conduction Studies
- Epidural Steroid Injections
- All services performed by plastic specialist, including but not limited to:
- Abdominoplasty
- Blepharoplasty
- Breast Reduction
- Reconstructive repair of excavatum
- Vein ligation

Chiropractic services under 19 years of age

All hyperbaric oxygen therapy

All bariatric services</td></tr>
<tr><td>Processes, Strategies, and Evidentiary Standards</td><td>Processes:
Explain the process, both in writing and in practice, for prior authorization that your MCO uses.</td><td>Strategies:
WHY does your MCO require prior authorization for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?</td><td>Evidentiary Standards:
What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.</td><td>Processes:
Explain the process, both in writing and in practice, for prior authorization that your MCO uses.</td><td>Strategies:
WHY does your MCO require prior authorization for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?</td><td>Evidentiary Standards:
What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.</td></tr>
</table>

PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	Prior authorization is a utilization management (UM) process which is conducted, except in emergency situations, prior to a patient's admission, stay, or other service or course of treatment. Prior authorization approval must be obtained for services to be covered under the member's plan. The prior authorization review process is performed telephonically, by web authorization, fax, and/or mail. A prior authorization review focuses on the clinical assessment of the member's physical and behavioral health needs and the practitioner's plan of treatment including the appropriateness of care, procedure and setting. The review is based on the prior authorization list requirements, thereby allowing the member and practitioner an	Our prior authorization process is designed to place members first by ensuring timely and appropriate access to medically necessary covered services as well as the appropriateness of the setting in the most effective manner. The prior authorization list is under the oversight of the Chief Medical Officer (CMO). The CMO, or a designee, reviews the list, at a minimum annually, or more frequently if necessary. The review includes an analysis of the current services, rate of approvals, denials, appeals and overturns. Services that have a denial rate of less than 2% should be further evaluated to determine if the service should remain on the list. The following criteria are considerations for services on the prior authorization list:	We use a comprehensive monitoring and oversight process to identify the inappropriate utilization and cost of services to determine our prior authorization requirements. We conduct monthly monitoring of health care cost trends and the clinical policies and payment methods that contribute to these trends through collaborative workgroups. The collaborative groups include a wide range of representatives, including Actuarial, Medical Informatics, Utilization Management, Network Strategy, Finance, and Population Health departments. Key agenda topics that affect our utilization management program include analysis of disparities between utilization	Prior authorization is a utilization management (UM) process which is conducted, except in emergency situations, prior to a patient's admission, stay, or other service or course of treatment. Prior authorization approval must be obtained for services to be covered under the member's plan. The prior authorization review process is performed telephonically, by web authorization, fax, and/or mail. A prior authorization review focuses on the clinical assessment of the member's physical and behavioral health needs and the practitioner's plan of treatment including the appropriateness of care, procedure and setting. The review is based on the prior authorization list requirements, thereby allowing the member and practitioner an	Our prior authorization process is designed to place members first by ensuring timely and appropriate access to medically necessary covered services as well as the appropriateness of the setting in the most effective manner. The prior authorization list is under the oversight of the Chief Medical Officer (CMO). The CMO, or a designee, reviews the list, at a minimum annually, or more frequently if necessary. The review includes an analysis of the current services, rate of approvals, denials, appeals and overturns. Services that have a denial rate of less than 2% should be further evaluated to determine if the service should remain on the list. The following criteria are considerations for services on the prior authorization list:	We use a comprehensive monitoring and oversight process to identify the inappropriate utilization and cost of services to determine our prior authorization requirements. We conduct monthly monitoring of health care cost trends and the clinical policies and payment methods that contribute to these trends through collaborative workgroups. The collaborative groups include a wide range of representatives, including Actuarial, Medical Informatics, Utilization Management, Network Strategy, Finance, and Population Health departments. Key agenda topics that affect our utilization management program include analysis of disparities between utilization

PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	opportunity to review alternative methods of treatment. The reviews are performed on an individualized basis for each member. Elements such as the patient's age, co-morbidities, complications, progress with treatment, psychosocial situation, and the member's home environment are considered. Prior authorizations are performed exclusively by a licensed practical nurse (LPN) or RN with an active license and a minimum of three (3) years clinical experience or, for Behavioral Health (BH) requests, licensed mental health clinicians such as Licensed Clinical Social Workers and Licensed Professional Counselors. RNs, LPNs, and licensed mental health clinicians receive orientation and	• benefit management; o services that may not be appropriate after a number have been done or to control out of network services; o benefits that potentially may not be covered e.g. investigational; • high cost services that would require coordination; • prevention of inappropriate utilization; • assure appropriate in network providers are used for appropriate service; • prevent off-label experimental utilization of services (e.g. EMDR, Equine Therapy); identification of members needing management; • and management by a delegated entity to ensure all requests are submitted to, and managed by, the delegate.	and dollars paid; payment policy changes, UM policy changes, and claims data analysis. Another key agenda item is presented by our Actuarial department of a detailed cost and utilization analysis called the Surveillance Report. The Surveillance Report is refreshed monthly to reflect the most recent data and the latest rolling 12-month trends related to 25 cost categories. Included in the data are unit cost, utilization, and total per member per month (PMPM) trends. Unit cost and utilization trends are reviewed by cost category and overall to identify where further analysis is required. The Medical Informatics department conducts detailed analysis over the selected time period using DRG, Revenue Code, or CPT-level analytics down to the provider	opportunity to review alternative methods of treatment. The reviews are performed on an individualized basis for each member. Elements such as the patient's age, co-morbidities, complications, progress with treatment, psychosocial situation, and the member's home environment are considered. Prior authorizations are performed exclusively by a licensed practical nurse (LPN) or RN with an active license and a minimum of three (3) years clinical experience or, for Behavioral Health (BH) requests, licensed mental health clinicians such as Licensed Clinical Social Workers and Licensed Professional Counselors. RNs, LPNs, and licensed mental health clinicians receive orientation and	• benefit management; o services that may not be appropriate after a number have been done or to control out of network services; o benefits that potentially may not be covered (e.g., cosmetic or investigational); • high cost services that would require coordination; • prevention of inappropriate utilization; • assure appropriate in network providers are used for appropriate service; • prevent off-label experimental utilization of services (e.g., hyperbaric oxygen, Botox); identification of members needing management (e.g., transplant, maternity, admissions); • and management by a delegated entity to ensure all requests are submitted to, and	and dollars paid; payment policy changes, UM policy changes, and claims data analysis. Another key agenda item is presented by our Actuarial department of a detailed cost and utilization analysis called the Surveillance Report. The Surveillance Report is refreshed monthly to reflect the most recent data and the latest rolling 12-month trends related to 25 cost categories. Included in the data are unit cost, utilization, and total per member per month (PMPM) trends. Unit cost and utilization trends are reviewed by cost category and overall to identify where further analysis is required. The Medical Informatics department conducts detailed analysis over the selected time period using DRG, Revenue Code, or CPT-level analytics down to the provider

PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	extensive training in the principles and procedures of UM. Clinical reviewers may approve requests and assign lengths of stay based on guidelines. During the review process, as needed, the clinical reviewer has access to consultation with a licensed doctor of medicine or osteopathic medicine. Clinical reviewers and licensed mental health clinicians do not deny cases for medical necessity; physicians render all medical necessity denials. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested and cannot be approved by the nurse reviewer are referred to internal physicians who have received orientation and extensive training in the principles and procedures of UM and hold a current,	Any change to the prior authorization list is communicated to providers through the appropriate channels, such as provider newsletters, phone calls, and electronic alerts. The communication is done a minimum of thirty (30) days prior to the effective date of the change.	level. In addition, this information is reviewed monthly by the business owners and presented to the medical directors and utilization managers for discussion and evaluation, as necessary, to recommend appropriate action and follow-up. This team discusses both over- and under-utilization occurrences and develops plans to address them as needed. Members identified as inappropriately using services are referred to the appropriate Care Coordination Program for management.	extensive training in the principles and procedures of UM. Clinical reviewers may approve requests and assign lengths of stay based on guidelines. During the review process, as needed, the clinical reviewer has access to consultation with a licensed doctor of medicine or osteopathic medicine. Clinical reviewers and licensed mental health clinicians do not deny cases for medical necessity; physicians render all medical necessity denials. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested and cannot be approved by the nurse reviewer are referred to internal physicians who have received orientation and extensive training in the principles and procedures of UM and hold a current,	managed by, the delegate. Any change to the prior authorization list is communicated to providers through the appropriate channels, such as provider newsletters, phone calls, and electronic alerts. The communication is done a minimum of thirty (30) days prior to the effective date of the change.	level. In addition, this information is reviewed monthly by the business owners and presented to the medical directors and utilization managers for discussion and evaluation, as necessary, to recommend appropriate action and follow-up. This team discusses both over- and under-utilization occurrences and develops plans to address them as needed. Members identified as inappropriately using services are referred to the appropriate Care Coordination Program for management.

PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	active non-restricted license of Doctor of Medicine or Doctor of Osteopathic Medicine in the State of Tennessee. Board certified physicians, psychiatrists and psychologists are available as needed to assist with medical necessity determinations. The physician reviewer evaluates all referred case documentation to determine if coverage for the care is medically necessary for the diagnosis and/or if care is being performed in the appropriate setting. If the request is received via telephone, the approval is provided verbally and by written notification to the attending physician or other ordering provider, the facility rendering service, and member. If the request is received via fax or web, written notification is mailed			active non-restricted license of Doctor of Medicine or Doctor of Osteopathic Medicine in the State of Tennessee. Board certified physicians, psychiatrists and psychologists are available as needed to assist with medical necessity determinations. The physician reviewer evaluates all referred case documentation to determine if coverage for the care is medically necessary for the diagnosis and/or if care is being performed in the appropriate setting. If the request is received via telephone, the approval is provided verbally and by written notification to the attending physician or other ordering provider, the facility rendering service, and member. If the request is received via fax or web, written notification is mailed		

PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	to the attending physician or other ordering provider, the facility rendering service, and member.			to the attending physician or other ordering provider, the facility rendering service, and member.		
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	While the lists of outpatient services requiring prior authorization vary between MH/SUD and M/S; prior authorization is required for both MH/SUD and M/S outpatient benefits. Policies and Procedures for outpatient prior authorization are the same for both MH/SUD and M/S benefits. Processes, strategies and evidentiary standards are the same for MH/SUD and M/S. Therefore, it has been determined that outpatient prior authorization processes, strategies and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied than outpatient prior authorization processes, strategies and evidentiary standards applied to M/S benefits.					
Evaluation of Processes, Strategies, and Evidentiary Standards	**If prior authorization requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of prior authorization is in parity. No additional information is needed.** **If prior authorization requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of prior authorization is not in parity. Proceed to the following row.**					

PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**	**Medical/Surgical Services**
Modifications Explain how prior authorization processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A – No modifications required to comply with parity.	

NQTL Analysis Module 1: Prior Authorization – EMERGENCY SERVICES

PRIOR AUTHORIZATION REQUIREMENTS – EMERGENCY SERVICES	**Mental Health/Substance Use Disorder Services**			**Medical/Surgical Services**		
List all emergency benefits requiring prior authorization.	*N/A – Prior authorization is not required for emergency services.*			*N/A – Prior authorization is not required for emergency services.*		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for prior authorization that your MCO uses.	**Strategies:** WHY does your MCO require prior authorization for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for prior authorization that your MCO uses.	**Strategies:** WHY does your MCO require prior authorization for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.
	N/A	N/A	N/A	N/A	N/A	N/A

PRIOR AUTHORIZATION REQUIREMENTS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	Emergency prior authorization processes, strategies and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied than emergency prior authorization processes, strategies and evidentiary standards applied to M/S benefits.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If prior authorization requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of prior authorization is in parity. No additional information is needed.** **If prior authorization requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of prior authorization is not in parity. Proceed to the following row.**	
Modifications Explain how prior authorization processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A – No modifications required to comply with parity.	

NQTL Analysis Module 2: Concurrent Review – INPATIENT SERVICES

<table>
<tr><th>CONCURRENT REVIEW REQUIREMENTS – INPATIENT SERVICES</th><th colspan="3">Mental Health/Substance Use Disorder Services</th><th colspan="3">Medical/Surgical Services</th></tr>
<tr><td>List all inpatient benefits requiring concurrent review.</td><td colspan="3">Inpatient Psychiatric Care

Inpatient Detoxification

Subacute Hospitalization

Inpatient - Residential Treatment</td><td colspan="3">Inpatient facilities with Per Diem contract rates (except maternity)

(DRG contracted rates do not require concurrent review)</td></tr>
<tr><td>Processes, Strategies, and Evidentiary Standards</td><td>Processes:
Explain the process, both in writing and in practice, for concurrent review that your MCO uses.</td><td>Strategies:
WHY does your MCO require concurrent review for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?</td><td>Evidentiary Standards:
What evidence supports the use of concurrent review for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.</td><td>Processes:
Explain the process, both in writing and in practice, for concurrent review that your MCO uses.</td><td>Strategies:
WHY does your MCO require concurrent review for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?</td><td>Evidentiary Standards:
What evidence supports the use of concurrent review for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.</td></tr>
</table>

CONCURRENT REVIEW REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	The Concurrent Review process is performed telephonically, by web authorization, fax, and/or mail. A concurrent review is defined as a review for an extension of a previously approved, ongoing course of treatment, or number of treatments, over a period of time. Concurrent reviews are typically associated with inpatient care or ongoing ambulatory care. It is a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the organization. It is sometimes called “continued stay review.” A concurrent review program monitors and reviews continued inpatient hospitalization, length of stay, or diagnostic ancillary services regarding their	Decisions for concurrent review are made on a case-by-case basis after considering the individual member’s needs and severity of their condition. To receive payment beyond the initial request, additional medical information that meets current guidelines and/or demonstrates medical necessity must be obtained to support the request. As with prior authorization review, current contractual mandates, BCBST Medical Policy, and MCG are used to render concurrent review decisions. Concurrent review is conducted to: • Determine that continued services are delivered at the appropriate setting • Monitor for transition of care and alternative service/settings	We use a comprehensive monitoring and oversight process to identify the inappropriate utilization and cost of services. We conduct monthly monitoring of health care cost trends and the clinical policies and payment methods that contribute to these trends through collaborative workgroups. The collaborative groups include a wide range of representatives, including Actuarial, Medical Informatics, Utilization Management, Network Strategy, Finance, and Population Health departments. Key agenda topics that affect our utilization management program include analysis of disparities between utilization and dollars paid, payment policy	The Concurrent Review process is performed telephonically, by web authorization, fax, and/or mail. A concurrent review is defined as a review for an extension of a previously approved, ongoing course of treatment, or number of treatments, over a period of time. Concurrent reviews are typically associated with inpatient care or ongoing ambulatory care. It is a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the organization. It is sometimes called “continued stay review.” A concurrent review program monitors and reviews continued inpatient hospitalization, length of stay, or diagnostic ancillary services regarding their	Decisions for concurrent review are made on a case-by-case basis after considering the individual member’s needs and severity of their condition. To receive payment beyond the initial request, additional medical information that meets current guidelines and/or demonstrates medical necessity must be obtained to support the request. As with prior authorization review, current contractual mandates, BCBST Medical Policy, and MCG are used to render concurrent review decisions. Concurrent review is conducted to: • Determine that continued services are delivered at the appropriate setting • Monitor for transition of care and alternative service/settings	We use a comprehensive monitoring and oversight process to identify the inappropriate utilization and cost of services. We conduct monthly monitoring of health care cost trends and the clinical policies and payment methods that contribute to these trends through collaborative workgroups. The collaborative groups include a wide range of representatives, including Actuarial, Medical Informatics, Utilization Management, Network Strategy, Finance, and Population Health departments. Key agenda topics that affect our utilization management program include analysis of disparities between utilization and dollars paid, payment policy

CONCURRENT REVIEW REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
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Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	While the lists of inpatient services requiring concurrent review vary between MH/SUD and M/S; concurrent review is required for both MH/SUD and M/S inpatient benefits. Policies and Procedures for inpatient concurrent review are the same for both MH/SUD and M/S benefits. Processes, strategies and evidentiary standards are the same for MH/SUD and M/S. Therefore, it has been determined that inpatient concurrent review processes, strategies and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied than inpatient concurrent review processes, strategies and evidentiary standards applied to M/S benefits.					
Evaluation of Processes, Strategies, and Evidentiary Standards	**If concurrent review requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of concurrent review is in parity. No additional information is needed.** **If concurrent review requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of concurrent review is not in parity. Proceed to the following row.**					

CONCURRENT REVIEW REQUIREMENTS – INPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**	**Medical/Surgical Services**
Modifications Explain how concurrent review processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A – No modifications required to comply with parity.	

NQTL Analysis Module 2: Concurrent Review – OUTPATIENT SERVICES

<table>
<tr><th>CONCURRENT REVIEW REQUIREMENTS – OUTPATIENT SERVICES</th><th colspan="3">Mental Health/Substance Use Disorder Services</th><th colspan="3">Medical/Surgical Services</th></tr>
<tr><td>List all outpatient benefits requiring concurrent review.</td><td colspan="3">Outpatient Therapy (Out of Network Providers Only)

Transcranial Magnetic Stimulation

Partial Hospitalization Program

Intensive Outpatient Program

BH Psych Testing

BH Psych Consult

BH ECT Outpatient</td><td colspan="3">Ongoing Out of Network Outpatient services

Ongoing Outpatient Therapies over 21 years of age (Physical, occupational, and speech)

Ongoing Chiropractic services under 19 years of age

Ongoing hyperbaric oxygen therapy</td></tr>
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CONCURRENT REVIEW REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
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CONCURRENT REVIEW REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	to the attending physician or other ordering provider, the facility rendering service, and member.			to the attending physician or other ordering provider, the facility rendering service, and member.		
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	While the lists of outpatient services requiring concurrent review vary between MH/SUD and M/S; concurrent review is required for both MH/SUD and M/S outpatient benefits. Policies and Procedures for outpatient concurrent review are the same for both MH/SUD and M/S benefits. Processes, strategies and evidentiary standards are the same for MH/SUD and M/S. Therefore, it has been determined that outpatient concurrent review processes, strategies and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied than outpatient concurrent review processes, strategies and evidentiary standards applied to M/S benefits.					
Evaluation of Processes, Strategies, and Evidentiary Standards	**If concurrent review requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of concurrent review is in parity. No additional information is needed.** **If concurrent review requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of concurrent review is not in parity. Proceed to the following row.**					

CONCURRENT REVIEW REQUIREMENTS – OUTPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**	**Medical/Surgical Services**
Modifications Explain how concurrent review processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A – No modifications required to comply with parity.	

NQTL Analysis Module 2: Concurrent Review – EMERGENCY SERVICES

CONCURRENT REVIEW REQUIREMENTS – EMERGENCY SERVICES	**Mental Health/Substance Use Disorder Services**			**Medical/Surgical Services**		
List all emergency benefits requiring concurrent review.	N/A No Concurrent Review of Emergency Services			N/A No Concurrent Review of Emergency Services		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for concurrent review that your MCO uses.	**Strategies:** WHY does your MCO require concurrent review for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of concurrent review for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for concurrent review that your MCO uses.	**Strategies:** WHY does your MCO require concurrent review for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of concurrent review for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.
	N/A	N/A	N/A	N/A	N/A	N/A

CONCURRENT REVIEW REQUIREMENTS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	Emergency service concurrent review processes, strategies and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied than emergency service concurrent review processes, strategies and evidentiary standards applied to M/S benefits.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If concurrent review requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of concurrent review is in parity. No additional information is needed.** **If concurrent review requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of concurrent review is not in parity. Proceed to the following row.**	
Modifications Explain how concurrent review processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A – No modifications required to comply with parity.	

NQTL Analysis Module 3: Medical Necessity – INPATIENT SERVICES

MEDICAL NECESSITY REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
What criteria are applied to make medical necessity/ appropriateness determinations for inpatient services?	The medical necessity criteria applied are contained within five different types of policy/guideline source documents: • Contractor Risk Agreement • TennCare Medical Necessity Criteria • BlueCross BlueShield of Tennessee medical policies • BlueCross BlueShield of Tennessee utilization management guidelines (UMGs) • MCG Care Guidelines			The medical necessity criteria applied are contained within five different types of policy/guideline source documents: • Contractor Risk Agreement • TennCare Medical Necessity Criteria • BlueCross BlueShield of Tennessee medical policies • BlueCross BlueShield of Tennessee utilization management guidelines (UMGs) • MCG Care Guidelines		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process your MCO uses, both in writing and in practice, for determining medical necessity.	**Strategies:** WHY does your MCO use the process described?	**Evidentiary Standards:** What evidence supports your MCO's MN criteria and processes for determining MN? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process your MCO uses, both in writing and in practice, for determining medical necessity.	**Strategies:** WHY does your MCO use the process described?	**Evidentiary Standards:** What evidence supports your MCO's MN criteria and processes for determining MN? Evidence may include practice guidelines and internal health plan utilization data.

MEDICAL NECESSITY REQUIREMENTS – INPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**			**Medical/Surgical Services**		
	BlueCare/TennCare*Select* (BC/TCS) covers medically necessary health care and behavioral health services as defined in the Contractor Risk Agreement, not otherwise excluded under the TennCare program, and based on the individual needs of the member. In the process of TennCare coverage determinations, BlueCare/TennCare*Select* (BC/TCS) considers both BCBST Medical Policy and the TennCare medical necessity definition. The medical necessity standard set forth in the TennCare reform statute and in these regulations shall govern the delivery of all services and items to all enrollees or classes of beneficiaries in the TennCare program. The definition of medical necessity will be implemented consistent with federal law, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	Goal is to ensure utilization management and quality service to our members through peer to peer communication of policy, practice guide lines and standards of care to providers.	The medical necessity criteria utilized by BlueCross BlueShield of Tennessee (BCBST) in determining medical necessity for both mental health and medical/surgical services are contained within five different groups of documents: Contractor Risk Agreement, TennCare Medical Necessity Criteria, BCBST medical policies, BCBST utilization management guidelines (UMGs) and MCG Care Guidelines. BCBST medical policies and UMGS are developed by BCBST's Medical Policy Department. The MCG Care Guidelines are purchased for company use from MCG Health, Inc.; MCG develops those guidelines. BCBST medical policy and UMGs contain policy positions and associated medical necessity criteria used in determining medical necessity. Those policy positions	BlueCare/TennCare*Select* (BC/TCS) covers medically necessary health care and behavioral health services as defined in the Contractor Risk Agreement, not otherwise excluded under the TennCare program, and based on the individual needs of the member. In the process of TennCare coverage determinations, BlueCare/TennCare*Select* (BC/TCS) considers both BCBST Medical Policy and the TennCare medical necessity definition. The medical necessity standard set forth in the TennCare reform statute and in these regulations shall govern the delivery of all services and items to all enrollees or classes of beneficiaries in the TennCare program. The definition of medical necessity will be implemented consistent with federal law, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	Goal is to ensure utilization management and quality service to our members through peer to peer communication of policy, practice guide lines and standards of care to providers.	The medical necessity criteria utilized by BlueCross BlueShield of Tennessee (BCBST) in determining medical necessity for both mental health and medical/surgical services are contained within five different groups of documents: Contractor Risk Agreement, TennCare Medical Necessity Criteria, BCBST medical policies, BCBST utilization management guidelines (UMGs) and MCG Care Guidelines. BCBST medical policies and UMGS are developed by BCBST's Medical Policy Department. The MCG Care Guidelines are purchased for company use from MCG Health, Inc.; MCG develops those guidelines. BCBST medical policy and UMGs contain policy positions and associated medical necessity criteria used in determining medical necessity. Those policy positions

MEDICAL NECESSITY REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	requirements, and within the state's authority to define what constitutes a medically necessary Medicaid service. A medical necessity determination is made by the Chief Medical Officer of the Bureau of TennCare or his or her clinical designee or by the Medical Director of one of its Managed Care Contractors or his or her clinical designee regarding whether a requested medical item or service satisfies the definition of medical necessity contained in Chapter 673 of the Public Acts of 2004 and these regulations as defined herein. When a request is received for an excluded item, the request may be approved by a licensed clinician or nurse reviewer or sent to a Medical Director to determine if it can be approved as a cost effective alternative or denied as an exclusion (see Exclusion List described in the TennCare Rules, Section 1200-13-14.10).		and associated medical necessity criteria are developed using an evidence-based evaluation/assessment process. The medical necessity criteria for all mental health and medical/surgical diagnostic and therapeutic procedures, devices and pharmaceutical agents addressed by those documents are developed using the following technology evaluation criteria: 1. The technology must have any necessary final approval from the appropriate governmental bodies. 2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. 3. The technology must improve the net health outcome 4. The technology must be as beneficial as any established alternative 5. The	requirements, and within the state's authority to define what constitutes a medically necessary Medicaid service. A medical necessity determination is made by the Chief Medical Officer of the Bureau of TennCare or his or her clinical designee or by the Medical Director of one of its Managed Care Contractors or his or her clinical designee regarding whether a requested medical item or service satisfies the definition of medical necessity contained in Chapter 673 of the Public Acts of 2004 and these regulations as defined herein. When a request is received for an excluded item, the request may be approved by a licensed clinician or nurse reviewer or sent to a Medical Director to determine if it can be approved as a cost effective alternative or denied as an exclusion (see Exclusion List described in the TennCare Rules, Section 1200-13-14.10).		and associated medical necessity criteria are developed using an evidence-based evaluation/assessment process. The medical necessity criteria for all mental health and medical/surgical diagnostic and therapeutic procedures, devices and pharmaceutical agents addressed by those documents are developed using the following technology evaluation criteria: 1. The technology must have any necessary final approval from the appropriate governmental bodies. 2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. 3. The technology must improve the net health outcome 4. The technology must be as beneficial as any established alternative 5. The

MEDICAL NECESSITY REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	To be medically necessary, a medical item or service must satisfy each of the following criteria: 1. It must be recommended by a licensed physician who is treating the member or other licensed healthcare provider practicing within the scope of his or her license who is treating the member 2. It must be required in order to diagnose or treat a member's medical or behavioral condition 3. It must be safe and effective 4. It must not be experimental or investigational 5. It must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition The convenience of an enrollee, the enrollee's family, the enrollee's caregiver, or a provider, shall not be a factor or justification in determining that a medical or behavioral		improvement must be attainable outside the investigational setting Each mental health or medical/surgical related diagnostic procedure, therapeutic procedure, device or pharmaceutical agent addressed by a BCBST medical policy or UMG must meet all of the above technology evaluation criteria in order to be considered medically necessary. If not met, it's possible that coverage is mandated by a federal or state regulation/bill. BCBST utilizes numerous sources in its evaluation of the available evidence, those sources include, but are not limited to, the following: • Published clinical trials • Professional association guidelines (e.g., National Comprehensive Cancer Network, American Psychological Association, American	To be medically necessary, a medical item or service must satisfy each of the following criteria: 1. It must be recommended by a licensed physician who is treating the member or other licensed healthcare provider practicing within the scope of his or her license who is treating the member 2. It must be required in order to diagnose or treat a member's medical or behavioral condition 3. It must be safe and effective 4. It must not be experimental or investigational 5. It must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition The convenience of an enrollee, the enrollee's family, the enrollee's caregiver, or a provider, shall not be a factor or justification in determining that a medical or behavioral		improvement must be attainable outside the investigational setting Each mental health or medical/surgical related diagnostic procedure, therapeutic procedure, device or pharmaceutical agent addressed by a BCBST medical policy or UMG must meet all of the above technology evaluation criteria in order to be considered medically necessary. If not met, it's possible that coverage is mandated by a federal or state regulation/bill. BCBST utilizes numerous sources in its evaluation of the available evidence, those sources include, but are not limited to, the following: • Published clinical trials • Professional association guidelines (e.g., National Comprehensive Cancer Network, American Psychological Association, American

MEDICAL NECESSITY REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	item or service is medically necessary. The UM program uses the CRA inclusive of exclusion lists and non-covered lists, BCBST Medical Policy, and MCG as significant resources for review of medical and behavioral health determinations. UM clinical decision tools are applied based on the member's individual needs.		College of Cardiology) • Medical technology assessment center evaluations (e.g., Hayes, ECRI, AHRQ) • Federal and state mandates • Nationally recognized pharmaceutical compendia • U.S. Food and Drug Administration (FDA) Once a new or revised BCBST medical policy or guideline document is written, it is posted on BCBST's Draft Medical Policies site for 30 days for provider review and comments. After that 30 day period the new or revised policy or guideline is presented to BCBST Medical Technology Assessment Committee (MTAC) for review and approval. All MTAC voting members are MDs and when mental health topics are presented at MTAC there is a behavioral health MD who takes part in the	item or service is medically necessary. The UM program uses the CRA inclusive of exclusion lists and non-covered lists, BCBST Medical Policy, and MCG as significant resources for review of medical and behavioral health determinations. UM clinical decision tools are applied based on the member's individual needs.		College of Cardiology) • Medical technology assessment center evaluations (e.g., Hayes, ECRI, AHRQ) • Federal and state mandates • Nationally recognized pharmaceutical compendia • U.S. Food and Drug Administration (FDA) Once a new or revised BCBST medical policy or guideline document is written, it is posted on BCBST's Draft Medical Policies site for 30 days for provider review and comments. After that 30 day period the new or revised policy or guideline is presented to BCBST Medical Technology Assessment Committee (MTAC) for review and approval. All MTAC voting members are MDs and when mental health topics are presented at MTAC there is a behavioral health MD who takes part in the

MEDICAL NECESSITY REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
			review and approval process. All revised pharmacy policies (there are no BCBST pharmacy guidelines) are presented to BCBST's Medical Technology Assessment Committee and BCBST's Pharmacy & Therapeutics Subcommittee for review and approval. New pharmacy policies are approved via an Executive Decision process in order for the medical policy document to be approved and available for use more quickly.			review and approval process. All revised pharmacy policies (there are no BCBST pharmacy guidelines) are presented to BCBST's Medical Technology Assessment Committee and BCBST's Pharmacy & Therapeutics Subcommittee for review and approval. New pharmacy policies are approved via an Executive Decision process in order for the medical policy document to be approved and available for use more quickly.
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	The medical necessity criteria contained within four different types of policy/guideline source documents are applied to both MH/SUD and M/S inpatient services. The processes, strategies, and evidentiary standards utilized to administer the medical necessity requirement are the same for both MH/SUD and M/S inpatient benefits. Therefore, it has been determined that the inpatient medical necessity requirement processes, strategies and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied than inpatient medical necessity requirement processes, strategies and evidentiary standards applied to M/S benefits.					

MEDICAL NECESSITY REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Evaluation of Processes, Strategies, and Evidentiary Standards	**If medical necessity requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of medical necessity is in parity. No additional information is needed.** **If medical necessity requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of medical necessity is not in parity. Proceed to the following row.**	
Modifications Explain how medical necessity processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A – No modifications required to comply with parity.	

NQTL Analysis Module 3: Medical Necessity – OUTPATIENT SERVICES

MEDICAL NECESSITY REQUIREMENTS – OUTPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**			**Medical/Surgical Services**		
What criteria are applied to make medical necessity/ appropriateness determinations for outpatient services?	The medical necessity criteria applied are contained within five different types of policy/guideline source documents: • Contractor Risk Agreement • TennCare Medical Necessity Criteria • BlueCross BlueShield of Tennessee medical policies • BlueCross BlueShield of Tennessee utilization management guidelines (UMGs) • MCG Care Guidelines			The medical necessity criteria applied are contained within five different types of policy/guideline source documents: • Contractor Risk Agreement • TennCare Medical Necessity Criteria • BlueCross BlueShield of Tennessee medical policies • BlueCross BlueShield of Tennessee utilization management guidelines (UMGs) • MCG Care Guidelines		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process your MCO uses, both in writing and in practice, for determining medical necessity.	**Strategies:** WHY does your MCO use the process described?	**Evidentiary Standards:** What evidence supports your MCO's MN criteria and processes for determining MN? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process your MCO uses, both in writing and in practice, for determining medical necessity.	**Strategies:** WHY does your MCO use the process described?	**Evidentiary Standards:** What evidence supports your MCO's MN criteria and processes for determining MN? Evidence may include practice guidelines and internal health plan utilization data.

MEDICAL NECESSITY REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	BlueCare/TennCare*Select* (BC/TCS) covers medically necessary health care and behavioral health services as defined in the Contractor Risk Agreement, not otherwise excluded under the TennCare program, and based on the individual needs of the member. In the process of TennCare coverage determinations, BlueCare/TennCare*Select* (BC/TCS) considers both BCBST Medical Policy and the TennCare medical necessity definition. The medical necessity standard set forth in the TennCare reform statute and in these regulations shall govern the delivery of all services and items to all enrollees or classes of beneficiaries in the TennCare program. The definition of medical necessity will be implemented consistent with federal law, including Early and Periodic Screening, Diagnosis, and	Goal is to ensure utilization management and quality service to our members through peer to peer communication of policy, practice guide lines and standards of care to providers.	The medical necessity criteria utilized by BlueCross BlueShield of Tennessee (BCBST) in determining medical necessity for both mental health and medical/surgical services are contained within five different groups of documents: Contractor Risk Agreement, TennCare Medical Necessity Criteria, BCBST medical policies, BCBST utilization management guidelines (UMGs) and MCG Care Guidelines. BCBST medical policies and UMGS are developed by BCBST's Medical Policy Department. The MCG Care Guidelines are purchased for company use from MCG Health, Inc.; MCG develops those guidelines. BCBST medical policy and UMGs contain policy positions and associated medical necessity criteria used in determining medical necessity.	BlueCare/TennCare*Select* (BC/TCS) covers medically necessary health care and behavioral health services as defined in the Contractor Risk Agreement, not otherwise excluded under the TennCare program, and based on the individual needs of the member. In the process of TennCare coverage determinations, BlueCare/TennCare*Select* (BC/TCS) considers both BCBST Medical Policy and the TennCare medical necessity definition. The medical necessity standard set forth in the TennCare reform statute and in these regulations shall govern the delivery of all services and items to all enrollees or classes of beneficiaries in the TennCare program. The definition of medical necessity will be implemented consistent with federal law, including Early and Periodic Screening, Diagnosis, and	Goal is to ensure utilization management and quality service to our members through peer to peer communication of policy, practice guide lines and standards of care to providers.	The medical necessity criteria utilized by BlueCross BlueShield of Tennessee (BCBST) in determining medical necessity for both mental health and medical/surgical services are contained within five different groups of documents: Contractor Risk Agreement, TennCare Medical Necessity Criteria, BCBST medical policies, BCBST utilization management guidelines (UMGs) and MCG Care Guidelines. BCBST medical policies and UMGS are developed by BCBST's Medical Policy Department. The MCG Care Guidelines are purchased for company use from MCG Health, Inc.; MCG develops those guidelines. BCBST medical policy and UMGs contain policy positions and associated medical necessity criteria used in determining medical necessity.

MEDICAL NECESSITY REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	Treatment (EPSDT) requirements, and within the state's authority to define what constitutes a medically necessary Medicaid service. A medical necessity determination is made by the Chief Medical Officer of the Bureau of TennCare or his or her clinical designee or by the Medical Director of one of its Managed Care Contractors or his or her clinical designee regarding whether a requested medical item or service satisfies the definition of medical necessity contained in Chapter 673 of the Public Acts of 2004 and these regulations as defined herein. When a request is received for an excluded item, the request may be approved by a licensed clinician or nurse reviewer or sent to a Medical Director to determine if it can be approved as a cost effective alternative or denied as an exclusion (see Exclusion List described in the		Those policy positions and associated medical necessity criteria are developed using an evidence-based evaluation/assessment process. The medical necessity criteria for all mental health and medical/surgical diagnostic and therapeutic procedures, devices and pharmaceutical agents addressed by those documents are developed using the following technology evaluation criteria: 1. The technology must have any necessary final approval from the appropriate governmental bodies. 2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. 3. The technology must improve the net health outcome 4. The technology must be as beneficial as any	Treatment (EPSDT) requirements, and within the state's authority to define what constitutes a medically necessary Medicaid service. A medical necessity determination is made by the Chief Medical Officer of the Bureau of TennCare or his or her clinical designee or by the Medical Director of one of its Managed Care Contractors or his or her clinical designee regarding whether a requested medical item or service satisfies the definition of medical necessity contained in Chapter 673 of the Public Acts of 2004 and these regulations as defined herein. When a request is received for an excluded item, the request may be approved by a licensed clinician or nurse reviewer or sent to a Medical Director to determine if it can be approved as a cost effective alternative or denied as an exclusion (see Exclusion List described in the		Those policy positions and associated medical necessity criteria are developed using an evidence-based evaluation/assessment process. The medical necessity criteria for all mental health and medical/surgical diagnostic and therapeutic procedures, devices and pharmaceutical agents addressed by those documents are developed using the following technology evaluation criteria: 1. The technology must have any necessary final approval from the appropriate governmental bodies. 2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. 3. The technology must improve the net health outcome 4. The technology must be as beneficial as any

MEDICAL NECESSITY REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	TennCare Rules, Section 1200-13-14.10). To be medically necessary, a medical item or service must satisfy each of the following criteria: 1. It must be recommended by a licensed physician who is treating the member or other licensed healthcare provider practicing within the scope of his or her license who is treating the member 2. It must be required in order to diagnose or treat a member's medical or behavioral condition 3. It must be safe and effective 4. It must not be experimental or investigational 5. It must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition The convenience of an enrollee, the enrollee's family, the enrollee's caregiver, or a provider, shall not be a factor or		established alternative 5. The improvement must be attainable outside the investigational setting Each mental health or medical/surgical related diagnostic procedure, therapeutic procedure, device or pharmaceutical agent addressed by a BCBST medical policy or UMG must meet all of the above technology evaluation criteria in order to be considered medically necessary. If not met, it's possible that coverage is mandated by a federal or state regulation/bill. BCBST utilizes numerous sources in its evaluation of the available evidence, those sources include, but are not limited to, the following: • Published clinical trials • Professional association guidelines (e.g., National Comprehensive Cancer Network,	TennCare Rules, Section 1200-13-14.10). To be medically necessary, a medical item or service must satisfy each of the following criteria: 1. It must be recommended by a licensed physician who is treating the member or other licensed healthcare provider practicing within the scope of his or her license who is treating the member 2. It must be required in order to diagnose or treat a member's medical or behavioral condition 3. It must be safe and effective 4. It must not be experimental or investigational 5. It must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition The convenience of an enrollee, the enrollee's family, the enrollee's caregiver, or a provider, shall not be a factor or		established alternative 5. The improvement must be attainable outside the investigational setting Each mental health or medical/surgical related diagnostic procedure, therapeutic procedure, device or pharmaceutical agent addressed by a BCBST medical policy or UMG must meet all of the above technology evaluation criteria in order to be considered medically necessary. If not met, it's possible that coverage is mandated by a federal or state regulation/bill. BCBST utilizes numerous sources in its evaluation of the available evidence, those sources include, but are not limited to, the following: • Published clinical trials • Professional association guidelines (e.g., National Comprehensive Cancer Network,

MEDICAL NECESSITY REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	justification in determining that a medical or behavioral item or service is medically necessary. The UM program uses the CRA inclusive of exclusion lists and non-covered lists, BCBST Medical Policy, and MCG as significant resources for review of medical and behavioral health determinations. UM clinical decision tools are applied based on the member's individual needs.		American Psychological Association, American College of Cardiology) • Medical technology assessment center evaluations (e.g., Hayes, ECRI, AHRQ) • Federal and state mandates • Nationally recognized pharmaceutical compendia • U.S. Food and Drug Administration (FDA) Once a new or revised BCBST medical policy or guideline document is written, it is posted on BCBST's Draft Medical Policies site for 30 days for provider review and comments. After that 30 day period the new or revised policy or guideline is presented to BCBST Medical Technology Assessment Committee (MTAC) for review and approval. All MTAC voting members are MDs and when mental health	justification in determining that a medical or behavioral item or service is medically necessary. The UM program uses the CRA inclusive of exclusion lists and non-covered lists, BCBST Medical Policy, and MCG as significant resources for review of medical and behavioral health determinations. UM clinical decision tools are applied based on the member's individual needs.		American Psychological Association, American College of Cardiology) • Medical technology assessment center evaluations (e.g., Hayes, ECRI, AHRQ) • Federal and state mandates • Nationally recognized pharmaceutical compendia • U.S. Food and Drug Administration (FDA) Once a new or revised BCBST medical policy or guideline document is written, it is posted on BCBST's Draft Medical Policies site for 30 days for provider review and comments. After that 30 day period the new or revised policy or guideline is presented to BCBST Medical Technology Assessment Committee (MTAC) for review and approval. All MTAC voting members are MDs and when mental health

MEDICAL NECESSITY REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
			topics are presented at MTAC there is a behavioral health MD who takes part in the review and approval process. All revised pharmacy policies (there are no BCBST pharmacy guidelines) are presented to BCBST's Medical Technology Assessment Committee and BCBST's Pharmacy & Therapeutics Subcommittee for review and approval. New pharmacy policies are approved via an Executive Decision process in order for the medical policy document to be approved and available for use more quickly.			topics are presented at MTAC there is a behavioral health MD who takes part in the review and approval process. All revised pharmacy policies (there are no BCBST pharmacy guidelines) are presented to BCBST's Medical Technology Assessment Committee and BCBST's Pharmacy & Therapeutics Subcommittee for review and approval. New pharmacy policies are approved via an Executive Decision process in order for the medical policy document to be approved and available for use more quickly.

MEDICAL NECESSITY REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	The medical necessity criteria contained within four different types of policy/guideline source documents are applied to both MH/SUD and M/S outpatient services. The processes, strategies, and evidentiary standards utilized to administer the medical necessity requirement are the same for both MH/SUD and M/S outpatient benefits. Therefore, it has been determined that the outpatient medical necessity requirement processes, strategies and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied than outpatient medical necessity requirement processes, strategies and evidentiary standards applied to M/S benefits.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If medical necessity requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of medical necessity is in parity. No additional information is needed.** **If medical necessity requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of medical necessity is not in parity. Proceed to the following row.**	
Modifications Explain how medical necessity processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A – No modifications required to comply with parity.	

NQTL Analysis Module 3: Medical Necessity – EMERGENCY SERVICES

MEDICAL NECESSITY REQUIREMENTS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
What criteria are applied to make medical necessity/ appropriateness determinations for emergency services?	*N/A No Medical Necessity Requirements for Emergency Services*			*N/A No Medical Necessity Requirements for Emergency Services*		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process your MCO uses, both in writing and in practice, for determining medical necessity.	**Strategies:** WHY does your MCO use the process described?	**Evidentiary Standards:** What evidence supports your MCO's MN criteria and processes for determining MN? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process your MCO uses, both in writing and in practice, for determining medical necessity.	**Strategies:** WHY does your MCO use the process described?	**Evidentiary Standards:** What evidence supports your MCO's MN criteria and processes for determining MN? Evidence may include practice guidelines and internal health plan utilization data.
	N/A	N/A	N/A	N/A	N/A	N/A

MEDICAL NECESSITY REQUIREMENTS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	Medical Necessity Requirements- Emergency Services processes, strategies and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied than Medical Necessity Requirements- Emergency Services processes, strategies and evidentiary standards applied to M/S benefits.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If medical necessity requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of medical necessity is in parity. No additional information is needed.** **If medical necessity requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of medical necessity is not in parity. Proceed to the following row.**	
Modifications Explain how medical necessity processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A No modifications required to comply with parity	

NQTL Analysis Module 4: Fail First and Step Therapy Protocols – INPATIENT SERVICES

FAIL FIRST AND STEP THERAPY PROTOCOLS – INPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**			**Medical/Surgical Services**		
Does the plan apply "fail first" requirements or step therapy protocols? List the inpatient services to which these requirements apply.	N/A – The plan does not have "fail first" or step therapy policies and procedures for inpatient services. The medical necessity criteria utilized by BlueCross BlueShield of Tennessee (BCBST) in determining medical necessity for both mental health and medical/surgical services are contained within four different groups of documents: Contractor Risk Agreement, BCBST medical policies, BCBST utilization management guidelines (UMGs) and MCG Care Guidelines. BCBST medical policies and UMGS are developed by BCBST's Medical Policy Department. The MCG Care Guidelines are purchased for company use from MCG Health, Inc. MCG develops those guidelines.			N/A – The plan does not have "fail first" or step therapy policies and procedures for inpatient services. The medical necessity criteria utilized by BlueCross BlueShield of Tennessee (BCBST) in determining medical necessity for both mental health and medical/surgical services are contained within four different groups of documents: Contractor Risk Agreement, BCBST medical policies, BCBST utilization management guidelines (UMGs) and MCG Care Guidelines. BCBST medical policies and UMGS are developed by BCBST's Medical Policy Department. The MCG Care Guidelines are purchased for company use from MCG Health, Inc. MCG develops those guidelines.		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for fail first and/or step therapy protocols that your MCO uses.	**Strategies:** WHY does your MCO use fail first or step therapy requirements f or these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of fail first or step therapy for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for fail first and/or step therapy protocols that your MCO uses.	**Strategies:** WHY does your MCO use fail first or step therapy requirements f or these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of fail first or step therapy for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.

FAIL FIRST AND STEP THERAPY PROTOCOLS – INPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**			**Medical/Surgical Services**		
	N/A	N/A	N/A	N/A	N/A	N/A
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	The plan does not have "fail first" or step therapy policies and procedures for inpatient services. The medical necessity criteria utilized by BlueCross BlueShield of Tennessee (BCBST) in determining medical necessity for both mental health and medical/surgical services are contained within four different groups of documents: Contractor Risk Agreement, BCBST medical policies, BCBST utilization management guidelines (UMGs) and MCG Care Guidelines. BCBST medical policies and UMGS are developed by BCBST's Medical Policy Department. The MCG Care Guidelines are purchased for company use from MCG Health, Inc. MCG develops those guidelines. Therefore, it is determined that inpatient "fail first" requirements or step therapy protocols processes, strategies and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied than inpatient "fail first" requirements or step therapy protocols processes, strategies and evidentiary standards applied to M/S benefits.					
Evaluation of Processes, Strategies, and Evidentiary Standards	**If fail first/step therapy requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of these requirements is in parity. No additional information is needed.** **If fail first/step therapy requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of these requirements is not in parity. Proceed to the following row.**					

FAIL FIRST AND STEP THERAPY PROTOCOLS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Modifications Explain how fail first or step therapy requirements for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A – No modifications required to comply with parity.	

NQTL Analysis Module 4: Fail First and Step Therapy Protocols – OUTPATIENT SERVICES

FAIL FIRST AND STEP THERAPY PROTOCOLS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
Does the plan apply "fail first" requirements or step therapy protocols? List the outpatient services to which these requirements apply.	N/A – The plan does not have "fail first" or step therapy policies and procedures for outpatient services. The medical necessity criteria utilized by BlueCross BlueShield of Tennessee (BCBST) in determining medical necessity for both mental health and medical/surgical services are contained within four different groups of documents: Contractor Risk Agreement, BCBST medical policies, BCBST utilization management guidelines (UMGs) and MCG Care Guidelines. BCBST medical policies and UMGS are developed by BCBST's Medical Policy Department. The MCG Care Guidelines are purchased for company use from MCG Health, Inc. MCG develops those guidelines.			N/A – The plan does not have "fail first" or step therapy policies and procedures for outpatient services. The medical necessity criteria utilized by BlueCross BlueShield of Tennessee (BCBST) in determining medical necessity for both mental health and medical/surgical services are contained within four different groups of documents: Contractor Risk Agreement, BCBST medical policies, BCBST utilization management guidelines (UMGs) and MCG Care Guidelines. BCBST medical policies and UMGS are developed by BCBST's Medical Policy Department. The MCG Care Guidelines are purchased for company use from MCG Health, Inc. MCG develops those guidelines.		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for fail first and/or step therapy protocols that your MCO uses.	**Strategies:** WHY does your MCO use fail first or step therapy requirements f or these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of fail first or step therapy for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for fail first and/or step therapy protocols that your MCO uses.	**Strategies:** WHY does your MCO use fail first or step therapy requirements f or these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of fail first or step therapy for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.

FAIL FIRST AND STEP THERAPY PROTOCOLS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	N/A	N/A	N/A	N/A	N/A	N/A
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	The plan does not have "fail first" or step therapy policies and procedures for outpatient services. The medical necessity criteria utilized by BlueCross BlueShield of Tennessee (BCBST) in determining medical necessity for both mental health and medical/surgical services are contained within four different groups of documents: Contractor Risk Agreement, BCBST medical policies, BCBST utilization management guidelines (UMGs) and MCG Care Guidelines. BCBST medical policies and UMGS are developed by BCBST's Medical Policy Department. The MCG Care Guidelines are purchased for company use from MCG Health, Inc. MCG develops those guidelines. Therefore, it is determined that outpatient "fail first" requirements or step therapy protocols processes, strategies and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied than outpatient "fail first" requirements or step therapy protocols processes, strategies and evidentiary standards applied to M/S benefits.					
Evaluation of Processes, Strategies, and Evidentiary Standards	**If fail first/step therapy requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of these requirements is in parity. No additional information is needed.** **If fail first/step therapy requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of these requirements is not in parity. Proceed to the following row.**					

FAIL FIRST AND STEP THERAPY PROTOCOLS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Modifications Explain how fail first or step therapy requirements for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A – No modifications required to comply with parity.	

NQTL Analysis Module 4: Fail First and Step Therapy Protocols – EMERGENCY SERVICES

FAIL FIRST AND STEP THERAPY PROTOCOLS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
Does the plan apply "fail first" requirements or step therapy protocols? List the emergency services to which these requirements apply.	N/A – The plan does not have "fail first" or step therapy policies and procedures for emergency services. The medical necessity criteria utilized by BlueCross BlueShield of Tennessee (BCBST) in determining medical necessity for both mental health and medical/surgical services are contained within four different groups of documents: Contractor Risk Agreement, BCBST medical policies, BCBST utilization management guidelines (UMGs) and MCG Care Guidelines. BCBST medical policies and UMGS are developed by BCBST's Medical Policy Department. The MCG Care Guidelines are purchased for company use from MCG Health, Inc. MCG develops those guidelines.			N/A – The plan does not have "fail first" or step therapy policies and procedures for emergency services. The medical necessity criteria utilized by BlueCross BlueShield of Tennessee (BCBST) in determining medical necessity for both mental health and medical/surgical services are contained within four different groups of documents: Contractor Risk Agreement, BCBST medical policies, BCBST utilization management guidelines (UMGs) and MCG Care Guidelines. BCBST medical policies and UMGS are developed by BCBST's Medical Policy Department. The MCG Care Guidelines are purchased for company use from MCG Health, Inc. MCG develops those guidelines.		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for fail first and/or step therapy protocols that your MCO uses.	**Strategies:** WHY does your MCO use fail first or step therapy requirements f or these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of fail first or step therapy for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for fail first and/or step therapy protocols that your MCO uses.	**Strategies:** WHY does your MCO use fail first or step therapy requirements f or these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of fail first or step therapy for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.

FAIL FIRST AND STEP THERAPY PROTOCOLS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	N/A	N/A	N/A	N/A	N/A	N/A
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	The plan does not have “fail first” or step therapy policies and procedures for emergency services. The medical necessity criteria utilized by BlueCross BlueShield of Tennessee (BCBST) in determining medical necessity for both mental health and medical/surgical services are contained within four different groups of documents: Contractor Risk Agreement, BCBST medical policies, BCBST utilization management guidelines (UMGs) and MCG Care Guidelines. BCBST medical policies and UMGS are developed by BCBST’s Medical Policy Department. The MCG Care Guidelines are purchased for company use from MCG Health, Inc. MCG develops those guidelines. Therefore, it is determined that emergency services “fail first” requirements or step therapy protocols processes, strategies and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied than emergency services “fail first” requirements or step therapy protocols processes, strategies and evidentiary standards applied to M/S benefits					
Evaluation of Processes, Strategies, and Evidentiary Standards	**If fail first/step therapy requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of these requirements is in parity. No additional information is needed.** **If fail first/step therapy requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of these requirements is not in parity. Proceed to the following row.**					

FAIL FIRST AND STEP THERAPY PROTOCOLS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Modifications Explain how fail first or step therapy requirements for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A – No modifications required to comply with parity.	

NQTL Analysis Module 5: Network Standards – INPATIENT SERVICES

NETWORK STANDARDS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
What are the plan's network admission requirements for inpatient providers?	The Network Standards procedures encompass all provider types as Network Standards are not specific to any one provider type. Blue Cross and BlueShield of Tennessee, Inc. (BCBST) and BlueCare Tennessee (BCT) have established network participation criteria detailing the terms and conditions for participation in the BCBST and BCT networks. These terms and conditions will be consistently applied to any provider who: • Is recruited by the Plan • Requests participation or re-applies for participation • Re-applies following voluntary or involuntary termination of provider's participation • Has a significant change in practice, which initiates a re-application and/or reconsideration of the provider's current participation status **Definitions:** Network status is defined for consistency and treatment of the network and is administered by the Behavioral Health Provider Network Management Team (BHPNMT). BHPNMT has established network status classifications as follows: • **OPEN**: The network is open and available to new providers seeking to join regardless of provider type and network need, so long as the provider meets the minimum network participation criteria, credentialing, and has not been otherwise recommended for exclusion from a network. For OPEN networks, contract requests are received and implemented without additional consideration. • **PARTIALLY CLOSED**: The network is closed to certain new providers seeking to join, including without limitation, providers of a certain provider type or providers located in a defined location. For PARTIALLY CLOSED networks, contract requests that are received are denied summarily, the provider is notified of the network status, and the provider is not sent contracts for such network(s). • **CLOSED**: The network is closed to new providers seeking to join. For CLOSED networks, contract requests that are received are denied summarily and a provider is not sent contracts for	The Network Standards procedures encompass all provider types as Network Standards are not specific to any one provider type. Blue Cross and BlueShield of Tennessee, Inc. (BCBST) and BlueCare Tennessee (BCT) have established network participation criteria detailing the terms and conditions for participation in the BCBST and BCT networks. These terms and conditions will be consistently applied to any provider who: • Is recruited by the Plan • Requests participation or re-applies for participation • Re-applies following voluntary or involuntary termination of provider's participation • Has a significant change in practice, which initiates a re-application and/or reconsideration of the provider's current participation status **Definitions:** Network status is defined for consistency and treatment of the network and is administered by Provider Network Management (PNM). PNM has established network status classifications as follows: • **OPEN**: The network is open and available to new providers seeking to join regardless of provider type and network need, so long as the provider meets the minimum network participation criteria, credentialing, and has not been otherwise recommended for exclusion from a network. For OPEN networks, contract requests are received and implemented without additional consideration. • **PARTIALLY CLOSED**: The network is closed to certain new providers seeking to join, including without limitation, providers of a certain provider type or providers located in a defined location. For PARTIALLY CLOSED networks, contract requests that are received are denied summarily, the provider is notified of the network status, and the provider is not sent contracts for such network(s). • **CLOSED**: The network is closed to new providers seeking to join. For CLOSED networks, contract requests that are received are denied summarily and a provider is not sent contracts for the CLOSED networks.

NETWORK STANDARDS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
	the CLOSED networks. A network may be PARTIALLY CLOSED or CLOSED as a result of saturation of required adequacy, quality gates and metrics, or because of other business needs. **BCT Network** The BCT network is classified as PARTIALLY CLOSED. This network is open to providers accepting standard contract language and standard rates in the following categories: • Any provider satisfying a network deficiency • Any provider joining a participating group with a group contract • Behavioral health professional providers joining a multi-specialty group with participating Medical specialists will be sent to the Director, Provider Contracting, Ancillary and Behavioral Health Networks for review and coordination with the Director, BlueCare Network Oversight Any provider, who applies to join a BCT network that does not fall into one of these categories, is presented to BCT senior leadership for consideration and a decision on inclusion in the BCT network. BHPNMT will ensure proper selection and retention of providers by requiring all applicable providers to apply and pass a rigorous credentialing process, which follows NCQA standards. **Credentialing Requirements** In order to establish consistent standards for network participation, and to meet regulatory requirements, BCBST/BlueCare Tennessee developed Network Participation Criteria. Practitioners applying for network admission are asked to complete an application through the Council for Affordable Quality Healthcare (CAQH) for individual professionals. BCBST/BlueCare Tennessee partners with CAQH Solutions, which offers Providers a single point of entry for application information. Organizational Providers will utilize the BCBST/BlueCare Tennessee Facility application information. Utilizing the CAQH application or Organizational Provider	A network may be PARTIALLY CLOSED or CLOSED as a result of saturation of required adequacy, quality gates and metrics, or because of other business needs. **BCT Network** The BCT network is classified as PARTIALLY CLOSED. This network is open to providers accepting standard contract language and standard rates in the following categories: • Primary Care (PCP) • Obstetrics and Gynecology • School based Physical, Occupational and Speech Therapy • Any provider satisfying a network deficiency • Any provider joining a participating group with a group contract • Medical specialists joining a multi-specialty group with participating behavioral health professional providers will be sent to the Director, Provider Contracting, Ancillary and Behavioral Health Networks for review and coordination with the Director, BlueCare Network Oversight Any provider, who applies to join a BCT network that does not fall into one of these categories, may be presented to BCT senior leadership for consideration and a decision on inclusion in the BCT network. PNM will ensure proper selection and retention of providers by requiring all applicable providers to apply and pass a rigorous credentialing process, which follows NCQA standards. **Credentialing Requirements** In order to establish consistent standards for network participation, and to meet regulatory requirements, BCBST/BlueCare Tennessee developed Network Participation Criteria. Practitioners applying for network admission are asked to complete an application through the Council for Affordable Quality Healthcare (CAQH) for individual professionals. BCBST/BlueCare Tennessee partners with CAQH Solutions, which offers Providers a single point of entry for application

NETWORK STANDARDS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
	application, BCBST/BlueCare conducts a preliminary evaluation for network participation. Practitioners must complete the application in its entirety, submit the required documentation, and complete the credentialing process prior to network participation. Verifying credentials of Practitioners and other Health Care Professionals/Providers is an essential component of an integrated health care system. The Credentialing process incorporates an ongoing assessment of the quality-of-care services provided by those Practitioners and other Health Care Professionals/Providers who wish to participate in the BCBST/BlueCare Tennessee network. Major components of the credentialing program include: • Credentialing Committee • Policies and Procedures • Initial Credentialing Process • Re-credentialing Process • Delegated Credentialing Activities	information. Organizational Providers will utilize the BCBST/BlueCare Tennessee Facility application information. Utilizing the CAQH application or Organizational Provider application, BCBST/BlueCare conducts a preliminary evaluation for network participation. Practitioners must complete the application in its entirety, submit the required documentation, and complete the credentialing process prior to network participation. Verifying credentials of Practitioners and other Health Care Professionals/Providers is an essential component of an integrated health care system. The Credentialing process incorporates an ongoing assessment of the quality-of-care services provided by those Practitioners and other Health Care Professionals/Providers who wish to participate in the BCBST/BlueCare Tennessee network. Major components of the credentialing program include: • Credentialing Committee • Policies and Procedures • Initial Credentialing Process • Re-credentialing Process • Delegated Credentialing Activities

NETWORK STANDARDS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Are there any geographic limitations on provider inclusion in the network (e.g., requirements for accessing out-of-state providers)? If so, describe these limitations.	The BCT provider network was developed and is monitored to meet the availability and accessibility standards of the Contractor Risk Agreement (CRA) and the TennCare*Select* Agreement (TSA). BCT along with Provider Resolutions monitors our network to ensure adherence to all geographic access standards by utilizing industry standard network accessibility analysis software, GeoAccess, along with other tools to monitor network adequacy and access for physical and behavioral health services. Provider Resolutions also utilizes the regional knowledge of our Behavioral Health Provider Contracting Team and BHPNMT to develop reports on where and when it is appropriate to utilize non-participating providers, taking into account the number of contracted providers who are not accepting new members, community standards, and the geographic location of providers in relation to members. In accordance with the CRA and as stated in the Provider Administration Manual (PAM), Minimum Institutional Network Participation Criteria, contracting in Tennessee & Contiguous Counties is required. BCT does not contract with providers located out of state with the exception of those located in contiguous counties.	The BCT provider network was developed and is monitored to meet the availability and accessibility standards of the Contractor Risk Agreement (CRA) and the TennCare*Select* Agreement (TSA). BCT along with Provider Resolutions monitors our network to ensure adherence to all geographic access standards by utilizing industry standard network accessibility analysis software, GeoAccess, along with other tools to monitor network adequacy and access for physical and behavioral health services. Provider Resolutions also utilizes the regional knowledge of our Provider Contracting Network Managers and Provider Service Consultants to develop reports on where and when it is appropriate to utilize non-participating providers, taking into account the number of contracted providers who are not accepting new members, community standards, and the geographic location of providers in relation to members. In accordance with the CRA and as stated in the Provider Administration Manual (PAM), Minimum Institutional Network Participation Criteria, contracting in Tennessee & Contiguous Counties is required. BCT does not contract with providers located out of state with the exception of those located in contiguous counties.
Describe the criteria applied in determining standards for access to out-of-network providers.	BlueCare Tennessee does not have out of network (OON) benefits except in the case of a medical emergency. All non-emergent OON services require a prior authorization. The following questions must be addressed for all OON requests when being reviewed for prior authorization: • Is the request a covered service? • Is it an emergency? • Is the service medically necessary? • Is there a participating provider available in the member's area? If OON service is approved, an authorization will be loaded and provider will be reimbursed for services at OON reimbursement rates. If provider requests negotiated rates, once the authorization is	BlueCare Tennessee does not have out of network (OON) benefits except in the case of a medical emergency. All non-emergent OON services require a prior authorization. The following questions must be addressed for all OON requests when being reviewed for prior authorization: • Is the request a covered service? • Is it an emergency? • Is the service medically necessary? • Is there a participating provider available in the member's area? If OON service is approved, an authorization will be loaded and provider will be reimbursed for services at OON reimbursement rates. If provider requests negotiated rates, once the authorization is

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If OON service is denied, a letter is sent to the provider and member advising of the denial and a listing of the participating providers is included in the response.</td><td colspan="3">complete a request is routed to the area that handles out of network rate negotiations once the rate is agreed upon by both parties, a single case agreement is completed.

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<tr><td>What methods are used to determine usual, customary, and reasonable charges?</td><td colspan="3">Behavioral Health BlueCare Tennessee rates are based on the following:
• Underlying knowledge of the market
• Provider research
• Ability to negotiate cost effective rates that satisfy network adequacy needs
• TennCare rate parameter guidance</td><td colspan="3">BlueCare Tennessee rates are based on the following:
• Percentage of CMS reimbursement
• Underlying knowledge of the market
• Provider research
• Ability to negotiate cost effective rates that satisfy network adequacy needs
• TennCare rate parameter guidance</td></tr>
<tr><td>Processes, Strategies, and Evidentiary Standards</td><td>Processes:
Explain the process, both in writing and in practice, for setting and implementing network admission standards.</td><td>Strategies:
WHY does your MCO use these processes and standards? What is the rationale and/or goal you are trying to achieve?</td><td>Evidentiary Standards:
What evidence supports the use of these processes and standards? Evidence may include practice guidelines and internal health plan utilization data.</td><td>Processes:
Explain the process, both in writing and in practice, for setting and implementing network admission standards.</td><td>Strategies:
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</table>

NETWORK STANDARDS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	The BCT provider network was developed and is monitored to meet the availability and accessibility standards of the Contractor Risk Agreement (CRA) and the TennCare*Select* Agreement (TSA). BHPNMT will ensure proper selection and retention of providers by requiring all applicable providers to apply and pass a rigorous credentialing process, which follows NCQA standards.	To ensure network sufficiency and an appropriate mix of providers to meet the member's needs. These guidelines are used to develop and maintain our provider network selection and retention process.	BCT maintains an adequate network of providers and is currently meeting all access and availability requirements as set forth in the CRA. BCT along with Provider Resolutions monitors our network to ensure adherence to all geographic access standards by utilizing industry standard network accessibility analysis software, GeoAccess, along with other tools to monitor network adequacy and access for physical and behavioral health services.	The BCT provider network was developed and is monitored to meet the availability and accessibility standards of the Contractor Risk Agreement (CRA) and the TennCare*Select* Agreement (TSA). PNM will ensure proper selection and retention of providers by requiring all applicable providers to apply and pass a rigorous credentialing process, which follows NCQA standards.	To ensure network sufficiency and an appropriate mix of providers to meet the member's needs. These guidelines are used to develop and maintain our provider network selection and retention process.	BCT maintains an adequate network of providers and is currently meeting all access and availability requirements as set forth in the CRA. BCT along with Provider Resolutions monitors our network to ensure adherence to all geographic access standards by utilizing industry standard network accessibility analysis software, GeoAccess, along with other tools to monitor network adequacy and access for physical and behavioral health services.
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	While the specific types of services and providers vary between MH/SUD and M/S; policies and procedures for network standards follow the same guidelines. Network standards processes, strategies and evidentiary standards applied to MH/SUD providers are comparable and no more stringently applied than network standards processes, strategies and evidentiary standards for M/S providers.					

NETWORK STANDARDS – INPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**	**Medical/Surgical Services**
Evaluation of Processes, Strategies, and Evidentiary Standards	**If network standards are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of these standards is in parity. No additional information is needed.** **If network standards are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of these standards is not in parity. Proceed to the following row.**	
Modifications Explain how network standards for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A – No modifications required to comply with parity.	

NQTL Analysis Module 5: Network Standards – OUTPATIENT SERVICES

NETWORK STANDARDS – OUTPATIENT SERVICES)	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
What are the plan's network admission requirements for outpatient providers?	The Network Standards procedures encompass all provider types as Network Standards are not specific to any one provider type. Blue Cross and BlueShield of Tennessee, Inc. (BCBST) and BlueCare Tennessee (BCT) have established network participation criteria detailing the terms and conditions for participation in the BCBST and BCT networks. These terms and conditions will be consistently applied to any provider who: • Is recruited by the Plan • Requests participation or re-applies for participation • Re-applies following voluntary or involuntary termination of provider's participation • Has a significant change in practice, which initiates a re-application and/or reconsideration of the provider's current participation status **Definitions:** Network status is defined for consistency and treatment of the network and is administered by the Behavioral Health Provider Network Management Team (BHPNMT). BHPNMT has established network status classifications as follows: • **OPEN**: The network is open and available to new providers seeking to join regardless of provider type and network need, so long as the provider meets the minimum network participation criteria, credentialing, and has not been otherwise recommended for exclusion from a network. For OPEN networks, contract requests are received and implemented without additional consideration. • **PARTIALLY CLOSED**: The network is closed to certain new providers seeking to join, including without limitation, providers of a certain provider type or providers located in a defined location. For PARTIALLY CLOSED networks, contract requests that are received are denied summarily, the provider is notified of the network status, and the provider is not sent contracts for such network(s). • **CLOSED**: The network is closed to new providers seeking to join. For CLOSED networks, contract requests that are received	The Network Standards procedures encompass all provider types as Network Standards are the not specific to any one provider type. Blue Cross and BlueShield of Tennessee, Inc. (BCBST) and BlueCare Tennessee (BCT) have established network participation criteria detailing the terms and conditions for participation in the BCBST and BCT networks. These terms and conditions will be consistently applied to any provider who: • Is recruited by the Plan • Requests participation or re-applies for participation • Re-applies following voluntary or involuntary termination of provider's participation • Has a significant change in practice, which initiates a re-application and/or reconsideration of the provider's current participation status **Definitions:** Network status is defined for consistency and treatment of the network and is administered by Provider Network Management (PNM). PNM has established network status classifications as follows: • **OPEN**: The network is open and available to new providers seeking to join regardless of provider type and network need, so long as the provider meets the minimum network participation criteria, credentialing, and has not been otherwise recommended for exclusion from a network. For OPEN networks, contract requests are received and implemented without additional consideration. • **PARTIALLY CLOSED**: The network is closed to certain new providers seeking to join, including without limitation, providers of a certain provider type or providers located in a defined location. For PARTIALLY CLOSED networks, contract requests that are received are denied summarily, the provider is notified of the network status, and the provider is not sent contracts for such network(s). • **CLOSED**: The network is closed to new providers seeking to join. For CLOSED networks, contract requests that are received are denied summarily and a provider is not sent contracts for

NETWORK STANDARDS – OUTPATIENT SERVICES)	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
	are denied summarily and a provider is not sent contracts for the CLOSED networks. A network may be PARTIALLY CLOSED or CLOSED as a result of saturation of required adequacy, quality gates and metrics, or because of other business needs. **BCT Network** The BCT Behavioral Health network is classified as OPEN for behavioral health professional outpatient services. This network is open to providers accepting standard contract language and standard rates in the following categories: • Psychiatry (M.D or O.D) • Advanced Practice Nurse, Behavioral Health (APN) • Psychology (PhD) • Licensed Senior Psychological Examiner (LSPE) • Licensed Clinical Social Worker (LCSW) • Licensed Professional Counselor (LPC) • Licensed Marriage and Family Therapist (LMFT) • Licensed/Board Certified Behavioral Analyst, Master's level or above (BCAB) • Any provider satisfying a network deficiency • Any provider joining a participating group with a group contract • Behavioral health professional providers joining a multi-specialty group with participating Medical specialists will be sent to the Director, Provider Contracting, Ancillary and Behavioral Health Networks for review and coordination with the Director, BlueCare Network Oversight Any provider, who applies to join a BCT network that does not fall into one of these categories, is presented to BCT senior leadership for consideration and a decision on inclusion in the BCT network. BHPNMT will ensure proper selection and retention of providers by requiring all applicable providers to apply and pass a rigorous credentialing process, which follows NCQA standards.	the CLOSED networks. A network may be PARTIALLY CLOSED or CLOSED as a result of saturation of required adequacy, quality gates and metrics, or because of other business needs. **BCT Network** The BCT network is classified as PARTIALLY CLOSED. This network is open to providers accepting standard contract language and standard rates in the following categories: • Primary Care (PCP) • Obstetrics and Gynecology • School based Physical, Occupational and Speech Therapy • Any provider satisfying a network deficiency • Any provider joining a participating group with a group contract • Medical specialists joining a multi-specialty group with participating behavioral health professional providers will be sent to the Director, Provider Contracting, Ancillary and Behavioral Health Networks for review and coordination with the Director, BlueCare Network Oversight Any provider, who applies to join a BCT network that does not fall into one of these categories, may be presented to BCT senior leadership for consideration and a decision on inclusion in the BCT network. PNM will ensure proper selection and retention of providers by requiring all applicable providers to apply and pass a rigorous credentialing process, which follows NCQA standards. **Credentialing Requirements** In order to establish consistent standards for network participation, and to meet regulatory requirements, BCBST/BlueCare Tennessee developed Network Participation Criteria. Practitioners applying for network admission are asked to complete an application through the Council for Affordable Quality Healthcare (CAQH) for individual professionals.

NETWORK STANDARDS – OUTPATIENT SERVICES)	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
	Credentialing Requirements In order to establish consistent standards for network participation, and to meet regulatory requirements, BCBST/BlueCare Tennessee developed Network Participation Criteria. Practitioners applying for network admission are asked to complete an application through the Council for Affordable Quality Healthcare (CAQH) for individual professionals. BCBST/BlueCare Tennessee partners with CAQH Solutions, which offers Providers a single point of entry for application information. Organizational Providers will utilize the BCBST/BlueCare Tennessee Facility application information. Utilizing the CAQH application or Organizational Provider application, BCBST/BlueCare conducts a preliminary evaluation for network participation. Practitioners must complete the application in its entirety, submit the required documentation, and complete the credentialing process prior to network participation. Verifying credentials of Practitioners and other Health Care Professionals/Providers is an essential component of an integrated health care system. The Credentialing process incorporates an ongoing assessment of the quality-of-care services provided by those Practitioners and other Health Care Professionals/Providers who wish to participate in the BCBST/BlueCare Tennessee network. Major components of the credentialing program include: • Credentialing Committee • Policies and Procedures • Initial Credentialing Process • Re-credentialing Process • Delegated Credentialing Activities	BCBST/BlueCare Tennessee partners with CAQH Solutions, which offers Providers a single point of entry for application information. Organizational Providers will utilize the BCBST/BlueCare Tennessee Facility application information. Utilizing the CAQH application or Organizational Provider application, BCBST/BlueCare conducts a preliminary evaluation for network participation. Practitioners must complete the application in its entirety, submit the required documentation, and complete the credentialing process prior to network participation. Verifying credentials of Practitioners and other Health Care Professionals/Providers is an essential component of an integrated health care system. The Credentialing process incorporates an ongoing assessment of the quality-of-care services provided by those Practitioners and other Health Care Professionals/Providers who wish to participate in the BCBST/BlueCare Tennessee network. Major components of the credentialing program include: • Credentialing Committee • Policies and Procedures • Initial Credentialing Process • Re-credentialing Process • Delegated Credentialing Activities

NETWORK STANDARDS – OUTPATIENT SERVICES)	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Are there any geographic limitations on provider inclusion in the network (e.g., requirements for accessing out-of-state providers)? If so, describe these limitations.	The BCT provider network was developed and is monitored to meet the availability and accessibility standards of the Contractor Risk Agreement (CRA) and the TennCare*Select* Agreement (TSA). BCT along with Provider Resolutions monitors our network to ensure adherence to all geographic access standards by utilizing industry standard network accessibility analysis software, GeoAccess, along with other tools to monitor network adequacy and access for physical and behavioral health services. Provider Resolutions also utilizes the regional knowledge of our Behavioral Health Network Managers to develop reports on where and when it is appropriate to utilize non-participating providers, taking into account the number of contracted providers who are not accepting new members, community standards, and the geographic location of providers in relation to members. In accordance with the CRA and as stated in the Provider Administration Manual (PAM), Minimum Institutional Network Participation Criteria, contracting in Tennessee & Contiguous Counties is required. BCT does not contract with providers located out of state with the exception of those located in contiguous counties.	The BCT provider network was developed and is monitored to meet the availability and accessibility standards of the Contractor Risk Agreement (CRA) and the TennCare*Select* Agreement (TSA). BCT along with Provider Resolutions monitors our network to ensure adherence to all geographic access standards by utilizing industry standard network accessibility analysis software, GeoAccess, along with other tools to monitor network adequacy and access for physical and behavioral health services. Provider Resolutions also utilizes the regional knowledge of our Provider Contracting Network Managers and Provider Service Consultants to develop reports on where and when it is appropriate to utilize non-participating providers, taking into account the number of contracted providers who are not accepting new members, community standards, and the geographic location of providers in relation to members. In accordance with the CRA and as stated in the Provider Administration Manual (PAM), Minimum Institutional Network Participation Criteria, contracting in Tennessee & Contiguous Counties is required. BCT does not contract with providers located out of state with the exception of those located in contiguous counties.

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<tr><td>Describe the criteria applied in determining standards for access to out-of-network providers.</td><td colspan="3">BlueCare Tennessee does not have out of network (OON) benefits except in the case of a medical emergency.

All non-emergent OON services require a prior authorization. The following questions must be addressed for all OON requests when being reviewed for prior authorization:

• Is the request a covered service?
• Is it an emergency?
• Is the service medically necessary?
• Is there a participating provider available in the member's area?

If OON service is approved, an authorization will be loaded and provider will be reimbursed for services at OON reimbursement rates.

If provider requests negotiated rates, once the authorization is complete a request is routed to the area that handles out of network rate negotiations once the rate is agreed upon by both parties, a single case agreement is completed.

If OON service is denied, a letter is sent to the provider and member advising of the denial and a listing of the participating providers is included in the response.</td><td colspan="3">BlueCare Tennessee does not have out of network (OON) benefits except in the case of a medical emergency.

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If OON service is approved, an authorization will be loaded and provider will be reimbursed for services at OON reimbursement rates.

If provider requests negotiated rates, once the authorization is complete a request is routed to the area that handles out of network rate negotiations once the rate is agreed upon by both parties, a single case agreement is completed.

If OON service is denied, a letter is sent to the provider and member advising of the denial and a listing of the participating providers is included in the response.</td></tr>
<tr><td>What methods are used to determine usual, customary, and reasonable charges?</td><td colspan="3">Behavioral Health BlueCare Tennessee rates are based on the following:
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• Percentage of CMS reimbursement
• Underlying knowledge of the market
• Provider research
• Ability to negotiate cost effective rates that satisfy network adequacy needs
• TennCare rate parameter guidance</td></tr>
<tr><td>Processes, Strategies, and Evidentiary Standards</td><td>Processes:
Explain the process, both in writing and in</td><td>Strategies:
WHY does your MCO use these processes</td><td>Evidentiary Standards:
What evidence</td><td>Processes:
Explain the process, both in writing and in</td><td>Strategies:
WHY does your MCO use these processes</td><td>Evidentiary Standards:
What evidence</td></tr>
</table>

NETWORK STANDARDS – OUTPATIENT SERVICES)	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	practice, for setting and implementing network admission standards.	and standards? What is the rationale and/or goal you are trying to achieve?	supports the use of these processes and standards? Evidence may include practice guidelines and internal health plan utilization data.	practice, for setting and implementing network admission standards.	and standards? What is the rationale and/or goal you are trying to achieve?	supports the use of these processes and standards? Evidence may include practice guidelines and internal health plan utilization data.
	The BCT provider network was developed and is monitored to meet the availability and accessibility standards of the Contractor Risk Agreement (CRA) and the TennCare*Select* Agreement (TSA). BHPNMT will ensure proper selection and retention of providers by requiring all applicable providers to apply and pass a rigorous credentialing process, which follows NCQA standards.	To ensure network sufficiency and an appropriate mix of providers to meet the member's needs. These guidelines are used to develop and maintain our provider network selection and retention process	BCT maintains an adequate network of providers and is currently meeting all access and availability requirements as set forth in the CRA. BCT along with Provider Resolutions monitors our network to ensure adherence to all geographic access standards by utilizing industry standard network accessibility analysis software, GeoAccess, along with other tools to monitor network adequacy and access for physical and behavioral health services.	The BCT provider network was developed and is monitored to meet the availability and accessibility standards of the Contractor Risk Agreement (CRA) and the TennCare*Select* Agreement (TSA). PNM will ensure proper selection and retention of providers by requiring all applicable providers to apply and pass a rigorous credentialing process, which follows NCQA standards.	To ensure network sufficiency and an appropriate mix of providers to meet the member's needs. These guidelines are used to develop and maintain our provider network selection and retention process	BCT maintains an adequate network of providers and is currently meeting all access and availability requirements as set forth in the CRA. BCT along with Provider Resolutions monitors our network to ensure adherence to all geographic access standards by utilizing industry standard network accessibility analysis software, GeoAccess, along with other tools to monitor network adequacy and access for physical and behavioral health services.

NETWORK STANDARDS – OUTPATIENT SERVICES)	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.?	While the specific types of services and providers vary between MH/SUD and M/S, policies and procedures for network standards follow the same guidelines. Network standards processes, strategies and evidentiary standards applied to MH/SUD providers are comparable and no more stringently applied than network standards processes, strategies and evidentiary standards for M/S providers. The Behavioral Health networks are actually more open to providers than medical networks.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If network standards are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of these standards is in parity. No additional information is needed.** **If network standards are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of these standards is not in parity. Proceed to the following row.**	
Modifications Explain how network standards for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A – No modifications required to comply with parity.	

NQTL Analysis Module 5: Network Standards – EMERGENCY SERVICES

NETWORK STANDARDS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
What are the plan's network admission requirements for emergency providers?	Emergency Services Mental Health and Substance Abuse Disorders are integrated in Emergency Medical Services. Once evaluated and medically stabilized, members are referred to the appropriate inpatient or outpatient behavioral health services. Please see applicable sections for Network Standards – Emergency Services for Medical/Surgical Services for this section.	The Network Standards procedures encompass all provider types as Network Standards are the not specific to any one provider type. Blue Cross and BlueShield of Tennessee, Inc. (BCBST) and BlueCare Tennessee (BCT) have established network participation criteria detailing the terms and conditions for participation in the BCBST and BCT networks. These terms and conditions will be consistently applied to any provider who: • Is recruited by the Plan • Requests participation or re-applies for participation • Re-applies following voluntary or involuntary termination of provider's participation • Has a significant change in practice, which initiates a re-application and/or reconsideration of the provider's current participation status **Definitions:** Network status is defined for consistency and treatment of the network and is administered by Provider Network Management (PNM). PNM has established network status classifications as follows: • **OPEN**: The network is open and available to new providers seeking to join regardless of provider type and network need, so long as the provider meets the minimum network participation criteria, credentialing, and has not been otherwise recommended for exclusion from a network. For OPEN networks, contract requests are received and implemented without additional consideration. • **PARTIALLY CLOSED**: The network is closed to certain new providers seeking to join, including without limitation, providers of a certain provider type or providers located in a defined location. For PARTIALLY CLOSED networks, contract requests that are received are denied summarily, the provider is notified of the network status, and the provider is not sent contracts for such network(s). • **CLOSED**: The network is closed to new providers seeking to join. For CLOSED networks, contract requests that are received are denied summarily and a provider is not sent contracts for the CLOSED networks.

NETWORK STANDARDS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
		A network may be PARTIALLY CLOSED or CLOSED as a result of saturation of required adequacy, quality gates and metrics, or because of other business needs. **BCT Network** The BCT network is classified as PARTIALLY CLOSED. This network is open to providers accepting standard contract language and standard rates in the following categories: • Primary Care (PCP) • Obstetrics and Gynecology • School based Physical, Occupational and Speech Therapy • Any provider satisfying a network deficiency • Any provider joining a participating group with a group contract • Medical specialists joining a multi-specialty group with participating behavioral health professional providers will be sent to the Director, Provider Contracting, Ancillary and Behavioral Health Networks for review and coordination with the Director, BlueCare Network Oversight Any provider, who applies to join a BCT network that does not fall into one of these categories, may be presented to BCT senior leadership for consideration and a decision on inclusion in the BCT network. PNM will ensure proper selection and retention of providers by requiring all applicable providers to apply and pass a rigorous credentialing process, which follows NCQA standards. **Credentialing Requirements** In order to establish consistent standards for network participation, and to meet regulatory requirements, BCBST/BlueCare Tennessee developed Network Participation Criteria. Practitioners applying for network admission are asked to complete an application through the Council for Affordable Quality Healthcare (CAQH) for individual professionals. BCBST/BlueCare Tennessee partners with CAQH Solutions, which offers Providers a single point of entry for application

NETWORK STANDARDS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
		information. Organizational Providers will utilize the BCBST/BlueCare Tennessee Facility application information. Utilizing the CAQH application or Organizational Provider application, BCBST/BlueCare conducts a preliminary evaluation for network participation. Practitioners must complete the application in its entirety, submit the required documentation, and complete the credentialing process prior to network participation. Verifying credentials of Practitioners and other Health Care Professionals/Providers is an essential component of an integrated health care system. The Credentialing process incorporates an ongoing assessment of the quality-of-care services provided by those Practitioners and other Health Care Professionals/Providers who wish to participate in the BCBST/BlueCare Tennessee network. Major components of the credentialing program include: • Credentialing Committee • Policies and Procedures • Initial Credentialing Process • Re-credentialing Process • Delegated Credentialing Activities

NETWORK STANDARDS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Are there any geographic limitations on provider inclusion in the network (e.g., requirements for accessing out-of-state providers)? If so, describe these limitations.	Please see applicable sections for Network Standards – Emergency Services for Medical/Surgical Services for this section.	The BCT provider network was developed and is monitored to meet the availability and accessibility standards of the Contractor Risk Agreement (CRA) and the TennCare*Select* Agreement (TSA). BCT along with Provider Resolutions monitors our network to ensure adherence to all geographic access standards by utilizing industry standard network accessibility analysis software, GeoAccess, along with other tools to monitor network adequacy and access for physical and behavioral health services. Provider Resolutions also utilizes the regional knowledge of our Provider Contracting Network Managers and Provider Service Consultants to develop reports on where and when it is appropriate to utilize non-participating providers, taking into account the number of contracted providers who are not accepting new members, community standards, and the geographic location of providers in relation to members. In accordance with the CRA and as stated in the Provider Administration Manual (PAM), Minimum Institutional Network Participation Criteria, contracting in Tennessee & Contiguous Counties is required. BCT does not contract with providers located out of state with the exception of those located in contiguous counties.
Describe the criteria applied in determining standards for access to out-of-network providers.	Please see applicable sections for Network Standards – Emergency Services for Medical/Surgical Services for this section.	BlueCare Tennessee does not have out of network (OON) benefits except in the case of a medical emergency. All non-emergent OON services require a prior authorization. The following questions must be addressed for all OON requests when being reviewed for prior authorization: • Is the request a covered service? • Is it an emergency? • Is the service medically necessary? • Is there a participating provider available in the member's area? If OON service is approved, an authorization will be loaded and provider will be reimbursed for services at OON reimbursement rates. If provider requests negotiated rates, once the authorization is

NETWORK STANDARDS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
				complete a request is routed to the area that handles out of network rate negotiations once the rate is agreed upon by both parties, a single case agreement is completed. If OON service is denied, a letter is sent to the provider and member advising of the denial and a listing of the participating providers is included in the response.		
What methods are used to determine usual, customary, and reasonable charges?	Please see applicable sections for Network Standards – Emergency Services for Medical/Surgical Services for this section.			BlueCare Tennessee rates are based on the following: • Percentage of CMS reimbursement • Underlying knowledge of the market • Provider research • Ability to negotiate cost effective rates that satisfy network adequacy needs • TennCare rate parameter guidance		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for setting and implementing network admission standards.	**Strategies:** WHY does your MCO use these processes and standards? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of these processes and standards? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for setting and implementing network admission standards.	**Strategies:** WHY does your MCO use these processes and standards? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of these processes and standards? Evidence may include practice guidelines and internal health plan utilization data.

NETWORK STANDARDS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	Please see applicable sections for Network Standards – Emergency Services for Medical/Surgical Services for this section.	Please see applicable sections for Network Standards – Emergency Services for Medical/Surgical Services for this section.	Please see applicable sections for Network Standards – Emergency Services for Medical/Surgical Services for this section.	The BCT provider network was developed and is monitored to meet the availability and accessibility standards of the Contractor Risk Agreement (CRA) and the TennCare*Select* Agreement (TSA). PNM will ensure proper selection and retention of providers by requiring all applicable providers to apply and pass a rigorous credentialing process, which follows NCQA standards.	To ensure network sufficiency and an appropriate mix of providers to meet the member's needs. These guidelines are used to develop and maintain our provider network selection and retention process	BCT maintains an adequate network of providers and is currently meeting all access and availability requirements as set forth in the CRA. BCT along with Provider Resolutions monitors our network to ensure adherence to all geographic access standards by utilizing industry standard network accessibility analysis software, GeoAccess, along with other tools to monitor network adequacy and access for physical and behavioral health services.
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	Since Emergency Services Mental Health and Substance Abuse Disorders are integrated in Emergency Medical Services, there is only one set of policies and procedures for network standards					

NETWORK STANDARDS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Evaluation of Processes, Strategies, and Evidentiary Standards	**If network standards are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of these standards is in parity. No additional information is needed.** **If network standards are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of these standards is not in parity. Proceed to the following row.**	
Modifications Explain how network standards for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A – No modifications required to comply with parity.	

UnitedHealthcare Community Plan

NQTL Analysis Module 1: Prior Authorization – INPATIENT SERVICES

PRIOR AUTHORIZATION REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
List all inpatient benefits requiring prior authorization.	Acute Mental Health Inpatient, Inpatient Detox, Residential Detox, Substance Abuse Residential, Mental Health Residential, Sex Offender Residential, Social Detox, Substance Abuse Rehab and Sub Acute Inpatient.			Acute – Medical, Surgical, Level 2 through Level 4 Nursery, Maternity, Rehabilitation, Skilled Nursing Facility, Sub-Acute. For a complete list of services requiring prior authorization, please see attached document titled *UnitedHealthcare Community Plan Prior Authorization TN Effective 7 -1-2017*.		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for prior authorization that your MCO uses.	**Strategies:** WHY does your MCO require prior authorization for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for prior authorization that your MCO uses.	**Strategies:** WHY does your MCO require prior authorization for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.
	All IP LOC is subject to medical necessity review when an authorization is required. It is applied during the Initial Facility Review (IFR). Each LOC has a specific clinical template that must be completed. Relevant clinical information is matched to MNC guidelines to determine if approval is appropriate.	To ensure that the service is in accordance with generally accepted standards of medical practice, clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the mental illness, substance use disorder, or its symptoms.	The LOC Guidelines support this and were developed utilizing literature reviews as well as input solicited from providers, Medical Directors and other clinical staff, members, and regulators. The evidence-base for these includes generally accepted standards of clinical practice, as well as governmental standards such as CMS' National Coverage	All inpatient admissions require a prior authorization. Clinical information is requested as needed to support medical necessity determination for inpatient admissions. State and Federal rules and regulations, health plan coverage guidelines and Milliman Care Guidelines (MCG) are all used to determine the medical necessity for the requested	The MCO is seeking to ensure appropriate cost utilization and reduce unnecessary inpatient admissions. In addition, the MCO is seeking to ensure that the service is in accordance with generally accepted standards of medical practice, clinically appropriate, in terms of type, frequency, extent, site and duration for medical/surgical appropriate admissions.	See attached policy *HS UM 2 Elective Admission Precertification* and *HS UM 01 Medical Necessity Review* State and Federal rules and regulations, health plan coverage guidelines and Milliman Care Guidelines (MCG) are all used to support the use of prior authorization for the listed benefits.

PRIOR AUTHORIZATION REQUIREMENTS – INPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**			**Medical/Surgical Services**		
			Determinations (NCDs) and Local Coverage Determinations (LCDs). The LOC Guidelines are annually updated to reflect changes to the network, regulatory requirements, significant advances in service delivery, current research, and other opportunities to improve its quality.	service. A specific clinical template based on nationally recognized practice guidelines must be completed.		
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	As evidenced above and in the cited policies and procedures, it is determined that the prior authorization requirements are applied comparably across all IP levels of care and utilize the same processes, strategies and standards. Therefore, there are no processes, strategies or standards applied to MH/SUH benefits more stringently applied that those for M/S benefits.					
Evaluation of Processes, Strategies, and Evidentiary Standards	**If prior authorization requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of prior authorization is in parity. No additional information is needed.** **If prior authorization requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of prior authorization is not in parity. Proceed to the following row.**					

PRIOR AUTHORIZATION REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Modifications Explain how prior authorization processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	NA	

NQTL Analysis Module 1: Prior Authorization – OUTPATIENT SERVICES

<table>
<tr><th>PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES</th><th colspan="3">Mental Health/Substance Use Disorder Services</th><th colspan="3">Medical/Surgical Services</th></tr>
<tr><td>List all outpatient benefits requiring prior authorization.</td><td colspan="3">Enhanced Supported Housing, Supported Housing, Nursing Home Plus, Comprehensive Child and Family Treatment, Continuous Treatment, Program of Assertive Community Treatment, Community Assessment Stabilization Team, Applied Behavioral Analysis, Psychological Testing, Supportive Community Living, Buprenorphine, Family Support Services, Transcranial Magnetic Stimulation, Electroconvulsive Therapy, Partial Hospitalization and Intensive Outpatient Program.</td><td colspan="3">Please see the attached document titled UnitedHealthcare Community Plan Prior Authorization TN effective 7 -1-2017 for a complete list of Outpatient benefits requiring prior authorization.</td></tr>
<tr><td rowspan="2">Processes, Strategies, and Evidentiary Standards</td><td>Processes:
Explain the process, both in writing and in practice, for prior authorization that your MCO uses.</td><td>Strategies:
WHY does your MCO require prior authorization for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?</td><td>Evidentiary Standards:
What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.</td><td>Processes:
Explain the process, both in writing and in practice, for prior authorization that your MCO uses.</td><td>Strategies:
WHY does your MCO require prior authorization for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?</td><td>Evidentiary Standards:
What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.</td></tr>
<tr><td>The identified OP LOC's are subject to medical necessity review when an authorization is required. It is applied during the Initial Facility Review (IFR).

EPAL (Enterprise Prior Authorization List) is utilized to make a determination if the service requires an authorization. Clinical information is requested as needed</td><td>To ensure that the service is in accordance with generally accepted standards of medical practice, clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the mental illness, substance use disorder, or its symptoms.</td><td>The LOC Guidelines support this and were developed utilizing literature reviews as well as input solicited from providers, Medical Directors and other clinical staff, members, and regulators. The evidence-base for these includes generally accepted standards of clinical practice, as well as governmental standards such as</td><td>The identified OP LOC's are subject to medical necessity review when an authorization is required. It is applied during the Initial Facility Review (IFR).

EPAL (Enterprise Prior Authorization List) is utilized to make a determination if the service requires an authorization. Clinical information is requested as needed</td><td>The MCO applies a prior authorization requirement to ensure there is a review for appropriate services to ensure appropriate cost utilization and because specific patient qualifying criteria must be met for safe and effective implementation.

In addition, the MCO applies prior authorization</td><td>See attached policy HS UM 01 Medical Necessity Review.

State and Federal rules and regulations, health plan coverage guidelines and Milliman Care Guidelines (MCG) are all used to support the use of prior authorization for the listed benefits.</td></tr>
</table>

PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	to support medical necessity determination for outpatient procedures. Each LOC has a specific clinical template that must be completed. Relevant clinical information is matched to MNC guidelines to determine if approval is appropriate.		CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The LOC Guidelines are annually updated to reflect changes to the network, regulatory requirements, significant advances in service delivery, current research, and other opportunities to improve its quality.	to support medical necessity determination for outpatient procedures. State and Federal rules and regulations, health plan coverage guidelines and Milliman Care Guidelines (MCG) are all used to determine the medical necessity for the requested service. A specific clinical template based on nationally recognized practice guidelines must be completed.	requirement to ensure the service is in accordance with generally accepted standards of medical practice, clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the identified medical/surgical treatment or procedure.	
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	As evidenced above and in the cited policies and procedures, it is determined that the prior authorization requirements are applied comparably across all OP levels of care and utilize the same processes, strategies and standards. Therefore, there are no processes, strategies or standards applied to MH/SUH benefits more stringently applied that those for M/S benefits.					

PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**	**Medical/Surgical Services**
Evaluation of Processes, Strategies, and Evidentiary Standards	**If prior authorization requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of prior authorization is in parity. No additional information is needed.** **If prior authorization requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of prior authorization is not in parity. Proceed to the following row.**	
Modifications Explain how prior authorization processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	NA	

NQTL Analysis Module 1: Prior Authorization – EMERGENCY SERVICES

PRIOR AUTHORIZATION REQUIREMENTS – EMERGENCY SERVICES	**Mental Health/Substance Use Disorder Services**			**Medical/Surgical Services**		
List all emergency benefits requiring prior authorization.	*NA – Prior authorization is not required for emergency services.*			*NA – Prior authorization is not required for emergency services.*		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for prior authorization that your MCO uses.	**Strategies:** WHY does your MCO require prior authorization for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for prior authorization that your MCO uses.	**Strategies:** WHY does your MCO require prior authorization for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.
	NA	NA	NA	NA	NA	NA

PRIOR AUTHORIZATION REQUIREMENTS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	NA	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If prior authorization requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of prior authorization is in parity. No additional information is needed.** **If prior authorization requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of prior authorization is not in parity. Proceed to the following row.**	
Modifications Explain how prior authorization processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	NA	

NQTL Analysis Module 2: Concurrent Review – INPATIENT SERVICES

CONCURRENT REVIEW REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
List all inpatient benefits requiring concurrent review.	Acute Mental Health Inpatient, Inpatient Detox, Residential Detox, Substance Abuse Residential, Mental Health Residential, Sex Offender Residential, Social Detox, Substance Abuse Rehab and Sub Acute Inpatient.			• Acute – medical, surgical, Level 2 through Level 4 nursery, maternity • Rehabilitation, Skilled nursing facility level of care, Sub-acute		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for concurrent review that your MCO uses.	**Strategies:** WHY does your MCO require concurrent review for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of concurrent review for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for concurrent review that your MCO uses.	**Strategies:** WHY does your MCO require concurrent review for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of concurrent review for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.
	All IP LOC is subject to medical necessity review when an authorization is required. It is applied during the concurrent review (CFRs). Each IP LOC has a specific clinical template that must be completed by utilization reviewer. Relevant clinical information is matched to a specific MNC guideline to determine if approval	Medical Necessity is defined as Services provided for the purpose of preventing, evaluating, diagnosing or treating a mental illness or substance use disorder, or its symptoms that are all of the following: • In accordance with Generally Accepted Standards of Medical Practice. • Clinically appropriate, in terms of type, frequency,	The criteria to determine medical necessity are embedded in the Level of Care Guidelines (LOC). The LOC Guidelines were developed utilizing literature reviews as well as input solicited from providers, Medical Directors and other clinical staff, members, and regulators. The evidence-base for the LOC Guidelines includes generally	All inpatient admissions require concurrent review. Clinical information is requested as needed to support medical necessity for continued inpatient stays. State and Federal rules and regulations, health plan coverage guidelines and Milliman Care Guidelines (MCG) are all used to determine the medical necessity	The MCO is seeking to ensure appropriate cost utilization and reduce unnecessary inpatient length of stay. The plan defines medical necessity as services provided by an institution, physician or other health care provider required to identify and treat a member's illness or injury including all of the	See attached policy- *HS UM 06 Performing Telephonic Initial and Concurrent Utilization Review* State and Federal rules and regulations, health plan coverage guidelines and Milliman Care Guidelines (MCG) are all used to support the use of concurrent review for these services.

CONCURRENT REVIEW REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	is appropriate. Frequency of concurrent review is determined by diagnosis, clinical review, provider recommendations, support systems, history of treatment and review of medical necessity level of care guidelines. Concurrent reviews may occur more frequently if factors are present that require a case to be escalated to staffing or clinical rounds. Also will take into consideration average length of stay. Upon review, utilization reviewer will inform provider of continued approval or intent to deny based on clinical information submitted. If intent to deny, UR will follow MNC Denial process. ASAM is used for all SA IP services requiring a medical necessity review and follow the same MNC	extent, site and duration, and considered effective for the mental illness, substance use disorder, or its symptoms. • Not mainly for the member's convenience or that of the member's doctor or other health care provider. • Not more costly than an alternative drug, service or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the member's mental illness, substance use disorder, or its symptoms.	accepted standards of clinical practice, as well as governmental standards such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The LOC Guidelines are annually updated to reflect changes to the network, regulatory requirements, significant advances in service delivery, current research, and other opportunities to improve its quality.	for the requested service. Nationally recognized clinical guidelines and evidence are used to assist clinicians in making informed decisions, including the frequency of the next required review.	following: • In accordance with Generally Accepted Standards of Medical Practice. • Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the illness or injury. Concurrent review ensures for timely discharge planning and safe transition to the next level of care. • Not mainly for the member's convenience or that of the member's doctor or other health care provider. • Not more costly than an alternative drug, service or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness or injury.	

CONCURRENT REVIEW REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	review process as MH IP services. Nationally recognized clinical guidelines and evidence are used to assist clinicians in making informed decisions, including the frequency of the next required review.					
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	The concurrent review requirements are applied comparably across all IP levels of care. As evidenced above and in the referenced policies, the MH/SUD benefits are applied no more stringently than the M/S benefits.					
Evaluation of Processes, Strategies, and Evidentiary Standards	**If concurrent review requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of concurrent review is in parity. No additional information is needed.** **If concurrent review requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of concurrent review is not in parity. Proceed to the following row.**					
Modifications Explain how concurrent review processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	NA					

NQTL Analysis Module 2: Concurrent Review – OUTPATIENT SERVICES

<table>
<tr><th>CONCURRENT REVIEW REQUIREMENTS – OUTPATIENT SERVICES</th><th colspan="3">Mental Health/Substance Use Disorder Services</th><th colspan="3">Medical/Surgical Services</th></tr>
<tr><td>List all outpatient benefits requiring concurrent review.</td><td colspan="3">Enhanced Supported Housing, Supported Housing, Nursing Home Plus, Comprehensive Child and Family Treatment, Continuous Treatment, Program of Assertive Community Treatment, Community Assessment Stabilization Team, Applied Behavioral Analysis, Psychological Testing, Supportive Community Living, Buprenorphine, Family Support Services, Transcranial Magnetic Stimulation and Electroconvulsive Therapy, PHP, IOP</td><td colspan="3">Private Duty Nursing Services</td></tr>
<tr><td rowspan="2">Processes, Strategies, and Evidentiary Standards</td><td>Processes:
Explain the process, both in writing and in practice, for concurrent review that your MCO uses.</td><td>Strategies:
WHY does your MCO require concurrent review for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?</td><td>Evidentiary Standards:
What evidence supports the use of concurrent review for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.</td><td>Processes:
Explain the process, both in writing and in practice, for concurrent review that your MCO uses.</td><td>Strategies:
WHY does your MCO require concurrent review for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?</td><td>Evidentiary Standards:
What evidence supports the use of concurrent review for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.</td></tr>
<tr><td>The identified OP LOC's are subject to medical necessity review when an authorization is required. It is applied during the during concurrent facility review (CFRs).

Each OP LOC has a specific clinical template that must be completed by provider or utilization reviewer. Relevant clinical information is</td><td>Medical Necessity is defined as Services provided for the purpose of preventing, evaluating, diagnosing or treating a mental illness or substance use disorder, or its symptoms that are all of the following:
• In accordance with Generally Accepted Standards of Medical Practice.
• Clinically</td><td>The criteria to determine medical necessity are embedded in the Level of Care Guidelines (LOC). The LOC Guidelines were developed utilizing literature reviews as well as input solicited from providers, Medical Directors and other clinical staff, members, and regulators. The evidence-base for the LOC Guidelines</td><td>Home Health Aide Services are reviewed with the medical director every 6 months or more frequently for any change in condition
Skilled Nursing Service is reviewed with the medical director every 8 weeks or more frequently for any change in condition.

Nationally recognized</td><td>The MCO is seeking to ensure the member is still in need of the medical services provided in an effort to provide the most appropriate care for the member and help control costs by reducing services as medically appropriate.

The plan defines medical necessity as services provided by an institution,</td><td>See attached document Private_Duty_Nursing_UM SOP</td></tr>
</table>

CONCURRENT REVIEW REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	matched to a specific MNC guideline to determine if approval is appropriate. Frequency of concurrent review is determined by diagnosis, clinical review, provider recommendations, support systems, history of treatment and review of medical necessity level of care guidelines. Concurrent reviews may occur more frequently if factors are present that require a case to be escalated to staffing or clinical rounds. Also will take into consideration average length of stay. ASAM is used for all SA OP services requiring a medical necessity review. Nationally recognized clinical guidelines and evidence are used to assist clinicians in making informed decisions, including the frequency of the next required review.	appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the mental illness, substance use disorder, or its symptoms. • Not mainly for the member's convenience or that of the member's doctor or other health care provider. • Not more costly than an alternative drug, service or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the member's mental illness, substance use disorder, or its symptoms.	includes generally accepted standards of clinical practice, as well as governmental standards such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The LOC Guidelines are annually updated to reflect changes to the network, regulatory requirements, significant advances in service delivery, current research, and other opportunities to improve its quality.	clinical guidelines and evidence are used to assist clinicians in making informed decisions, including the frequency of the next required review.	physician or other health care provider required to identify and treat a member's illness or injury including all of the following: • In accordance with Generally Accepted Standards of Medical Practice. • Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the illness or injury • Not mainly for the member's convenience or that of the member's doctor or other health care provider. • Not more costly than an alternative drug, service or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness or injury.	

CONCURRENT REVIEW REQUIREMENTS – OUTPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**			**Medical/Surgical Services**		
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	Due to the OP MH/SUD services requiring authorization for no services comparable to the OP M/S services requiring authorization (Private Duty Nursing), there is no ability to evaluate for comparability and stringency. Therefore, it can be concluded that the OP requirements for concurrent review are in parity.					
Evaluation of Processes, Strategies, and Evidentiary Standards	**If concurrent review requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of concurrent review is in parity. No additional information is needed.** **If concurrent review requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of concurrent review is not in parity. Proceed to the following row.**					

CONCURRENT REVIEW REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Modifications Explain how concurrent review processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	NA	

NQTL Analysis Module 2: Concurrent Review – EMERGENCY SERVICES

CONCURRENT REVIEW REQUIREMENTS – EMERGENCY SERVICES	**Mental Health/Substance Use Disorder Services**			**Medical/Surgical Services**		
List all emergency benefits requiring concurrent review.	NA-Emergency Services do not require Concurrent Review.			NA-Emergency Services do not require Concurrent Review.		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for concurrent review that your MCO uses.	**Strategies:** WHY does your MCO require concurrent review for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of concurrent review for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for concurrent review that your MCO uses.	**Strategies:** WHY does your MCO require concurrent review for these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of concurrent review for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.
	NA	NA	NA	NA	NA	NA

CONCURRENT REVIEW REQUIREMENTS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	NA	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If concurrent review requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of concurrent review is in parity. No additional information is needed.** **If concurrent review requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of concurrent review is not in parity. Proceed to the following row.**	
Modifications Explain how concurrent review processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	NA	

NQTL Analysis Module 3: Medical Necessity – INPATIENT SERVICES

MEDICAL NECESSITY REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
What criteria are applied to make medical necessity/ appropriateness determinations for inpatient services?	ASAM criteria are used for all SA IP services requiring a medical necessity review. We use our Corporate LOCGs and add in any TennCare specific requirements specifically, TennCare Rules Chapter 1200-13-16-.05 Medical Necessity Criteria. The plan uses DRGs to cover the review of information from the providers to our UM staff for the day-to-day course of reviews.			TennCare Rules Chapter 1200-13-16-.05 Medical Necessity Criteria State and Federal Policies and Guidelines UnitedHealth Care Policies MCG (formerly called Milliman Care Guidelines)		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process your MCO uses, both in writing and in practice, for determining medical necessity.	**Strategies:** WHY does your MCO use the process described?	**Evidentiary Standards:** What evidence supports your MCO's MN criteria and processes for determining MN? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process your MCO uses, both in writing and in practice, for determining medical necessity.	**Strategies:** WHY does your MCO use the process described?	**Evidentiary Standards:** What evidence supports your MCO's MN criteria and processes for determining MN? Evidence may include practice guidelines and internal health plan utilization data.
	We apply MNC for all authorized services at the time of each request. Relevant clinical information is matched to MNC guidelines to determine if approval is appropriate. All IP care is subject to medical necessity	The plan defines medical necessity as services provided for the purpose of preventing, evaluating, diagnosing or treating a mental illness or substance use disorder, or its symptoms that are all of the following: • In accordance with	The LOC Guidelines were developed utilizing literature reviews as well as input solicited from providers, Medical Directors and other clinical staff, members, and regulators. The evidence-base for the LOC Guidelines includes	We use State and Federal Policies and Guidelines and/or MCG to develop medical necessity policies and practices. We apply the guidelines, medical necessity criteria and policies to each	The MCO is seeking to ensure appropriate cost utilization and reduce unnecessary inpatient admissions. The plan defines medical necessity as services provided by an institution, physician or	Please see policy attached *HS UM 01 Medical Necessity Review.*

MEDICAL NECESSITY REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	review when an authorization is required. It is applied during the Initial Facility Review (IFR) and during concurrent review (CFRs). The criteria to determine medical necessity are embedded in the Level of Care Guidelines.	Generally Accepted Standards of Medical Practice. • Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the mental illness, substance use disorder, or its symptoms.	generally accepted standards of clinical practice, as well as governmental standards such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The LOC Guidelines are annually updated to reflect changes to the network, regulatory requirements, significant advances in service delivery, current research, and other opportunities to improve its quality.	requested service at the time of authorization. Relevant clinical information is matched to determine if approval is appropriate. All IP care is subject to medical necessity review when authorization is required. It is applied during the initial authorization and during concurrent review. MCG Guidelines and TennCare Medical Necessity Criteria are used to determine medical necessity.	other health care provider required to identify and treat a member's illness or injury including all of the following: • In accordance with Generally Accepted Standards of Medical Practice. • Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the treatment of the illness or injury.	

MEDICAL NECESSITY REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	As evidenced above and in the cited policies and procedures, it is determined that the medical necessity requirements are applied comparably across all IP levels of care and utilize the same processes, strategies and standards. Therefore, there are no processes, strategies or standards applied to MH/SUH benefits more stringently applied that those for M/S benefits.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If medical necessity requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of medical necessity is in parity. No additional information is needed.** **If medical necessity requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of medical necessity is not in parity. Proceed to the following row.**	
Modifications Explain how medical necessity processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A	

NQTL Analysis Module 3: Medical Necessity – OUTPATIENT SERVICES

MEDICAL NECESSITY REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
What criteria are applied to make medical necessity/ appropriateness determinations for outpatient services?	ASAM criteria are used for all SA OP services requiring a medical necessity review. We use our Corporate LOCGs and add in any TennCare specific requirements specifically, TennCare Rules Chapter 1200-13-16-.05 Medical Necessity Criteria. The plan uses DRGs to cover the review of information from the providers to our UM staff for the day-to-day course of reviews.			TennCare Rules Chapter 1200-13-16-.05 Medical Necessity Criteria State and Federal Policies and Guidelines UnitedHealth Care Policies MCG (formerly called Milliman Care Guidelines)		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process your MCO uses, both in writing and in practice, for determining medical necessity.	**Strategies:** WHY does your MCO use the process described?	**Evidentiary Standards:** What evidence supports your MCO's MN criteria and processes for determining MN? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process your MCO uses, both in writing and in practice, for determining medical necessity.	**Strategies:** WHY does your MCO use the process described?	**Evidentiary Standards:** What evidence supports your MCO's MN criteria and processes for determining MN? Evidence may include practice guidelines and internal health plan utilization data.

MEDICAL NECESSITY REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	We apply MNC for all authorized services at the time of each request. Relevant clinical is matched to MNC guidelines to determine if approval is appropriate. All OP LOC is subject to medical necessity review when an authorization is required. It is applied during the Initial Review and during concurrent review (CFRs). The criteria to determine medical necessity are embedded in the Level of Care Guidelines.	The plan defines medical necessity as services provided for the purpose of preventing, evaluating, diagnosing or treating a mental illness or substance use disorder, or its symptoms that are all of the following: • In accordance with generally accepted standards of medical practice. • Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the mental illness, substance use disorder, or its symptoms.	The LOC Guidelines were developed utilizing literature reviews as well as input solicited from providers, Medical Directors and other clinical staff, members, and regulators. The evidence-base for the LOC Guidelines includes generally accepted standards of clinical practice, as well as governmental standards such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The LOC Guidelines are annually updated to reflect changes to the network, regulatory requirements, significant advances in service delivery, current research, and other opportunities to improve its quality.	We use State and Federal Policies and Guidelines and/or MCG to develop medical necessity policies and practices. We apply the guidelines, medical necessity criteria and policies to each requested service at the time of authorization. Relevant clinical information is matched to determine if approval is appropriate. All OP services are subject to medical necessity review when authorization is required. It is applied during the initial authorization and during concurrent review. MCG Guidelines and TennCare Medical Necessity Criteria are used to determine medical necessity.	The MCO is seeking to ensure appropriate cost utilization and reduce over-utilization of outpatient services. The MCO seeks to ensure the proper services are provided in an appropriate setting at the appropriate time. The plan defines medical necessity as services provided by an institution, physician or other health care provider required to identify and treat a member's illness or injury including all of the following: • In accordance with Generally Accepted Standards of Medical Practice. • Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the treatment of the illness or injury.	State and Federal Policies and Guidelines and MCG are used to develop the UnitedHealth Care policies on medical necessity determination. Please see policy attached *HS UM 01 Medical Necessity Review*.

MEDICAL NECESSITY REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	As evidenced above and in the cited policies and procedures, it is determined that the medical necessity requirements are applied comparably across all OP levels of care and utilize the same processes, strategies and standards. Therefore, there are no processes, strategies or standards applied to MH/SUH benefits more stringently applied that those for M/S benefits.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If medical necessity requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of medical necessity is in parity. No additional information is needed.** **If medical necessity requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of medical necessity is not in parity. Proceed to the following row.**	
Modifications Explain how medical necessity processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A	

NQTL Analysis Module 3: Medical Necessity – EMERGENCY SERVICES

MEDICAL NECESSITY REQUIREMENTS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
What criteria are applied to make medical necessity/ appropriateness determinations for emergency services?	N/A -No criteria reviewed for emergency/perceived emergency services			N/A -No criteria reviewed for emergency/perceived emergency services		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process your MCO uses, both in writing and in practice, for determining medical necessity.	**Strategies:** WHY does your MCO use the process described?	**Evidentiary Standards:** What evidence supports your MCO's MN criteria and processes for determining MN? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process your MCO uses, both in writing and in practice, for determining medical necessity.	**Strategies:** WHY does your MCO use the process described?	**Evidentiary Standards:** What evidence supports your MCO's MN criteria and processes for determining MN? Evidence may include practice guidelines and internal health plan utilization data.

MEDICAL NECESSITY REQUIREMENTS – EMERGENCY SERVICES	**Mental Health/Substance Use Disorder Services**			**Medical/Surgical Services**		
	The Health Plan ensures the safety of Members during a time of medical/behavioral emergency or perceived medical/behavioral emergency. SEE attached policy *HS UM 09 Emergency Services*	The Health Plan ensures the safety of Members during a time of medical/behavioral emergency or perceived medical/behavioral emergency.	Please see policy attached *HS UM 09 Emergency Services*	The Health Plan ensures the safety of Members during a time of medical/behavioral emergency or perceived medical/behavioral emergency.	The Health Plan ensures the safety of Members during a time of medical/behavioral emergency or perceived medical/behavioral emergency.	Please see policy attached *HS UM 09 Emergency Services.*
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	There are no medical necessity review requirements for emergency services for MH/SUD or M/S benefits. Therefore, there are no processes, strategies or standards applied to MH/SUH benefits more stringently applied that those for M/S benefits.					
Evaluation of Processes, Strategies, and Evidentiary Standards	**If medical necessity requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of medical necessity is in parity. No additional information is needed.** **If medical necessity requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of medical necessity is not in parity. Proceed to the following row.**					

MEDICAL NECESSITY REQUIREMENTS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Modifications Explain how medical necessity processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A	

NQTL Analysis Module 4: Fail First and Step Therapy Protocols – INPATIENT SERVICES

FAIL FIRST AND STEP THERAPY PROTOCOLS – INPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**			**Medical/Surgical Services**		
Does the plan apply “fail first” requirements or step therapy protocols? List the inpatient services to which these requirements apply.	No, we do not apply a fail first requirement.			All non-emergent surgeries would require failure of conservative therapy prior to approval for surgical intervention. Milliman Care Guidelines and UnitedHealthcare Clinical Coverage Guidelines have embedded recommendations and requirements for various fail-first therapies for inpatient services/devices before approval of more invasive or complex/costly services. There is not a complete all-inclusive list that can be provided without opening each individual guideline. One example for inpatient services would be hysterectomy for dysfunctional uterine bleeding requiring hormone replacement trial prior to surgical intervention. Another example would be failure of conservative medication treatment and physical therapy prior to consideration of an elective joint replacement surgery (total knee or total hip replacement).		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for fail first and/or step therapy protocols that your MCO uses.	**Strategies:** WHY does your MCO use fail first or step therapy requirements f or these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of fail first or step therapy for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for fail first and/or step therapy protocols that your MCO uses.	**Strategies:** WHY does your MCO use fail first or step therapy requirements f or these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of fail first or step therapy for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.

FAIL FIRST AND STEP THERAPY PROTOCOLS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	NA	NA	NA	Milliman Care Guidelines and UnitedHealthcare Clinical Coverage Guidelines have embedded recommendations and requirements for various fail-first therapies before approval of more invasive services. Whenever therapies are considered equivalent, we ask providers to use the most cost effective agent prior to going to the more expensive one.	The MCO is seeking to ensure appropriate cost utilization and reduce unnecessary inpatient admissions.	MCG and Clinical Coverage Guidelines are utilized to support the fail first and step therapy services.
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	NA – There are no fail first requirements for MH/SUD benefits.					
Evaluation of Processes, Strategies, and Evidentiary Standards	**If fail first/step therapy requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of these requirements is in parity. No additional information is needed.** **If fail first/step therapy requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of these requirements is not in parity. Proceed to the following row.**					

FAIL FIRST AND STEP THERAPY PROTOCOLS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Modifications Explain how fail first or step therapy requirements for MH/SUD and/or M/S benefits will be modified to comply with parity.	NA	

NQTL Analysis Module 4: Fail First and Step Therapy Protocols – OUTPATIENT SERVICES

FAIL FIRST AND STEP THERAPY PROTOCOLS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
Does the plan apply "fail first" requirements or step therapy protocols? List the outpatient services to which these requirements apply.	No, we do not apply a fail first requirement.			Milliman Care Guidelines and UnitedHealthcare Clinical Coverage Guidelines have embedded recommendations and requirements for various fail-first therapies for outpatient services/devices before approval of more invasive or complex/costly services. There is not a complete all-inclusive list that can be provided without opening each individual guideline. One example for outpatient services would be Insulin Pumps requiring failure of conservative insulin therapy prior to consideration for a continuous insulin pump. Certain injectable medications are not part of the TennCare pharmacy carve out and covered under the medical benefit and additionally require step therapy or fail-first criteria. The medications that require this criteria include: Nucala Cinqair Xolair Cerezyme Elelyso Botulinum toxins (some indications) Immune globulins (some indications)		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for fail first and/or step therapy protocols that your MCO uses.	**Strategies:** WHY does your MCO use fail first or step therapy requirements f or these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of fail first or step therapy for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for fail first and/or step therapy protocols that your MCO uses.	**Strategies:** WHY does your MCO use fail first or step therapy requirements f or these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of fail first or step therapy for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.

FAIL FIRST AND STEP THERAPY PROTOCOLS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	NA	NA	NA	Milliman Care Guidelines and UnitedHealthcare Clinical Coverage Guidelines have embedded recommendations and requirements for various fail-first therapies before approval of more invasive services. Whenever therapies are considered to be equivalent, we ask providers to use the most cost effective agent prior to going to the more expensive one	The MCO is seeking to ensure appropriate cost utilization and reduce over-utilization of outpatient services. The MCO seeks to ensure the proper services are provided in an appropriate setting at the appropriate time.	MCG and Clinical Coverage Guidelines are utilized to support the fail first and step therapy services.
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	NA – There are no fail first requirements for MH/SUD benefits.					
Evaluation of Processes, Strategies, and Evidentiary Standards	**If fail first/step therapy requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of these requirements is in parity. No additional information is needed.** **If fail first/step therapy requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of these requirements is not in parity. Proceed to the following row.**					

FAIL FIRST AND STEP THERAPY PROTOCOLS – OUTPATIENT SERVICES	**Mental Health/Substance Use Disorder Services**	**Medical/Surgical Services**
Modifications Explain how fail first or step therapy requirements for MH/SUD and/or M/S benefits will be modified to comply with parity.	NA	

NQTL Analysis Module 4: Fail First and Step Therapy Protocols – EMERGENCY SERVICES

FAIL FIRST AND STEP THERAPY PROTOCOLS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
Does the plan apply "fail first" requirements or step therapy protocols? List the emergency services to which these requirements apply.	NA – There are no fail first requirements for MH/SUD benefits.			NA – There are no fail first requirement for emergency M/S services.		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for fail first and/or step therapy protocols that your MCO uses.	**Strategies:** WHY does your MCO use fail first or step therapy requirements f or these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of fail first or step therapy for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for fail first and/or step therapy protocols that your MCO uses.	**Strategies:** WHY does your MCO use fail first or step therapy requirements f or these services, and why do you use the process described? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of fail first or step therapy for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.
	NA	NA	NA	NA	NA	NA

FAIL FIRST AND STEP THERAPY PROTOCOLS – EMERGENCY SERVICES	**Mental Health/Substance Use Disorder Services**	**Medical/Surgical Services**
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	NA – There are no fail first requirements for MH/SUD benefits or for Emergency M/S benefits.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If fail first/step therapy requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of these requirements is in parity. No additional information is needed.** **If fail first/step therapy requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of these requirements is not in parity. Proceed to the following row.**	
Modifications Explain how fail first or step therapy requirements for MH/SUD and/or M/S benefits will be modified to comply with parity.	NA	

NQTL Analysis Module 5: Network Standards – INPATIENT SERVICES

NETWORK STANDARDS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
What are the plan's network admission requirements for inpatient providers?	Network will enter into participation discussions with any facility serving in a GEO access needed area. If that facility agrees to agreement language and reimbursement rates, we move forward with the credentialing process. The provider would have to meet credentialing criteria prior to loading as "in network". All contracting is contingent upon credentialing approval. Please reference documents titled *C_02_Clinician_Credentialing_Process* and *TennCare Addendum to Credentialing Policies*.	Network will enter into participation discussions with any facility serving the area where a geographic need exists. If that facility agrees to agreement language and reimbursement rates, we move forward with the agreement process. There are no documented requirement criteria or defined policies for the process. If contracted, the provider would have to meet credentialing criteria prior to loading as "in network". All contracting is contingent upon credentialing approval. Please reference documents titled *Credentialing-Plan-2017* and *Credentialing_PlanState_and_Federal_Regulatory_Addendum*.
Are there any geographic limitations on provider inclusion in the network (e.g., requirements for accessing out-of-state providers)? If so, describe these limitations.	No, if we have no contracted or available BH providers in the state where the member resides, UHCCP clinical staff will coordinate care with "out of state" providers. We have a contracted BH network in bordering states around TN to support additional BH resources for care.	No geographic limitations. An out of state location does not preclude a provider from the process. UHCCP clinical staff will coordinate care with "out of state" providers. We have contracted providers in bordering states around TN. UHCCP clinical staff will coordinate care with "out of state" providers. We have contracted providers in bordering states around TN.
Describe the criteria applied in determining standards for access to out-of-network providers.	If no in network BH provider is available, UHCCP clinical Staff will facilitate a "single case agreement" with the out of network provider to seek an agreement to provide the service and authorize services accordingly. Access standards do not differentiate between in network or out of network providers.	If no in-network provider is available, UHCCP clinical Staff will facilitate a "single case agreement" with the out-of-network provider to seek an agreement to provide the service and authorize services accordingly. Access standards do not differentiate between in network or out of network providers.

NETWORK STANDARDS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
What methods are used to determine usual, customary, and reasonable charges?	UCR is determined by FairHealth, which is an outside vendor, to determine percentiles of average rates by region.			Extended Non-Network Reimbursement Program (ENRP), Maximum Non-Network Reimbursement Program (MNRP) and shared savings program. For in network, the rates are based on any unique services by the provider, keeping within TennCare corridors.		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for setting and implementing network admission standards.	**Strategies:** WHY does your MCO use these processes and standards? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of these processes and standards? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for setting and implementing network admission standards.	**Strategies:** WHY does your MCO use these processes and standards? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of these processes and standards? Evidence may include practice guidelines and internal health plan utilization data.
	Our network is reviewed for access and availability based on GEO access standards set forth with our risk agreement with TennCare.	We prefer to not contract using UCR methodology, instead we contract using per diems or DRG methodologies for IP services. We also seek to ensure adequate access to services, and to ensure that qualified providers deliver services.	Geo Access reporting.	Provider admission into network is based on geographic need, their agreement with contract terms and rates. Our network is reviewed for access and availability based on GeoAccess standards set forth with our risk agreement with TennCare.	The goal is establishment of mutually beneficial partnerships that provide efficient quality care choices for health plan members. We also seek to ensure adequate access to services, and to ensure that qualified providers deliver services.	We would seek to establish partnerships with inpatient providers that are the facilities of choice of our members and network providers whenever possible. Additionally, we would monitor GeoAccess Reporting to assure that we meet or exceed GeoAccess standards set forth with our risk agreement with TennCare.

NETWORK STANDARDS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	As evidenced above and in the referenced policies, all members shall be provided care in the same manner, on the same basis, and in accordance with the same standards offered to all other patients of the provider. Covered services will be available and accessible to all members. Therefore, there are no IP MH/SUD benefits applied more stringently than the M/S benefits.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If network standards are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of these standards is in parity. No additional information is needed.** **If network standards are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of these standards is not in parity. Proceed to the following row.**	
Modifications Explain how network standards for MH/SUD and/or M/S benefits will be modified to comply with parity.	No modification needed.	

NQTL Analysis Module 5: Network Standards – OUTPATIENT SERVICES

NETWORK STANDARDS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
What are the plan's network admission requirements for outpatient providers?	Network will enter into participation discussions with any outpatient provider serving in a GEO access needed area. If that provider agrees to agreement language and reimbursement rates, we move forward with the credentialing process. The provider would have to meet credentialing criteria prior to loading as "in network". All contracting is contingent upon credentialing approval. Please reference documents titled C_02_Clinician_Credentialing_Process and TennCare Addendum to Credentialing Policies.	Network will enter into participation discussions with any outpatient services provider serving the area. If that provider agrees to agreement language and reimbursement rates, we move forward with the agreement process if there is a geographic need. There are no documented requirement criteria or defined policies for the process. If contracted, the provider would have to meet credentialing criteria prior to loading as "in network". All contracting is contingent upon credentialing approval. Please reference document titled *Credentialing-Plan-2017*.
Are there any geographic limitations on provider inclusion in the network (e.g., requirements for accessing out-of-state providers)? If so, describe these limitations.	No, if we have no contracted or available BH providers in the state where the member resides, UHCCP clinical staff will coordinate care with "out of state" providers. We have a contracted BH network in bordering states around TN to support additional BH resources for care.	No geographic limitations. An out of state location does not preclude a provider from the process. UHCCP clinical staff will coordinate care with "out of state" providers. We have contracted providers in bordering states around TN.
Describe the criteria applied in determining standards for access to out-of-network providers.	If no in network BH provider is available, UHCCP clinical Staff will facilitate a "single case agreement" with the out of network provider to seek an agreement to provide the service and authorize services accordingly. Access standards do not differentiate between in network or out of network providers.	In state members may access outpatient service providers located in other states if they are contracted and in-network for Tennessee members. If no in-network provider is available, UHCCP clinical Staff will facilitate a "single case agreement" with the out-of-network provider to seek an agreement to provide the service and authorize services accordingly. Access standards do not differentiate between in network or out of network providers.

NETWORK STANDARDS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
What methods are used to determine usual, customary, and reasonable charges?	UCR is determined by FairHealth, an outside vendor, who determines percentiles of average rates by region.			Extended Non-Network Reimbursement Program (ENRP), Maximum Non-Network Reimbursement Program (MNRP) and shared savings program for out of network. For in network, the rates are based on any unique services by the provider, keeping within TennCare corridors.		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for setting and implementing network admission standards.	**Strategies:** WHY does your MCO use these processes and standards? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of these processes and standards? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for setting and implementing network admission standards.	**Strategies:** WHY does your MCO use these processes and standards? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of these processes and standards? Evidence may include practice guidelines and internal health plan utilization data.
	Our network is reviewed for access and availability based on GEO access standards set forth with our risk agreement with TennCare.	We prefer to not contract using UCR methodology, instead we contract using per diems or DRG methodologies for OP services. We seek to ensure adequate access to services, and to ensure that qualified providers deliver services.	Geo Access reporting.	Provider admission into network is based on geographic need, their agreement with contract terms and rates. Our network is reviewed for access and availability based on GeoAccess standards set forth with our risk agreement with TennCare.	The goal is establishment of mutually beneficial partnerships that provide efficient quality care choices for health plan members. We seek to ensure adequate access to services, and to ensure that qualified providers deliver services.	We would seek to establish partnerships with outpatient service providers that are the providers of choice of our members and network providers whenever possible. Additionally, we would monitor GeoAccess Reporting to assure that we meet or exceed GeoAccess standards set forth with our risk agreement with TennCare.

NETWORK STANDARDS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.?	As evidenced above and in the referenced policies, all members shall be provided care in the same manner, on the same basis, and in accordance with the same standards offered to all other patients of the provider. Covered services will be available and accessible to all members. Therefore, there are no OP MH/SUD benefits applied more stringently than the M/S benefits.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If network standards are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of these standards is in parity. No additional information is needed.** **If network standards are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of these standards is not in parity. Proceed to the following row.**	
Modifications Explain how network standards for MH/SUD and/or M/S benefits will be modified to comply with parity.	No modification needed.	

NQTL Analysis Module 5: Network Standards – EMERGENCY SERVICES

NETWORK STANDARDS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
What are the plan's network admission requirements for emergency providers?	BH benefits for emergency services are covered under Medical/Surgical Services Benefits.	Network will enter into participation discussions with any emergency care providers serving the area. If that provider agrees to agreement language and reimbursement rates and there is a geographic need, we move forward with the agreement process. There are no documented requirement criteria or defined policies for the process. If contracted, provider would have to meet credentialing criteria prior to loading as "in network". All contracting is contingent upon credentialing approval. Please reference document titled *Credentialing-Plan-2017*.
Are there any geographic limitations on provider inclusion in the network (e.g., requirements for accessing out-of-state providers)? If so, describe these limitations.	BH benefits for emergency services are covered under Medical/Surgical Services Benefits.	No geographic limitations. An out of state location does not preclude a provider from the process.
Describe the criteria applied in determining standards for access to out-of-network providers.	BH benefits for emergency services are covered under Medical/Surgical Services Benefits.	In state members may access emergency care providers located in other states if they are contracted and in-network for Tennessee members.

NETWORK STANDARDS – EMERGENCY SERVICES	**Mental Health/Substance Use Disorder Services**			**Medical/Surgical Services**		
What methods are used to determine usual, customary, and reasonable charges?	NA BH benefits for emergency services are covered under Medical/Surgical Services Benefits.			Extended Non-Network Reimbursement Program (ENRP), Maximum Non-Network Reimbursement Program (MNRP) and shared savings program.		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for setting and implementing network admission standards.	**Strategies:** WHY does your MCO use these processes and standards? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of these processes and standards? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for setting and implementing network admission standards.	**Strategies:** WHY does your MCO use these processes and standards? What is the rationale and/or goal you are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of these processes and standards? Evidence may include practice guidelines and internal health plan utilization data.
	NA BH benefits for emergency services are covered under Medical/Surgical Services Benefits.	NA BH benefits for emergency services are covered under Medical/Surgical Services Benefits.	NA BH benefits for emergency services are covered under Medical/Surgical Services Benefits.	Provider admission into network is based on their agreement with contract terms and rates and geographic need. No written policies outline selection process.	The goal is establishment of mutually beneficial partnerships that provide efficient quality care choices for health plan members.	We would seek to establish partnerships with emergency care providers that are the providers of choice of our members and network providers whenever possible.

NETWORK STANDARDS – EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	NA – Because BH Emergency benefits are covered under Medical/Surgical Services, member benefits are the same for Emergency Services.	
Evaluation of Processes, Strategies, and Evidentiary Standards	**If network standards are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of these standards is in parity. No additional information is needed.** **If network standards are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of these standards is not in parity. Proceed to the following row.**	
Modifications Explain how network standards for MH/SUD and/or M/S benefits will be modified to comply with parity.	No modifications needed.	

TennCare Pharmacy Services

NQTL Analysis Module: PHARMACY – Prior Authorization

PRIOR AUTHORIZATION REQUIREMENTS	**Mental Health/Substance Use Disorder Services**			**Medical/Surgical Services**		
Does TennCare require prior authorization for any covered pharmacy services? Which ones?	Yes, prior authorization is required for some Mental Health/Substance Use Disoder services. For a complete listing of services that require prior authorization, please see the links below: https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_PDL.pdf https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/Criteria_PDL.pdf#nameddest=smoking_cessation_agents_section			Yes, prior authorization is required for some Medical/Surgical services. For a complete listing of services that require prior authorization, please see the links below: https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_PDL.pdf https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/Criteria_PDL.pdf#nameddest=smoking_cessation_agents_section		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process, both in writing and in practice, for prior authorization.	**Strategies:** WHY do we require prior authorization for these services, and why do we use the process described? What is the rationale and/or goal we are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process, both in writing and in practice, for prior authorization.	**Strategies:** WHY do we require prior authorization for these services, and why do we use the process described? What is the rationale and/or goal we are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.
	All prior authorization (PA) requests are reviewed by TennCare's contracted pharmacy benefit manager (PBM), and every prior authorization request is handled with the same procedure. The PBM will receive these requests for products that have clinical edits for the TennCare program. PA request(s) are made by the prescribing physician	Prior authorization is required for select medications as a safety and cost-savings measure. The process described in the previous column is utilized to allow practicing providers (e.g. physicians, pharmacists, nurses) to provide recommendations. The goal is to ensure that TennCare	As per Tennessee Code Annotated 71-5-2401, the TennCare Pharmacy Advisory Committee is utilized to provide recommendations regarding the management of enrollees' access to newly released or approved pharmaceuticals by using available evidence-based research to encourage and	All prior authorization (PA) requests are reviewed by TennCare's contracted pharmacy benefit manager (PBM), and every prior authorization request is handled with the same procedure. The PBM will receive these requests for products that have clinical edits for the TennCare program. PA request(s) are made by the prescribing physician or	Prior authorization is required for select medications as a safety and cost-savings measure. The process described in the previous column is utilized to allow practicing providers (e.g. physicians, pharmacists, nurses) to provide recommendations. The goal is to ensure	As per Tennessee Code Annotated 71-5-2401, the TennCare Pharmacy Advisory Committee is utilized to provide recommendations regarding the management of enrollees' access to newly released or approved pharmaceuticals by using available evidence-based research to encourage and

PRIOR AUTHORIZATION REQUIREMENTS	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	or the prescribing physician's agent. Requests may be initiated by telephone, fax, or Web PA. The member may also initiate a PA request by contacting the Member PA line. The Clinical Call Center will send a fax to the member's prescriber, requesting the required information needed to issue a PA. This is only done after the Clinical Call Center determines that 24 hours have elapsed since the claim for the requested medication was submitted and denied and no PA has been initiated and/or issued. PA decisions are based on all available pertinent information, including the enrollee's prescription history (inclusive of paid and denied claims) and available medical history. If the request is consistent with the PA and/or medical necessity criteria, the PBM shall document the request in	members have access to high-quality, cost-effective care.	recommend safe, effective and financially stable drug use guidelines. Evidence provided in practice guidelines, clinical trials, and FDA-approved labeling is used to support the use of prior authorizations. TennCare, in conjunction with the Pharmacy Advisory Committee, relies on high-quality systematic reviews and evidence-based guidelines in creating PA criteria. The following are considered preferred sources of high quality evidence: • Oregon Health and Science University's (OHSU's) Drug Effectiveness Review Project (DERP); • Veterans Affairs and the Department of Defense (VA/DoD) Clinical Practice Guidelines; • Agency for Healthcare Research and Quality (AHRQ); • Canadian Agency for	the prescribing physician's agent. Requests may be initiated by telephone, fax, or Web PA. The member may also initiate a PA request by contacting the Member PA line. The Clinical Call Center will send a fax to the member's prescriber, requesting the required information needed to issue a PA. This is only done after the Clinical Call Center determines that 24 hours have elapsed since the claim for the requested medication was submitted and denied and no PA has been initiated and/or issued. PA decisions are based on all available pertinent information, including the enrollee's prescription history (inclusive of paid and denied claims) and available medical history. If the request is consistent with the PA and/or medical necessity criteria, the PBM shall document the request in the PBM pharmacy case management system and	that TennCare members have access to high-quality, cost-effective care.	recommend safe, effective and financially stable drug use guidelines. Evidence provided in practice guidelines, clinical trials, and FDA-approved labeling is used to support the use of prior authorizations. TennCare, in conjunction with the Pharmacy Advisory Committee, relies on high-quality systematic reviews and evidence-based guidelines in creating PA criteria. The following are considered preferred sources of high quality evidence: • Oregon Health and Science University's (OHSU's) Drug Effectiveness Review Project (DERP); • Veterans Affairs and the Department of Defense (VA/DoD) Clinical Practice Guidelines; • Agency for Healthcare Research and Quality (AHRQ); • Canadian Agency for

PRIOR AUTHORIZATION REQUIREMENTS	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	the PBM pharmacy case management system and enter an override in TennCare-POS system for the appropriate period of time. If the request is not consistent with applicable PA criteria, the request shall be referred to a clinical pharmacist in the PA Unit. If upon review, the clinical pharmacist finds sufficient justification for an override, the request and clinical rationale for the outcome shall be documented and an override entered in the TennCare-POS system. If sufficient justification is not evident, this shall be documented and the PA shall be denied. All PA denials must be made with the judgment of a clinical pharmacist. When a clinical PA request is denied, the PBM will produce and mail a denial letter to the beneficiary and notify the prescriber on the denial per fax. Additionally, some PA requirements can be bypassed for certain		Drugs and Technologies in Health (CADTH); • The Cochrane Collaboration; • National Institute for Clinical Evidence (NICE); • Institute for Clinical and Economic Review (ICER); • Published systematic reviews from validated, evidence-based medical sources. The following types of evidence are preferred and may be considered if they have been independently evaluated and determined to be of high quality: • Systematic reviews of randomized controlled trials (RCTs); • Individual comparative effectiveness RCTs evaluating clinically important outcomes; • FDA review documents; • Guidelines	enter an override in TennCare-POS system for the appropriate period of time. If the request is not consistent with applicable PA criteria, the request shall be referred to a clinical pharmacist in the PA Unit. If upon review, the clinical pharmacist finds sufficient justification for an override, the request and clinical rationale for the outcome shall be documented and an override entered in the TennCare-POS system. If sufficient justification is not evident, this shall be documented and the PA shall be denied. All PA denials must be made with the judgment of a clinical pharmacist. When a clinical PA request is denied, the PBM will produce and mail a denial letter to the beneficiary and notify the prescriber on the denial per fax. Additionally, some PA requirements can be bypassed for certain medications when specific medical conditions exist. Those		Drugs and Technologies in Health (CADTH); • The Cochrane Collaboration; • National Institute for Clinical Evidence (NICE); • Institute for Clinical and Economic Review (ICER); • Published systematic reviews from validated, evidence-based medical sources. The following types of evidence are preferred and may be considered if they have been independently evaluated and determined to be of high quality: • Systematic reviews of randomized controlled trials (RCTs); • Individual comparative effectiveness RCTs evaluating clinically important outcomes; • FDA review documents; • Guidelines

PRIOR AUTHORIZATION REQUIREMENTS	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	medications when specific medical conditions exist. Those specific medications and diagnoses are available at https://tenncare.magellanhealth.com. Prescribers are encouraged to include the applicable diagnosis code on written for on the electronic pharmacy claim.		developed using an explicit evidence evaluation process.	specific medications and diagnoses are available at https://tenncare.magellanhealth.com. Prescribers are encouraged to include the applicable diagnosis code on written for on the electronic pharmacy claim.		developed using an explicit evidence evaluation process
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	Policies, strategies, and evidentiary standards for prior authorization are the same for both MH/SUD and M/S pharmacy benefits. Therefore, prior authorization processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied than prior authorization processes, strategies,and evidentiary standards applied to M/S benefits.					
Evaluation of Processes, Strategies, and Evidentiary Standards	**If prior authorization requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of prior authorization is in parity. No additional information is needed.** **If prior authorization requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of prior authorization is not in parity. Proceed to the following row.**					

PRIOR AUTHORIZATION REQUIREMENTS	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Modifications Explain how prior authorization processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A – No modifications required to comply with parity.	

NQTL Analysis Module: PHARMACY – USE OF MEDICAL NECESSITY

USE OF MEDICAL NECESSITY REQUIREMENTS	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
What criteria does TennCare apply to make medical necessity/ appropriateness determinations for pharmacy services?	The medical necessity standard set forth in TCA Section 71-5-144 is utilized to make appropriateness determinations for MH/SUD pharmacy services.			The medical necessity standard set forth in TCA Section 71-5-144 is utilized to make appropriateness determinations for M/S pharmacy services.		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process TennCare uses, both in writing and in practice, for determining medical necessity.	**Strategies:** WHY does TennCare use the processes described?	**Evidentiary Standards:** What evidence supports our MN criteria and/or our processes for determining MN? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process TennCare uses, both in writing and in practice, for determining medical necessity.	**Strategies:** WHY does TennCare use the processes described?	**Evidentiary Standards:** What evidence supports our MN criteria and/or our processes for determining MN? Evidence may include practice guidelines and internal health plan utilization data.
	Certain items or services may be identified that, for purposes of determining medical necessity, shall require prior authorization. To be medically necessary, a medical item or service must satisfy each of the following criteria: (a) It must be recommended by a licensed physician who is treating the enrollee or other licensed healthcare provider practicing	The medical necessity standard set forth in Tennessee Code Annotated Section 71-5-144 is used to govern the delivery of all medical items and services to all enrollees or classes of beneficiaries in the TennCare program. The definition of medical necessity is implemented consistent with federal law, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	As per Tennessee Code Annotated 71-5-2401, the Pharmacy Advisory Committee is utilized to provide recommendations regarding the managing of enrollees' access to newly released or approved pharmaceuticals by using available evidence-based research to encourage and recommend safe, effective and financially stable drug use guidelines. Evidence provided in	Certain items or services may be identified that, for purposes of determining medical necessity, shall require prior authorization. To be medically necessary, a medical item or service must satisfy each of the following criteria: (a) It must be recommended by a licensed physician who is treating the enrollee or other licensed healthcare provider practicing	The medical necessity standard set forth in Tennessee Code Annotated Section 71-5-144 is used to govern the delivery of all medical items and services to all enrollees or classes of beneficiaries in the TennCare program. The definition of medical necessity is implemented consistent with federal law, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	As per Tennessee Code Annotated 71-5-2401, the Pharmacy Advisory Committee is utilized to provide recommendations regarding the managing of enrollees' access to newly released or approved pharmaceuticals by using available evidence-based research to encourage and recommend safe, effective and financially stable drug use guidelines. Evidence provided in

USE OF MEDICAL NECESSITY REQUIREMENTS	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	within the scope of his or her license who is treating the enrollee; (b) It must be required in order to diagnose or treat an enrollee's medical condition; (c) It must be safe and effective; (d) It must not be experimental or investigational; and (e) It must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition. TennCare is ultimately responsible for determining whether specific medical items and/or services under TennCare (a) are covered services and (b) are medically necessary. In the vast majority of cases, medical necessity determinations will be made by the prescribing physician or by the prescribing physician and	requirements, and within the state's authority to define what constitutes a medically necessary Medicaid service. It is recognized that current EPSDT requirements include coverage of "necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illness and conditions discovered by screening services, whether or not such services are covered under the state plan".	practice guidelines, clinical trials, and FDA-approved labeling is used to support the use of prior authorizations. TennCare, in conjunction with the Pharmacy Advisory Committee, relies on high-quality systematic reviews and evidence-based guidelines in creating PA criteria. The following are considered preferred sources of high quality evidence: • Oregon Health and Science University's (OHSU's) Drug Effectiveness Review Project (DERP); • Veterans Affairs and the Department of Defense (VA/DoD) Clinical Practice Guidelines; • Agency for Healthcare Research and Quality (AHRQ); • Canadian Agency	within the scope of his or her license who is treating the enrollee; (b) It must be required in order to diagnose or treat an enrollee's medical condition; (c) It must be safe and effective; (d) It must not be experimental or investigational; and (e) It must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition. TennCare is ultimately responsible for determining whether specific medical items and/or services under TennCare (a) are covered services and (b) are medically necessary. In the vast majority of cases, medical necessity determinations will be made by the prescribing physician or by the prescribing physician and	requirements, and within the state's authority to define what constitutes a medically necessary Medicaid service. It is recognized that current EPSDT requirements include coverage of "necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illness and conditions discovered by screening services, whether or not such services are covered under the state plan".	practice guidelines, clinical trials, and FDA-approved labeling is used to support the use of prior authorizations. TennCare, in conjunction with the Pharmacy Advisory Committee, relies on high-quality systematic reviews and evidence-based guidelines in creating PA criteria. The following are considered preferred sources of high quality evidence: • Oregon Health and Science University's (OHSU's) Drug Effectiveness Review Project (DERP); • Veterans Affairs and the Department of Defense (VA/DoD) Clinical Practice Guidelines; • Agency for Healthcare Research and Quality (AHRQ); • Canadian Agency

USE OF MEDICAL NECESSITY REQUIREMENTS	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	TennCare together through a prior authorization process. However, less frequently such determinations may be made retrospectively in the course of the investigation of unusual billing or practice patterns. All medical necessity decisions must be made by licensed medical staff with appropriate clinical expertise. TennCare may review such decisions as a part of routine monitoring or as a result of an enrollee appeal or provider complaint and may overturn such decisions if not made in accordance with these rules. TennCare will rely upon all relevant information in making a medical necessity determination. Such determinations must be individualized and made in the context of medical/behavioral history information		for Drugs and Technologies in Health (CADTH); • The Cochrane Collaboration; • National Institute for Clinical Evidence (NICE); • Institute for Clinical and Economic Review (ICER); • Published systematic reviews from validated, evidence-based medical sources. The following types of evidence are preferred and may be considered if they have been independently evaluated and determined to be of high quality: • Systematic reviews of randomized controlled trials (RCTs); • Individual comparative effectiveness RCTs evaluating clinically important	TennCare together through a prior authorization process. However, less frequently such determinations may be made retrospectively in the course of the investigation of unusual billing or practice patterns. All medical necessity decisions must be made by licensed medical staff with appropriate clinical expertise. TennCare may review such decisions as a part of routine monitoring or as a result of an enrollee appeal or provider complaint and may overturn such decisions if not made in accordance with these rules. TennCare will rely upon all relevant information in making a medical necessity determination. Such determinations must be individualized and made in the context of medical/behavioral history information		for Drugs and Technologies in Health (CADTH); • The Cochrane Collaboration; • National Institute for Clinical Evidence (NICE); • Institute for Clinical and Economic Review (ICER); • Published systematic reviews from validated, evidence-based medical sources. The following types of evidence are preferred and may be considered if they have been independently evaluated and determined to be of high quality: • Systematic reviews of randomized controlled trials (RCTs); • Individual comparative effectiveness RCTs evaluating clinically important

<table>
<tr><th>USE OF MEDICAL NECESSITY REQUIREMENTS</th><th colspan="3">Mental Health/Substance Use Disorder Services</th><th colspan="3">Medical/Surgical Services</th></tr>
<tr><td></td><td>included in the enrollee’s medical record.

An enrollee may appeal a determination that a medical item or service that is within the enrollee’s scope of covered benefits is not medically necessary.</td><td></td><td>outcomes;
• FDA review documents;
• Guidelines developed using an explicit evidence evaluation process.</td><td>included in the enrollee’s medical record.

An enrollee may appeal a determination that a medical item or service that is within the enrollee’s scope of covered benefits is not medically necessary.</td><td></td><td>outcomes;
• FDA review documents;
• Guidelines developed using an explicit evidence evaluation process.</td></tr>
<tr><td>Comparability and Stringency

Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied to M/S benefits.</td><td colspan="6">The processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable to M/S benefits as applicable to medical necessity. The processes, strategies, and evidentiary standards applied are not more stringently applied to MH/SUD benefits than to M/S benefits.</td></tr>
<tr><td>Evaluation of Processes, Strategies, and Evidentiary Standards</td><td colspan="6">If prior authorization requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of prior authorization is in parity. No additional information is needed.

If prior authorization requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of prior authorization is not in parity. Proceed to the following row.</td></tr>
<tr><td>Modifications

Explain how medical necessity processes for MH/SUD and/or M/S benefits will be modified to comply with parity.</td><td colspan="6">N/A – No modifications required to comply with parity.</td></tr>
</table>

NQTL Analysis Module: PHARMACY -- USE OF FAIL FIRST OR STEP THERAPY PROTOCOLS

PHARMACY -- USE OF FAIL FIRST OR STEP THERAPY PROTOCOLS	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
Does TennCare use fail first or step therapy protocols for any pharmacy services? Which ones?	Yes, step therapy protocols are utilized for some MH/SUD pharmacy services. For a complete listing, please see links below: https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_PDL.pdf https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/Criteria_PDL.pdf#nameddest=smoking_cessation_agents_section			Yes, step therapy protocols are utilized for some M/S pharmacy services. For a complete listing, please see links below: https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_PDL.pdf https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/Criteria_PDL.pdf#nameddest=smoking_cessation_agents_section		
Processes, Strategies, and Evidentiary Standards	**Processes:** Explain the process TennCare uses, both in writing and in practice, to implement its fail first policy or step therapy protocol.	**Strategies:** WHY does TennCare use fail first or step therapy requirements for these services, and why do we use the process described? What is the rationale and/or goal we are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of fail first or step therapy for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	**Processes:** Explain the process TennCare uses, both in writing and in practice, to implement its fail first policy or step therapy protocol.	**Strategies:** WHY does TennCare use fail first or step therapy requirements for these services, and why do we use the process described? What is the rationale and/or goal we are trying to achieve?	**Evidentiary Standards:** What evidence supports the use of fail first or step therapy for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.
	As per Tennessee Code Annotated 71-5-2401, the TennCare Pharmacy Advisory Committee (PAC) is utilized to provide recommendations regarding the management of enrollees' access to newly released or approved pharmaceuticals by using available evidence-based	All other things equal, step therapy requirements are used to ensure appropriate utilization of medications (based on clinical guidelines) and to manage cost. Step therapy requirements ensure that members utilize the most cost-effective therapies first before moving on to more costly alternatives.	As per Tennessee Code Annotated 71-5-2401, the TennCare Pharmacy Advisory Committee is utilized to provide recommendations regarding the managing of enrollees' access to newly released or approved pharmaceuticals by using available evidence-based research to encourage and recommend safe,	As per Tennessee Code Annotated 71-5-2401, the TennCare Pharmacy Advisory Committee (PAC) is utilized to provide recommendations regarding the management of enrollees' access to newly released or approved pharmaceuticals by using available evidence-based	All other things equal, step therapy requirements are used to ensure appropriate utilization of medications (based on clinical guidelines) and to manage cost. Step therapy requirements ensure that members utilize the most cost-effective therapies first before moving on to more costly alternatives.	As per Tennessee Code Annotated 71-5-2401, the TennCare Pharmacy Advisory Committee is utilized to provide recommendations regarding the managing of enrollees' access to newly released or approved pharmaceuticals by using available evidence-based research to encourage and recommend safe, effective and financially

PHARMACY -- USE OF FAIL FIRST OR STEP THERAPY PROTOCOLS	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	research to encourage and recommend safe, effective and financially stable drug use guidelines. The primary clinical decision to be made by the PAC is whether the drugs within the therapeutic class can be considered therapeutic alternatives to established drugs used to treat the same condition. Upon reviewing a class, the PAC will propose standard recommendations based on comparative efficacy and safety information and, if necessary, prior authorization criteria for coverage. Adopted recommendations will be implemented on day one of the first full month following adoption. The PAC will consider the overall quality of the evidence available at the time of review and public comments,		effective and financially stable drug use guidelines. Evidence provided in practice guidelines, clinical trials, and FDA-approved labeling is used to support the use of prior authorizations. TennCare, in conjunction with the Pharmacy Advisory Committee, relies on high-quality systematic reviews and evidence-based guidelines in creating PA criteria. The following are considered preferred sources of high quality evidence: • Oregon Health and Science University's (OHSU's) Drug Effectiveness Review Project (DERP); • Veterans Affairs and the Department of Defense (VA/DoD) Clinical Practice Guidelines; • Agency for Healthcare	research to encourage and recommend safe, effective and financially stable drug use guidelines. The primary clinical decision to be made by the PAC is whether the drugs within the therapeutic class can be considered therapeutic alternatives to established drugs used to treat the same condition. Upon reviewing a class, the PAC will propose standard recommendations based on comparative efficacy and safety information and, if necessary, prior authorization criteria for coverage. Adopted recommendations will be implemented on day one of the first full month following adoption. The PAC will consider the overall quality of the evidence available at the time of review		stable drug use guidelines. Evidence provided in practice guidelines, clinical trials, and FDA-approved labeling is used to support the use of prior authorizations. TennCare, in conjunction with the Pharmacy Advisory Committee, relies on high-quality systematic reviews and evidence-based guidelines in creating PA criteria. The following are considered preferred sources of high quality evidence: • Oregon Health and Science University's (OHSU's) Drug Effectiveness Review Project (DERP); • Veterans Affairs and the Department of Defense (VA/DoD) Clinical Practice Guidelines; • Agency for Healthcare Research and Quality (AHRQ); • Canadian Agency for Drugs and Technologies in

PHARMACY -- USE OF FAIL FIRST OR STEP THERAPY PROTOCOLS	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	and will act as follows: • Accept or reject the review and recommendations as written; or • Make edits to the review and recommendations and accept as modified; or • Request additional information from the TennCare Pharmacy staff on the topic; and • If additional information is requested, findings may be presented to the PAC at the next scheduled meeting.		Research and Quality (AHRQ); • Canadian Agency for Drugs and Technologies in Health (CADTH); • The Cochrane Collaboration; • National Institute for Clinical Evidence (NICE); • Institute for Clinical and Economic Review (ICER); • Published systematic reviews from validated, evidence-based medical sources. The following types of evidence are preferred and may be considered if they have been independently evaluated and determined to be of high quality: • Systematic reviews of randomized controlled trials (RCTs); • Individual comparative effectiveness RCTs evaluating clinically important	and public comments, and will act as follows: • Accept or reject the review and recommendations as written; or • Make edits to the review and recommendations and accept as modified; or • Request additional information from the TennCare Pharmacy staff on the topic; and • If additional information is requested, findings may be presented to the PAC at the next scheduled meeting.		Health (CADTH); • The Cochrane Collaboration; • National Institute for Clinical Evidence (NICE); • Institute for Clinical and Economic Review (ICER); • Published systematic reviews from validated, evidence-based medical sources. The following types of evidence are preferred and may be considered if they have been independently evaluated and determined to be of high quality: • Systematic reviews of randomized controlled trials (RCTs); • Individual comparative effectiveness RCTs evaluating clinically important outcomes; • FDA review documents; • Guidelines developed using an

PHARMACY -- USE OF FAIL FIRST OR STEP THERAPY PROTOCOLS	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
			outcomes; • FDA review documents; • Guidelines developed using an explicit evidence evaluation process.			explicit evidence evaluation process.
Comparability and Stringency Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are **comparable** and **no more stringently applied** to M/S benefits.	The processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable to those applied to M/S benefits as applicable to the fail first/step therapy. The processes, strategies, and evidentiary standards are applied no more stringently to MH/SUD benefits than to M/S benefits.					
Evaluation of Processes, Strategies, and Evidentiary Standards	**If prior authorization requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of prior authorization is in parity. No additional information is needed.** **If prior authorization requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of prior authorization is not in parity. Proceed to the following row.**					

PHARMACY – CONCURRENT REVIEW	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Evaluation of Processes, Strategies, and Evidentiary Standards	**If prior authorization requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the application of prior authorization is in parity. No additional information is needed.** **If prior authorization requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the application of prior authorization is not in parity. Proceed to the following row.**	
Modifications Explain how concurrent review processes for MH/SUD and/or M/S benefits will be modified to comply with parity.	N/A	