

Mental Health Parity

in the TennCare and CoverKids Programs

 ${\it Tennessee \ Department \ of \ Finance \ \& \ Administration \ | \ Division \ of \ TennCare}$ 

Originally published July 2017.

Updated September 2019.

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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<sup>1</sup> 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

<sup>&</sup>lt;sup>1</sup> 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	Covered medications and drugs requiring a prescription.
Drugs	

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.<sup>2</sup> 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

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<sup>&</sup>lt;sup>2</sup> 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<sup>3</sup> 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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<sup>&</sup>lt;sup>3</sup> 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	\$5	\$15
community mental health		
agency services⁴		
Physician specialists and	\$5	\$20
dentists		
Non-emergency services	\$10	\$50
received at a hospital		
emergency room		
PRESCRIPTION DRUGS		
Prescription drugs	\$1.50 for generics	\$1.50 for generics
	\$3.00 for brands	\$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.

<sup>&</sup>lt;sup>4</sup> 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	\$5	\$100
inpatient admissions		
Inpatient mental health and substance abuse treatment	\$5	\$100
OUTPATIENT SERVICES		
Physician office visit	\$5 (primary care)	\$15 (primary care)
	\$5 (specialist)	\$20 (specialist)
Chiropractic care	\$5	\$15
Dental services	\$5	\$15
Vision services	\$5	\$15
Physical, speech, and	\$5	\$15
occupational therapy		
Outpatient mental health and	\$5	\$15
substance abuse treatment		
services		
Non-emergency services	\$10	\$50
received at hospital		
emergency room		
PRESCRIPTION DRUGS		
Prescription drugs	\$1 for generics	\$5 for generics
	\$3 for preferred brands	\$20 for preferred brands
	\$5 for non-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 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<sup>5</sup>, and UnitedHealthcare Community Plan<sup>6</sup>. 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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<sup>&</sup>lt;sup>5</sup> 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.

<sup>&</sup>lt;sup>6</sup> 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 used by the plan to determine whether treatment or
criteria	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	The plan requires the enrollee to try one level of treatment before
and/or step therapy	another level of treatment is approved.
protocols	
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<sup>7</sup> care guidelines and ASAM<sup>8</sup> 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.

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<sup>&</sup>lt;sup>7</sup> Formerly called the Milliman Care Guidelines.

<sup>&</sup>lt;sup>8</sup> 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 innetwork 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 The PAC relies on high-quality, systematic reviews and evidence-based requirements. 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

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

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

## **Attachments:**

NQTL Modules Completed by Health Plans



#### NQTL Analysis Module 1: Prior Authorization – INPATIENT SERVICES

PRIOR AUTHORIZATION REQUIREMENTS – INPATIENT SERVICES	Mental Hea	Ith/Substance Use Disor	der Services		Medical/Surgical Service	s
List all inpatient benefits requiring prior authorization.	<ul> <li>Psychiatric Acute Inpatient</li> <li>Psychiatric Residential Treatment Center Services</li> </ul>			Medical/Surgical (M/S) inpatient admissions require prior authorization. Examples include:  • Acute Inpatient surgeries (Joint replacement, Spinal, Bariatric)  • Organ/Tissue Transplant surgeries  • Sub-acute hospitalizations		
	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.
Processes, Strategies, and Evidentiary Standards	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	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	See attachment, "Amerigroup Evidentiary Standards"	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	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	See attachment, "Amerigroup Evidentiary Standards"

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

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

PRIOR AUTHORIZATION REQUIREMENTS – INPATIENT SERVICES	Mandal Hadib (Cabatana Had Biranda Carrian	Madical (Constant Constant
IIII 7 III SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
	requests for the	requests for the addition of new
	addition of new	
	precertification	precertification
	rules and/or	rules and/or
	revisions to existing	revisions to existing
	rules. This includes	rules. This includes
	authorization	authorization
	waivers and	waivers and
	managing Provider	managing Provider
	status.	status.
	2) PCC decisions are	2) PCC decisions are
	evidence based. The	evidence based. The
	requestor is	requestor is
	required to submit	required to submit
	an analysis to	an analysis to
	demonstrate the	demonstrate the
	effects on the	effects on the
	business	business
	operations, and	operations, and
	provide a summary	provide a summary
	on how the change	on how the change
	will impact the	will impact the
	health	health
	plan/division.	plan/division.
	Refer to	Refer to
	Amerigroup	Amerigroup
	Precertification	Precertification
	Committee policy	Committee policy
	55	55

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

PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/S	Substance Use Disorder S	Services	Medica	al/Surgical Services	
List all outpatient benefits requiring prior authorization.	Mental Health/Substance Use Disorder Services  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		<ul> <li>Auditory Surgery</li> <li>Cardiac Rehab- outpatient</li> <li>Dental Services (under age of 21)</li> <li>ENT (Otolaryngology)         Surgery</li> <li>Genetic Testing</li> <li>Gynecology Surgery</li> <li>Hematology</li> <li>Home Health Aide</li> <li>Home Health Skilled         Nursing</li> <li>Home Health Therapy</li> <li>Home Infusion</li> <li>Hospice</li> <li>Interventional Cardiology</li> <li>LTSS services</li> <li>Medical Injectable</li> </ul>	<ul> <li>Nephrology</li> <li>Neurology</li> <li>OON services</li> <li>Ophthalmology Sure</li> <li>Oral Maxillofacial</li> <li>Organ/Tissue Transorgan</li> <li>Pain Management</li> <li>Plastic/Cosmetic/R Surgery</li> <li>Private Duty Nursine</li> <li>Prosthetics/Orthot</li> <li>Radiation Therapy</li> <li>Radiology/Imaging</li> <li>Rehab Therapy (PT</li> <li>Sleep Study</li> <li>Urology Services</li> <li>Vision Services (unitality)</li> </ul>	econstructive ng ics /ST/OT)	
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 REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medica	ıl/Surgical Services	
	All MH/SUD outpatient	Amerigroup's	See	All M/S outpatient benefits	Amerigroup's	See
	benefits that require	approach to	attachment,	that require prior	approach to	attachment,
	prior authorization are:	precertification	"Amerigroup	authorization are:	precertification	"Amerigroup
		promotes	Evidentiary		promotes	Evidentiary
	1) Submitted by the	appropriate care.	Standards"	1) Submitted by the provider	appropriate care.	Standards"
	provider to AGP	Established		to AGP through an online	Established	
	through an online	procedures are		portal, fax or verbally.	procedures are	
	portal, fax or verbally.	followed for		2) AGP licensed clinician	followed for applying	
	2) AGP licensed	applying criteria		reviews submitted clinical to	criteria based on	
	clinician reviews	based on individual		determine medical necessity	individual member's	
	submitted clinical to	member's medical		using TennCare Rules,	medical necessity	
	determine medical	necessity and		Amerigroup Medical Policy,	and community	
	necessity using	community		and Amerigroup Clinical UM	standards of care,	
	TennCare Rules,	standards of care,		guidelines.	minimizing	
	Amerigroup Medical	minimizing		- The authorization is	administrative	
	Policy, and Amerigroup	administrative		completed in accordance	barriers for	
	Clinical UM guidelines.	barriers for		with NCQA timeframes.	physicians and other	
	- The authorization is	physicians and other		3) If the reviewing clinician	providers while	
	completed in	providers while		determines medical necessity	promoting	
	accordance with NCQA	promoting		is met, requestor is notified	appropriate care.	
	timeframes.	appropriate care.		and provided a reference		
	3) If the reviewing			number.	We utilize this	
	clinician determines	We utilize this		4) If the reviewing clinician	process to enhance	
	medical necessity is	process to enhance		determines medical necessity	consistency in	
	met, requestor is	consistency in		criteria is NOT met, outreach	reviewing cases by	
	notified and provided a	reviewing cases by		is made to the requestor for	providing a	
	reference number.	providing a		additional supporting clinical	framework for	
	4) If the reviewing	framework for		information.	clinical decision	
	clinician determines	clinical decision		5) If the reviewing clinician	making. This process	
	medical necessity	making. This		determines medical necessity	ensures compliance	
	criteria is NOT met,	process ensures		criteria is still NOT met, the	with local, state, and	
	outreach is made to the	compliance with		request is sent to Medical	federal	
	requestor for additional	local, state, and		Director review to determine	requirements, as	
	supporting clinical	federal		if medical necessity is met.	well as accreditation	
	information.	requirements, as		6) The reviewing clinician	bodies, i.e., NCQA.	

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

PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Servi	ces Medical/Surgical Services
	requests to add,	current rules
	delete or change	periodically for
	precertification	potential changes
	rules for the	and reviews/makes
	organization.	decisions on
	Changes to the	requests to add,
	precertification	delete or change
	rules are not to be	precertification rules
	operationalized via	for the organization.
	system changes or	Changes to the
	manual processes	precertification rules
	without PCC	are not to be
	approval.	operationalized via
		system changes or
	1) The PCC is	manual processes
	responsible for	without PCC
	reviewing all	approval.
	requests for the	
	addition of new	1) The PCC is
	precertification	responsible for
	rules and/or	reviewing all
	revisions to existing	requests for the
	rules. This includes	addition of new
	authorization	precertification rules
	waivers and	and/or revisions to
	managing Provider	existing rules. This
	status.	includes
		authorization
	2) PCC decisions are	waivers and
	evidence based. The	managing Provider
	requestor is	status.
	required to submit	2) 200 1
	an analysis to	2) PCC decisions are
	demonstrate the	evidence based. The
	effects on the	requestor is required

PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder S	prvices	Medica	I/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 stands authorization process.  Stringency: The processes, strategies, and evidentiary stands				·

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 M application of prior authorization is in parity. No additional information of prior authorization requirements are not comparably applied betwee application of prior authorization is not in parity. Proceed to the follow	n MH/SUD and M/S benefits, or are applied more stringently, then the
Modifications	N/A	
Explain how prior authorization processes for MH/SUD and/or M/S benefits will be modified to comply with parity.		

#### NQTL Analysis Module 1: Prior Authorization – EMERGENCY SERVICES

PRIOR AUTHORIZATION REQUIREMENTS – EMERGENCY SERVICES	Mental Hea	Ith/Substance Use Disore	der Services		Medical/Surgical Service	s
List all emergency benefits requiring prior authorization.				N/A – Prior authoriza	tion is not required for	emergency services.
	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.
Processes, Strategies, and Evidentiary Standards	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	Comparability: The processes, strategies, and evidentiary standards applied to MH emergency services.	The processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable to M/S benefits as applicable to					
Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied to M/S benefits.	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	N/A						
Explain how prior authorization processes for MH/SUD and/or M/S benefits will be modified to comply with parity.							

# NQTL Analysis Module 2: Concurrent Review – INPATIENT SERVICES

CONCURRENT REVIEW REQUIREMENTS – INPATIENT SERVICES		Ith/Substance Use Disor	der Services		Medical/Surgical Service	s
List all inpatient benefits requiring concurrent review.	<ul> <li>Mental Health (MH) Services</li> <li>Psychiatric Acute Inpatient</li> <li>Psychiatric Residential Treatment Center Services</li> <li>Psychiatric Sub-acute Care</li> <li>Substance Use Disorders (SUD) Services</li> <li>Substance Abuse Inpatient or Residential Level Detoxification</li> </ul>			<ul> <li>Acute Inpatient Hospital Services</li> <li>Long Term Acute Care (LTAC)</li> <li>Inpatient Rehab (under 21)</li> <li>Skilled Nursing Facility (CEA)</li> </ul>		
	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.
Processes, Strategies, and Evidentiary Standards	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.	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.	See attachment, "Amerigroup Evidentiary Standards"

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

CONCURRENT REVIEW REQUIREMENTS – INPATIENT SERVICES	Mental Hea	alth/Substance Use Disorde	er Services		Medical/Surgical Services	5
	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.	concurrent review pro	gies, and evidentiary sta ocess. gies, and evidentiary sta				

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

# NQTL Analysis Module 2: Concurrent Review – OUTPATIENT SERVICES

CONCURRENT REVIEW REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services			rices
List all outpatient benefits requiring concurrent review.	<ul> <li>Mental Health (MH) Services</li> <li>Applied Behavioral Analysis (ABA)</li> <li>Electroconvulsive Therapy (ECT)</li> <li>Intensive Community Based Treatment</li> <li>Intensive Outpatient (IOP)</li> <li>Partial Hospitalization (PHP)</li> <li>Psychological Testing</li> <li>Supported Housing</li> <li>Transcranial Magnetic Stimulation (TMS)</li> </ul> Substance Use Disorders (SUD) Services <ul> <li>Ambulatory Detoxification</li> <li>Intensive Outpatient</li> <li>Partial Hospitalization</li> </ul>		<ul> <li>Auditory Surgery</li> <li>Cardiac Rehab- outpatient</li> <li>Dental Services (under age of 21)</li> <li>ENT (Otolaryngology)     Surgery</li> <li>Genetic Testing</li> <li>Gynecology Surgery</li> <li>Hematology</li> <li>Home Health Aide</li> <li>Home Health Skilled Nursing</li> <li>Home Health Therapy</li> <li>Home Infusion</li> <li>Hospice</li> <li>Interventional Cardiology</li> <li>LTSS services</li> <li>Medical Injectables</li> <li>Nephrology</li> </ul>		<ul><li>Neurology</li><li>OON services</li></ul>		
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.	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		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.

CONCURRENT REVIEW REQUIREMENTS –						
OUTPATIENT SERVICES	Mental Hea	Ith/Substance Use Disor	der Services		Medical/Surgical Serv	rices
	All MH/SUD	The purpose of the	See attachment,	All M/S outpatient	The purpose of the	See attachment,
	outpatient benefits	concurrent review	"Amerigroup	benefits that	concurrent review	"Amerigroup Evidentiary
	that require	process is to assist	Evidentiary	require concurrent	process is to assist	Standards"
	concurrent review	the Health Plan in	Standards"	review are:	the Health Plan in	
	are:	ensuring that			ensuring that	
		eligible members		1) Submitted by	eligible members	
	1) Submitted by	continue to receive		the provider to	continue to receive	
	the provider to	the most clinically		AGP through an	the most clinically	
	AGP through an	appropriate care		online portal, fax or	appropriate care	
	online portal, fax	and services in the		verbally.	and services in the	
	or verbally.	most efficient		2) AGP licensed	most efficient	
	2) AGP licensed	manner possible.		clinician reviews	manner possible.	
	clinician reviews			submitted clinical		
	submitted clinical	We utilize this		to determine	We utilize this	
	to determine	process to enhance		medical necessity	process to enhance	
	medical necessity	consistency in		using TennCare	consistency in	
	using Amerigroup	reviewing cases by		Rules, InterQual®	reviewing cases by	
	Medical Policy and	providing a		Level of Care,	providing a	
	Amerigroup	framework for		Amerigroup	framework for	
	Clinical UM	clinical decision		Medical Policy, and	clinical decision	
	guidelines.	making. This		Amerigroup Clinical	making. This	
	The authorization	process ensures		UM guidelines.	process ensures	
	is completed in	compliance with		The authorization	compliance with	
	accordance with	local, state, and		is completed in	local, state, and	
	NCQA timeframes.	federal		accordance with	federal	
	3) If the reviewing	requirements, as		NCQA timeframes.	requirements, as	
	clinician	well as		3) If the reviewing	well as	
	determines	accreditation		clinician	accreditation	
	medical necessity	bodies, i.e., NCQA.		determines	bodies, i.e., NCQA.	
	is met, requestor is			medical necessity is	The goals of the	
	notified and	The goals of the		met, requestor is	The goals of the	
	provided a	concurrent review		notified and	concurrent review	
	reference number.	process are to		provided a	process are to	
	4) If the reviewing	ensure adequacy of		reference number.	ensure adequacy of	
	clinician	service availability		4) If the reviewing	service availability	

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

CONCURRENT REVIEW REQUIREMENTS – OUTPATIENT SERVICES	Montal Has	Ith/Substance Use Disor	dar Sarvisas		Medical/Surgical Serv	deac
OUTPATIENT SERVICES	requirements.	in substance use bison	der Services	well as NCQA requirements.	iviedical/Surgical Serv	ices
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.					
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 –		
		AA 1' 1/0 ' 10 '
OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Modifications	N/A	
Explain how concurrent review processes for MH/SUD and/or M/S benefits will be modified to comply with parity.		

# NQTL Analysis Module 2: Concurrent Review – EMERGENCY SERVICES

CONCURRENT REVIEW REQUIREMENTS – EMERGENCY SERVICES	Mental Hea	olth/Substance Use Disor	der Services		Medical/Surgical Service	s
List all emergency benefits requiring concurrent review.				N/A – Prior authoriza	tion is not required for	emergency services.
	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.
Processes, Strategies, and Evidentiary Standards	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	Comparability: The processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable to M/S benefits as applicable emergency services.					
Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied to M/S benefits.	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.					
	N/A					
Modifications						
Explain how concurrent review processes for MH/SUD and/or M/S benefits will be modified to comply with parity.						

# NQTL Analysis Module 3: Medical Necessity – INPATIENT SERVICES

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

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

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

MEDICAL NECESSITY REQUIREMENTS – INPATIENT		
SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and		. 0
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/S medical necessity.  Stringency: The processes, strategies, and evidentiary standards applied to M/S is a second control of the processes.	
Evaluation of Processes, Strategies, and Evidentiary Standards	If medical necessity requirements are applied comparably between then the application of medical necessity is in parity. No additional If medical necessity requirements are not comparably applied between the application of medical necessity is not in parity. Proceed to	information is needed. reen MH/SUD and M/S benefits, or are applied more stringently,
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 He	alth/Substance Use Disor	der Services		Medical/Surgical Service	ıs
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		1.1 /o.1				
SERVICES		Ith/Substance Use Disord			Medical/Surgical Services	
	Amerigroup, TN	Medical Necessity	Annually, the	Amerigroup, TN	Medical Necessity	Annually, the
	utilizes the	criteria utilized by	Anthem Medical	utilizes the	criteria utilized by	Anthem Medical
	TennCare medical	Amerigroup, TN	Policy & Technology	TennCare medical	Amerigroup, TN	Policy & Technology
	necessity rules 1200-	provide a rules-	Assessment	necessity rules 1200-	provide a rules-	Assessment
	13-16 and criteria in	based system for	Committee (MPTAC)	13-16 and criteria in	based system for	Committee (MPTAC)
	Tennessee Code	screening proposed	reviews all criteria	Tennessee Code	screening proposed	reviews all criteria
	Annotated (TCA) 71-	medical/behavioral	used to determine	Annotated (TCA) 71-	medical/behavioral	used to determine
	5-144 in making	health care based on	medical necessity	5-144 in making	health care based on	medical necessity
	medical necessity	patient-specific, best	coverage decisions.	medical necessity	patient-specific, best	coverage decisions.
	decisions in addition	health care	The committee	decisions in addition	health care	The committee
	to the use of	processes and	reviews the criteria	to the use of	processes and	reviews the criteria
	nationally	consistently match	more frequently if a	nationally	consistently match	more frequently if a
	recognized medical	medical/behavioral	new version of the	recognized medical	medical/behavioral	new version of the
	criteria to help	services to patient	criteria is published	criteria to help	services to patient	criteria is published
	ensure medically	needs, based upon	before the annual	ensure medically	needs, based upon	before the annual
	necessary health	clinical	review date.	necessary health	clinical	review date.
	services are	appropriateness.	Once the criteria are	services are	appropriateness.	Once the criteria are
	available to		approved by the	available to		approved by the
	members. These		Corporate MPTAC,	members. These		Corporate MPTAC,
	include services that		the criteria are	include services that		the criteria are
	are:		reviewed, discussed	are:		reviewed, discussed
	1) Reasonable and		and approved by the	1) Reasonable and		and approved by the
	necessary to prevent		Amerigroup Medical	necessary to prevent		Amerigroup Medical
	illnesses or medical		Advisory Committee	illnesses or medical		Advisory Committee
	conditions or		(MAC), which	conditions or		(MAC), which
	provide early		includes members	provide early		includes members
	screening,		who are actively	screening,		who are actively
	interventions or		practicing clinicians	interventions or		practicing clinicians
	treatments for		with relevant	treatments for		with relevant
	conditions that		professional	conditions that		professional
	cause suffering or		knowledge and	cause suffering or		knowledge and
	pain, physical		clinical expertise.	pain, physical		clinical expertise.
	deformity or		1) In the event the	deformity or		1) In the event the
	limitations in		Amerigroup, TN	limitations in		Amerigroup, TN
	function, threaten to		MAC identifies	function, threaten to		MAC identifies

MEDICAL					
NECESSITY					
REQUIREMENTS -					
OUTPATIENT SERVICES	Montal Health /Substa	nce Use Disorder Services		Medical/Surgical Services	
SERVICES	cause or worsen	issue(s) with the	cause or worsen	ivieuicai/ Surgicai Services	issue(s) with the
	handicap, cause	criteria, to the	handicap, cause		criteria, to the
	illness or infirmity of		• •		
	a member or	extent that approval of the criteria is	illness or infirmity of		extent that approval of the criteria is
			a member or		
	endanger life.	deferred until	endanger life.		deferred until
	2) Provided at	clarification is	2) Provided at		clarification is
	appropriate facilities	obtained, the	appropriate facilities		obtained, the
	and at the	Regional Vice	and at the		Regional Vice
	appropriate levels of	President Medical	appropriate levels of		President Medical
	care for the	Director (RVPMD) or	care for the		Director (RVPMD) or
	treatment of a	designee	treatment of a		designee
	member's medical	communicates the	member's medical		communicates the
	condition.	identified issue(s) to	condition.		identified issue(s) to
	3) Consistent with	the Chair of the	3) Consistent with		the Chair of the
	health care practice	Corporate MPTAC.	health care practice		Corporate MPTAC.
	guidelines and	2) Once the	guidelines and		2) Once the
	standards that are	identified issue(s) is	standards that are		identified issue(s) is
	issued by	addressed by the	issued by		addressed by the
	professionally	MPTAC, the	professionally		MPTAC, the
	recognized health	resolution of the	recognized health		resolution of the
	care organizations	issue is	care organizations		issue is
	or governmental	communicated to	or governmental		communicated to
	agencies.	the Amerigroup TN	agencies.		the Amerigroup TN
	4) Consistent with	MAC members and a	4) Consistent with		MAC members and a
	the diagnoses of the	vote occurs.	the diagnoses of the		vote occurs.
	conditions.		conditions.		
	5) No more intrusive		5) No more intrusive		
	or restrictive than		or restrictive than		
	necessary to provide		necessary to provide		
	a proper balance of		a proper balance of		
	safety, effectiveness		safety, effectiveness		
	and efficiency.		and efficiency.		
	and emerciney.		and emolency.		
	The Behavioral		Amerigroup utilizes		
	Health UM Program		InterQual® Level of		
	Health Olvi Flugraili		iliterQual Level 01		

MEDICAL NECESSITY REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
	primarily utilizes	Care criteria along
	Amerigroup Medical	with Amerigroup
	Policies and	Medical Policies and
	Amerigroup Clinical	Amerigroup Clinical
	Utilization	Utilization
	Management	Management
	Guidelines for	Guidelines to review
	behavioral health	the medical
	services unless	necessity and
	superseded by state	appropriateness of
	requirements or	physical health
	regulatory guidance.	services, unless
	Amerigroup, TN	superseded by state
	follows established	requirements or
	procedures for	regulatory guidance.
	applying medical	
	necessity criteria	Amerigroup, TN
	based on individual	follows established
	member needs and	procedures for
	standards of care for	applying medical
	medical and	necessity criteria
	behavioral health	based on individual
	services. These	member needs and
	procedures apply to	standards of care for
	prior authorization,	medical and
	concurrent and	behavioral health
	retrospective	services. These
	reviews.	procedures apply to
		prior authorization,
		concurrent and
		retrospective
		reviews.
		161161131

MEDICAL		
NECESSITY		
REQUIREMENTS –		
OUTPATIENT		
SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and		
Stringency	Comparability:	
- 1 . 1	The processes, strategies, and evidentiary standards applied to MH/S	UD benefits are comparable to M/S benefits as applicable to medical
Explain how the	necessity.	
processes,		
strategies, and	Stringency:	
evidentiary	The processes, strategies, and evidentiary standards applied to M/S b	enefits are not more stringently applied to MH/SUD benefits.
standards applied to MH/SUD		
benefits are		
comparable and no		
more stringently		
applied to M/S		
benefits.		
Evaluation of	If medical necessity requirements are applied comparably between MH/SU	• • • • • • • • • • • • • • • • • • • •
Processes,	application of medical necessity is in parity. No additional information is r	eeded.
Strategies, and		
Evidentiary	If medical necessity requirements are not comparably applied between MI	· · · · · · · · · · · · · · · · · · ·
Standards	application of medical necessity is not in parity. Proceed to the following r	DW.
Modifications	N/A	
Explain how		
medical necessity		
processes for		
MH/SUD and/or		
M/S benefits will		
be modified to		
comply with parity.		

# NQTL Analysis Module 3: Medical Necessity – EMERGENCY SERVICES

MEDICAL NECESSITY REQUIREMENTS – EMERGENCY SERVICES  What criteria are applied to make medical necessity/ appropriateness determinations for emergency services?				M/S emergency services.		
	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.
Processes, Strategies, and Evidentiary Standards	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	Comparability: The processes, strategies, and evidentiary standards applied to MH emergency services.	The processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable to M/S benefits as applicable to				
Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied to M/S benefits.	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	N/A					
Explain how medical necessity processes for MH/SUD and/or M/S benefits will be modified 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 Hea	ılth/Substance Use Disor	der Services		Medical/Surgical Service	s
Does the plan apply "fail first" requirements or step therapy protocols? List the inpatient services to which these requirements apply.	Yes, but not obligatory.  • Electroconvulsive Therapy (ECT)			Yes.  Abdominal Hysterectomy Bariatric Surgery Hip Joint Replacement Laminectomy Orthopedic Joint Replacement Orthopedic Joint Arthroscopy Panniculectomy & Abdominoplasty Reduction Mammoplasty Spinal Surgery		
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?	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		alth/Substance Use Disor		Medical/Surgical Services		
	Prior authorization	Amerigroup applies	Amerigroup Clinical	Prior authorization	Amerigroup applies	
	request process for	fail first	UM Guideline CG-	request process for	fail first	Amerigroup
	ECT is the following:	methodology to	BEH-03.	specific planned	methodology to	maintains
		ensure the safest		M/S inpatient	ensure the safest	Amerigroup Medical
	1) Submitted by the	and most cost		services	and most cost	Policies and
	provider to AGP	effective therapy		incorporating fail	effective therapy	Amerigroup Clinical
	through an online	that will treat the		first criteria:	that will treat the	UM Guidelines to
	portal, fax or	member's condition			member's condition	address the above
	verbally.	is utilized first.		1) Submitted by the	is utilized first.	listed services. See
	2) AGP licensed	Progression to other		provider to AGP	Progression to other	attachment,
	clinician reviews	more risky and		through an online	more risky and	Amerigroup Medical
	submitted clinical	costly treatments is		portal, fax or	costly treatments is	Policies and
	to determine	used only if		verbally.	used only if	Amerigroup UM
	medical necessity	necessary.		2) AGP licensed	necessary	Clinical Guidelines,
	using Amerigroup			clinician reviews		for complete listing
	Medical Policy and			submitted clinical to		of specific
	Amerigroup Clinical			include fail first		Amerigroup Medical
	UM guidelines. The			criteria to		Policies and
	authorization is			determine medical		Amerigroup UM
	completed in			necessity using		Clinical Guidelines.
	accordance with			Amerigroup Medical		
	NCQA timeframes.			Policy and		
	3) If the reviewing			Amerigroup Clinical		
	clinician			UM guidelines. The		
	determines medical			authorization is		
	necessity is met,			completed in		
	requestor is			accordance with		
	notified and			NCQA timeframes.		
	provided a			3) If the reviewing		
	reference number.			clinician determined		
	4) If the reviewing			medical necessity is		
	clinician			met, requestor is		
	determines medical			notified and		
	necessity criteria is			provided a		
	NOT met, outreach			reference number.		
	is made to the			4) If the reviewing		

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

FAIL FIRST AND STEP THERAPY PROTOCOLS –	Montal Hoalth/Substance Use Disers	dar Sarvicas		Madical/Surgical Sarvica	
INPATIENT SERVICES	Mental Health/Substance Use Disorce 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)	der Services	After initial inpatient admission is approved, concurrent reviews will occur as applicable.	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	application of these requirements is in parity. No If fail first/step therapy requirements are not con	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
		ivieuical/ Surgical Services
Modifications	N/A	
Explain how fail first or step therapy requirements for MH/SUD and/or M/S benefits will be modified to comply with parity.		

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

FAIL FIRST AND STEP THERAPY PROTOCOLS –	Montallia	lkh /Cuhakawaa Haa Diagra	dan Camiliana		Madical/Conginal Compine	
OUTPATIENT SERVICES	Yes.	Ith/Substance Use Disor	uer services		Medical/Surgical Service	5
Does the plan apply "fail first" requirements or step therapy protocols? List the outpatient services to which these requirements apply.	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.  Prior authorization	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? Amerigroup applies	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. ECT: Amerigroup	Processes: Explain the process, both in writing and in practice, for fail first and/or step therapy protocols that your MCO uses.  Prior authorization	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? Amerigroup applies	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. Amerigroup
	request process for ECT is the following:  1) Submitted by the provider to AGP through an online portal, fax or	fail first methodology to ensure the safest and most cost effective therapy that will treat the member's condition	Clinical UM Guideline CG-BEH- 03.  TMS: Amerigroup Medical Policy BEH.00002	request process for specific M/S outpatient services incorporating fail first criteria:  1) Submitted by the	fail first methodology to ensure the safest and most cost effective therapy that will treat the member's condition	maintains Amerigroup Medical Policies and Amerigroup Clinical UM Guidelines to address the above

FAIL FIRST AND STEP THERAPY PROTOCOLS –						
OUTPATIENT SERVICES	Mental Hea	Ith/Substance Use Disor	der Services		Medical/Surgical Service	S
THERAPY PROTOCOLS –	Mental Heaverbally.  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 clinical information.  5) If the reviewing clinical information.	is utilized first.  Progression to other more risky and costly treatments is used only if necessary.	der Services	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	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 Healt	th/Substance Use Disor	der Services		Medical/Surgical Service	s
OUTPATIENT 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.	th/Substance Use Disort	der 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.	vedicai/Surgicai Service	

FAIL FIRST AND STEP THERAPY PROTOCOLS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services				
Comparability and Stringency	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.					
Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied to M/S benefits.	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	N/A					
Explain how fail first or step therapy requirements for MH/SUD and/or M/S benefits will be modified 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 Service	s
Does the plan apply "fail first" requirements or step therapy protocols? List the emergency services to which these requirements apply.	No.			No.	not required for emer	
	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.
Processes, Strategies, and Evidentiary Standards	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	Comparability: The processes, strategies, and evidentiary standards applied to MF fail first/step therapy.	I/SUD benefits are comparable to M/S benefits as applicable to the			
Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied to M/S benefits.	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	N/A				
Explain how fail first or step therapy requirements for MH/SUD and/or M/S benefits will be modified 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?	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 innetwork 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 innetwork 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		Ith/Substance Use Disor		Medical/Surgical Services		
What methods are used to determine usual, customary, and reasonable charges?	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: 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.
Processes, Strategies, and Evidentiary Standards	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 Hea	Ith/Substance Use Disord	der Services		Medical/Surgical Services	5
	complete. Provider	geographical or		complete. Provider	geographical or	
	must complete	clinical need. The		must complete	clinical need. The	
	package in its	purpose of the		package in its	purpose of the	
	entirety. Provider	Network Grid is to		entirety. Provider	Network Grid is to	
	must meet all	have a one source		must meet all	have a one source	
	credentialing	document that shows		credentialing	document that shows	
	requirements (i.e.	which specialties are		requirements (i.e.	which specialties are	
	licensures,	open/closed in every		licensures,	open/closed in every	
	accreditations,	county in TN. It's an		accreditations,	county in TN. It's an	
	certifications,	easy to read		certifications,	easy to read	
	attestations,	document that clearly		attestations,	document that clearly	
	Disclosures, liability	shows the Provider		Disclosures, liability	shows the Provider	
	coverage, sanctions,	Relations Team if the		coverage, sanctions,	Relations Team if the	
	etc.) in accordance to	network is OPEN and		etc.) in accordance to	network is OPEN and	
	NCQA and	if they should send an		NCQA and	if they should send an	
	state/TennCare	application/contract		state/TennCare	application/contract	
	requirements).	package. The Network		requirements).	package. The Network	
	Provider must sign a	Grid is based on		Provider must sign a	Grid is based on	
	contract agreeing to	Geographical		contract agreeing to	Geographical	
	comply with state,	market/network		comply with state,	market/network	
	federal and health	adequacy and clinical		federal and health	adequacy and clinical	
	plan regulations,	need.		plan regulations,	need.	
	policies/procedures			policies/procedures		
	and rates. If an			and rates. If an		
	inpatient provider			inpatient provider		
	successfully meets all			successfully meets all		
	requirements then			requirements then		
	they are allowed			they are allowed		
	admission in the			admission in the		
	network.			network.		

NETWORK STANDARDS  – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and Stringency	The application of standards are the same for Network Standards for Inpa	
Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied to M/S benefits.		
Evaluation of Processes, Strategies, and Evidentiary Standards	If network standards are applied comparably between MH/SUD and M/these standards is in parity. No additional information is needed.  If network standards are not comparably applied between MH/SUD and 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  Monthly the health plan reviews OPEN/CLOSED specialties (facility/non-facility) per county.	Medical/Surgical Services  Monthly the health plan reviews OPEN/CLOSED specialties (facility/non-facility) per county.
What are the plan's network admission requirements for outpatient providers?	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.	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	Mantal Haalth /Cubatanaa Haa Disandan Camirasa			Madical/Suggical Samisas		
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.			Medical/Surgical Services  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: 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.
Processes, Strategies, and Evidentiary Standards	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	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	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	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	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	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

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

NETWORK STANDARDS		
- OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and Stringency	The application of the Network Standards for Outpatient Services are the	e same.
Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied to M/S benefits.?		
Evaluation of Processes, Strategies, and Evidentiary Standards	these standards is in parity. No additional information is needed.	/S benefits and are not applied more stringently, then the application of d M/S benefits, or are applied more stringently, then the application of
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		/0				
- EMERGENCY SERVICES		Ith/Substance Use Disor		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.		
	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.
Processes, Strategies, and Evidentiary Standards	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 Hea	Ith/Substance Use Disord	der Services	Medical/Surgical Services		
	complete. Provider	geographical or		complete. Provider	geographical or	
	must complete	clinical need. The		must complete	clinical need. The	
	package in its	purpose of the		package in its	purpose of the	
	entirety. Provider	Network Grid is to		entirety. Provider	Network Grid is to	
	must meet all	have a one source		must meet all	have a one source	
	credentialing	document that shows		credentialing	document that shows	
	requirements (i.e.	which specialties are		requirements (i.e.	which specialties are	
	licensures,	open/closed in every		licensures,	open/closed in every	
	accreditations,	county in TN. It's an		accreditations,	county in TN. It's an	
	certifications,	easy to read		certifications,	easy to read	
	attestations,	document that clearly		attestations,	document that clearly	
	Disclosures, liability	shows the Provider		Disclosures, liability	shows the Provider	
	coverage, sanctions,	Relations Team if the		coverage, sanctions,	Relations Team if the	
	etc.) in accordance to	network is OPEN and		etc.) in accordance to	network is OPEN and	
	NCQA and	if they should send an		NCQA and	if they should send an	
	state/TennCare	application/contract		state/TennCare	application/contract	
	requirements).	package. The Network		requirements).	package. The Network	
	Provider must sign a	Grid is based on		Provider must sign a	Grid is based on	
	contract agreeing to	Geographical		contract agreeing to	Geographical	
	comply with state,	market/network		comply with state,	market/network	
	federal and health	adequacy and clinical		federal and health	adequacy and clinical	
	plan regulations,	need.		plan regulations,	need.	
	policies/procedures			policies/procedures		
	and rates. If an			and rates. If an		
	emergency provider			emergency provider		
	successfully meets all			successfully meets all		
	requirements then			requirements then		
	they are allowed			they are allowed		
	admission in the			admission in the		
	network.			network.		

NETWORK STANDARDS		
- EMERGENCY SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and Stringency	The application of Network Standards for Emergency Services are the sam	
Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied to M/S benefits.		
Evaluation of Processes, Strategies, and Evidentiary Standards	If network standards are applied comparably between MH/SUD and M/Sthese standards is in parity. No additional information is needed.  If network standards are not comparably applied between MH/SUD and 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	Manadala	lik (Calantana III a Diagram	dan Camidada		Marking Mountain Commission	
		Ilth/Substance Use Disor	der Services	Medical/Surgical Services Inpatient Medical (except maternity)		
	Inpatient Psychiatric Ca	re		inpatient Medicai (exce	pt maternity)	
	Inpatient Detoxification			Inpatient Surgical		
				inpatient Surgical		
List all inpatient benefits	Subacute Hospitalizatio	n		Transplant		
requiring prior	·					
authorization.	Inpatient - Residential T	reatment		NICU		
	Processes:	Strategies:	Evidentiary	Processes:	Strategies:	Evidentiary
	Explain the process,	WHY does your MCO	Standards:	Explain the process,	WHY does your MCO	Standards:
	both in writing and in	require prior	What evidence	both in writing and in	require prior	What evidence
	practice, for prior	authorization for	supports the use of	practice, for prior	authorization for	supports the use of
	authorization that	these services, and	prior authorization for	authorization that	these services, and	prior authorization for
	your MCO uses.	why do you use the	the listed benefits?	your MCO uses.	why do you use the	the listed benefits?
		process described?	Evidence may include		process described?	Evidence may include
		What is the rationale	practice guidelines		What is the rationale	practice guidelines
		and/or goal you are	and internal health		and/or goal you are	and internal health
		trying to achieve?	plan utilization data.		trying to achieve?	plan utilization data.
	Prior authorization is	Our prior	We use a	Prior authorization is	Our prior	We use a
Processes, Strategies,	a utilization	authorization process	comprehensive	a utilization	authorization process	comprehensive
and Evidentiary	management (UM)	is designed to place	monitoring and	management (UM)	is designed to place	monitoring and
Standards	process which is	members first by	oversight process to	process which is	members first by	oversight process to
Staridards	conducted, except in	ensuring timely and	identify the	conducted, except in	ensuring timely and	identify the
	emergency situations,	appropriate access to	inappropriate	emergency situations,	appropriate access to	inappropriate
	prior to a patient's	medically necessary	utilization and cost of	prior to a patient's	medically necessary	utilization and cost of
	admission, stay, or	covered services as	services to determine	admission, stay, or	covered services as	services to determine
	other service or	well as the	our prior	other service or	well as the	our prior
	course of treatment.	appropriateness of	authorization	course of treatment.	appropriateness of	authorization
	Prior authorization	the setting in the	requirements. We	Prior authorization	the setting in the	requirements. We
	approval must be	most effective	conduct monthly	approval must be	most effective	conduct monthly
	obtained for services	manner.	monitoring of health	obtained for services	manner.	monitoring of health
	to be covered under	The prior	care cost trends and	to be covered under	The prior	care cost trends and
	the member's plan.	authorization list is	the clinical policies	the member's plan.	authorization list is	the clinical policies
	The prior	under the oversight of	and payment	The prior	under the oversight of	and payment

PRIOR AUTHORIZATION REQUIREMENTS – INPATIENT SERVICES						
		Ith/Substance Use Disor	1		Medical/Surgical Services	
	authorization review	the Chief Medical	methods that	authorization review	the Chief Medical	methods that
	process is performed	Officer (CMO). The	contribute to these	process is performed	Officer (CMO). The	contribute to these
	telephonically, by	CMO, or a designee,	trends through	telephonically, by	CMO, or a designee,	trends through
	web authorization,	reviews the list, at a	collaborative	web authorization,	reviews the list, at a	collaborative
	fax, and/or mail. A	minimum annually, or	workgroups.	fax, and/or mail. A	minimum annually, or	workgroups.
	prior authorization	more frequently if	The collaborative	prior authorization	more frequently if	The collaborative
	review focuses on the	necessary. The review	groups include a wide	review focuses on the	necessary. The review	groups include a wide
	clinical assessment of	includes an analysis of	range of	clinical assessment of	includes an analysis of	range of
	the member's	the current services,	representatives,	the member's	the current services,	representatives,
	physical and	rate of approvals,	including Actuarial,	physical and	rate of approvals,	including Actuarial,
	behavioral health	denials, appeals and	Medical Informatics,	behavioral health	denials, appeals and	Medical Informatics,
	needs and the	overturns. Services	Utilization	needs and the	overturns. Services	Utilization
	practitioner's plan of	that have a denial	Management,	practitioner's plan of	that have a denial	Management,
	treatment including	rate of less than 2%	Network Strategy,	treatment including	rate of less than 2%	Network Strategy,
	the appropriateness	should be further	Finance, and	the appropriateness	should be further	Finance, and
	of care, procedure	evaluated to	Population Health	of care, procedure	evaluated to	Population Health
	and setting. The	determine if the	departments. Key	and setting. The	determine if the	departments. Key
	review is based on the	service should remain	agenda topics that	review is based on the	service should remain	agenda topics that
	prior authorization list	on the list.	affect our utilization	prior authorization list	on the list.	affect our utilization
	requirements,	The following criteria	management	requirements,	The following criteria	management
	thereby allowing the	are considerations for	program include	thereby allowing the	are considerations for	program include
	member and	services on the prior	analysis of disparities	member and	services on the prior	analysis of disparities
	practitioner an	authorization list:	between utilization	practitioner an	authorization list:	between utilization
	opportunity to review	<ul> <li>benefit</li> </ul>	and dollars paid;	opportunity to review	<ul> <li>benefit</li> </ul>	and dollars paid;
	alternative methods	management;	payment policy	alternative methods	management;	payment policy
	of treatment. The	o services that	changes, UM policy	of treatment. The	o services that	changes, UM policy
	reviews are	may not be	changes, and claims	reviews are	may not be	changes, and claims
	performed on an	appropriate after a	data analysis. Another	performed on an	appropriate after a	data analysis. Another
	individualized basis	number have been	key agenda item is	individualized basis	number have been	key agenda item is
	for each member.	done or to control out	presented by our	for each member.	done or to control out	presented by our
	Elements such as the	of network services;	Actuarial department	Elements such as the	of network services;	Actuarial department
	patient's age, co-	o benefits that	of a detailed cost and	patient's age, co-	o benefits that	of a detailed cost and
	morbidities,	potentially may not	utilization analysis	morbidities,	potentially may not	utilization analysis
	complications,	be covered e.g.	called the Surveillance	complications,	be covered (e.g.,	called the Surveillance
	progress with	investigational;	Report. The	progress with	cosmetic or	Report. The
	treatment,	<ul> <li>high cost</li> </ul>	Surveillance Report is	treatment,	investigational);	Surveillance Report is
	psychosocial	services that would	refreshed monthly to	psychosocial	<ul> <li>high cost</li> </ul>	refreshed monthly to
	situation, and the	require coordination;	reflect the most	situation, and the	services that would	reflect the most
	member's home	<ul> <li>prevention</li> </ul>	recent data and the	member's home	require coordination;	recent data and the

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

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

PRIOR AUTHORIZATION REQUIREMENTS -				
INPATIENT SERVICES	Mental Health/Substance Use	Disorder Services	Medica	I/Surgical Services
	case documentation		case documentation	
	to determine if		to determine if	
	coverage for the care		coverage for the care	
	is medically necessary		is medically necessary	
	for the diagnosis		for the diagnosis	
	and/or if care is being		and/or if care is being	
	performed in the		performed in the	
	appropriate setting.		appropriate setting.	
	If the request is		If the request is	
	received via		received via	
	telephone, the		telephone, the	
	approval is provided		approval is provided	
	verbally and by		verbally and by	
	written notification to		written notification to	
	the attending		the attending	
	physician or other		physician or other	
	ordering provider, the		ordering provider, the	
	facility rendering		facility rendering	
	service, and member.		service, and member.	
	If the request is		If the request is	
	received via fax or		received via fax or	
	web, written		web, written	
	notification is mailed		notification is mailed	
	to the attending		to the attending	
	physician or other		physician or other	
	ordering provider, the		ordering provider, the	
	facility rendering		facility rendering	
	service, and member.		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.	and M/S inpatient benefits. Policies and Procedures for inpatient prior aut strategies and evidentiary standards are the same for MH/SUD and M/S. T processes, strategies and evidentiary standards applied to MH/SUD benefi	he lists of inpatient services requiring prior authorization vary between MH/SUD and M/S; prior authorization is required for both MH/SUD (S inpatient benefits. Policies and Procedures for inpatient prior authorization are the same for both MH/SUD and M/S benefits. Processes, ies and evidentiary standards are the same for MH/SUD and M/S. Therefore, it has been determined that inpatient prior authorization ses, strategies and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied than inpatient prior zation 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 application of prior authorization is in parity. No additional information  If prior authorization requirements are not comparably applied between application of prior authorization is not in parity. Proceed to the following	is needed.  MH/SUD and M/S benefits, or are applied more stringently, then the					
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

PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES						
		Ith/Substance Use Disor			Medical/Surgical Service	S
	Outpatient Therapy (Ou	t of Network Providers O	nly)	All out of network Outp	patient services	
	Transcranial Magnetic S	timulation		Outpatient Therapies o speech)	ver 21 years of age (Physi	ical, occupational, and
	Partial Hospitalization P	rogram				
	Intensive Outpatient Program			Selected elective Outpa - Arthroscopy - Endoscopy	itient Procedures	
	BH Psych Testing			• •	Cholecystectomy tion Studies	
	BH Psych Consult			- Epidural Stero		
List all outpatient benefits requiring prior authorization.	BH ECT Outpatient		- All services per limited to: - Abdominopl - Blepharoplas - Breast Reduc	rformed by plastic special asty ty tion ve repair of excavatum ander 19 years of age	list, including but not	
	Processes:	Strategies:	Evidentiary	Processes:	Strategies:	Evidentiary
Processes, Strategies, and Evidentiary Standards	Explain the process, both in writing and in practice, for prior authorization that your MCO uses.	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?	Standards: What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	Explain the process, both in writing and in practice, for prior authorization that your MCO uses.	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?	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						
REQUIREMENTS –						
OUTPATIENT SERVICES						
		Ith/Substance Use Disor			Medical/Surgical Services	
	Prior authorization is	Our prior	We use a	Prior authorization is	Our prior	We use a
	a utilization	authorization process	comprehensive	a utilization	authorization process	comprehensive
	management (UM)	is designed to place	monitoring and	management (UM)	is designed to place	monitoring and
	process which is	members first by	oversight process to	process which is	members first by	oversight process to
	conducted, except in	ensuring timely and	identify the	conducted, except in	ensuring timely and	identify the
	emergency situations,	appropriate access to	inappropriate	emergency situations,	appropriate access to	inappropriate
	prior to a patient's	medically necessary	utilization and cost of	prior to a patient's	medically necessary	utilization and cost of
	admission, stay, or	covered services as	services to determine	admission, stay, or	covered services as	services to determine
	other service or	well as the	our prior	other service or	well as the	our prior
	course of treatment.	appropriateness of	authorization	course of treatment.	appropriateness of	authorization
	Prior authorization	the setting in the	requirements. We	Prior authorization	the setting in the	requirements. We
	approval must be	most effective	conduct monthly	approval must be	most effective	conduct monthly
	obtained for services	manner.	monitoring of health	obtained for services	manner.	monitoring of health
	to be covered under	The prior	care cost trends and	to be covered under	The prior	care cost trends and
	the member's plan.	authorization list is	the clinical policies	the member's plan.	authorization list is	the clinical policies
	The prior	under the oversight of	and payment	The prior	under the oversight of	and payment
	authorization review	the Chief Medical	methods that	authorization review	the Chief Medical	methods that
	process is performed	Officer (CMO). The	contribute to these	process is performed	Officer (CMO). The	contribute to these
	telephonically, by	CMO, or a designee,	trends through	telephonically, by	CMO, or a designee,	trends through
	web authorization,	reviews the list, at a	collaborative	web authorization,	reviews the list, at a	collaborative
	fax, and/or mail. A	minimum annually, or	workgroups.	fax, and/or mail. A	minimum annually, or	workgroups.
	prior authorization	more frequently if	The collaborative	prior authorization	more frequently if	The collaborative
	review focuses on the	necessary. The review	groups include a wide	review focuses on the	necessary. The review	groups include a wide
	clinical assessment of	includes an analysis of	range of	clinical assessment of	includes an analysis of	range of
	the member's	the current services,	representatives,	the member's	the current services,	representatives,
	physical and	rate of approvals,	including Actuarial,	physical and	rate of approvals,	including Actuarial,
	behavioral health	denials, appeals and	Medical Informatics,	behavioral health	denials, appeals and	Medical Informatics,
	needs and the	overturns. Services	Utilization	needs and the	overturns. Services	Utilization
	practitioner's plan of	that have a denial	Management,	practitioner's plan of	that have a denial	Management,
	treatment including	rate of less than 2%	Network Strategy,	treatment including	rate of less than 2%	Network Strategy,
	the appropriateness	should be further	Finance, and	the appropriateness	should be further	Finance, and
	of care, procedure	evaluated to	Population Health	of care, procedure	evaluated to	Population Health
	and setting. The	determine if the	departments. Key	and setting. The	determine if the	departments. Key
	review is based on the	service should remain	agenda topics that	review is based on the	service should remain	agenda topics that
	prior authorization list	on the list.	affect our utilization	prior authorization list	on the list.	affect our utilization
	requirements,	The following criteria	management	requirements,	The following criteria	management
	thereby allowing the	are considerations for	program include	thereby allowing the	are considerations for	program include
	member and	services on the prior	analysis of disparities	member and	services on the prior	analysis of disparities
	practitioner an	authorization list:	between utilization	practitioner an	authorization list:	between utilization

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

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

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

PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use D	isorder Services		Medical/Surgical Service	s	
	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 appl application of prior authorization is in parity If prior authorization requirements are not application of prior authorization is not in p	<ul> <li>No additional information</li> <li>comparably applied betwee</li> </ul>	n is needed. n MH/SUD and M/S bene			

PRIOR AUTHORIZATION REQUIREMENTS -		
OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
	N/A – No modifications required to comply with parity.	-
Modifications		
Explain how prior authorization processes for MH/SUD and/or M/S benefits will be modified 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.		
Processes, Strategies, and Evidentiary Standards	Processes: Explain the process, both in writing and in practice, for prior authorization that your MCO uses.  N/A	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? N/A	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	Processes: Explain the process, both in writing and in practice, for prior authorization that your MCO uses.  N/A	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? N/A	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

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

# NQTL Analysis Module 2: Concurrent Review – INPATIENT SERVICES

CONCURRENT REVIEW REQUIREMENTS – INPATIENT SERVICES							
		Ith/Substance Use Disor	der Services		Medical/Surgical Service		
	Inpatient Psychiatric Care			Inpatient facilities with	Per Diem contract rates (	except maternity)	
	Inpatient Detoxification			(DRG contracted rates of	(DRG contracted rates do not require concurrent review)		
List all inpatient benefits	Subacute Hospitalizatio	n					
requiring concurrent review.	Inpatient - Residential Treatment						
	Processes:	Strategies:	Evidentiary	Processes:	Strategies:	Evidentiary	
	Explain the process,	WHY does your MCO	Standards:	Explain the process,	WHY does your MCO	Standards:	
	both in writing and in	require concurrent	What evidence	both in writing and in	require concurrent	What evidence	
Processes, Strategies,	practice, for	review for these	supports the use of	practice, for	review for these	supports the use of	
and Evidentiary	concurrent review	services, and why do	concurrent review for	concurrent review	services, and why do	concurrent review for	
Standards	that your MCO uses.	you use the process	the listed benefits?	that your MCO uses.	you use the process	the listed benefits?	
Standards		described? What is	Evidence may include		described? What is	Evidence may include	
		the rationale and/or	practice guidelines		the rationale and/or	practice guidelines	
		goal you are trying to	and internal health		goal you are trying to	and internal health	
		achieve?	plan utilization data.		achieve?	plan utilization data.	

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

CONCURRENT REVIEW						
REQUIREMENTS –						
INPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
	appropriateness and	Refer	changes, UM policy	appropriateness and	Refer	changes, UM policy
	medical necessity.	potentially complex	changes, and claims	medical necessity.	potentially complex	changes, and claims
	Concurrent reviews	or long term cases to	data analysis. Another	Concurrent reviews	or long term cases to	data analysis. Another
	validate the necessity	medical and	key agenda item is	validate the necessity	medical and	key agenda item is
	for continued	behavioral care	presented by our	for continued	behavioral care	presented by our
	stay/services and	management	Actuarial department	stay/services and	management	Actuarial department
	monitors quality of	programs	of a detailed cost and	monitors quality of	programs	of a detailed cost and
	care.	Identify and	utilization analysis	care.	Identify and	utilization analysis
	All reviews are	refer potential quality	called the Surveillance	All reviews are	refer potential quality	called the Surveillance
	screened on initial	of care issues to	Report. The	screened on initial	of care issues to	Report. The
	review for discharge	Clinical Risk	Surveillance Report is	review for discharge	Clinical Risk	Surveillance Report is
	planning needs and	Management	refreshed monthly to	planning needs and	Management	refreshed monthly to
	ongoing management		reflect the most	ongoing management		reflect the most
	intervention.		recent data and the	intervention.		recent data and the
	Proactive discharge		latest rolling 12-	Proactive discharge		latest rolling 12-
	planning on initial		month trends related	planning on initial		month trends related
	review assists the		to 25 cost categories.	review assists the		to 25 cost categories.
	hospital and the		Included in the data	hospital and the		Included in the data
	member with the		are unit cost,	member with the		are unit cost,
	provision of		utilization, and total	provision of		utilization, and total
	appropriate inpatient		per member per	appropriate inpatient		per member per
	hospital services and		month (PMPM)	hospital services and		month (PMPM)
	a smooth transition to		trends. Unit cost and	a smooth transition to		trends. Unit cost and
	the next level of care		utilization trends are	the next level of care		utilization trends are
	needed.		reviewed by cost	needed.		reviewed by cost
	For concurrent		category and overall	For concurrent		category and overall
	reviews, the		to identify where	reviews, the		to identify where
	frequency of reviews		further analysis is	frequency of reviews		further analysis is
	for the extension of		required. The Medical	for the extension of		required. The Medical
	initial determinations		Informatics	initial determinations		Informatics
	is based on the		department conducts	is based on the		department conducts
	severity or complexity		detailed analysis over	severity or complexity		detailed analysis over
	of the member's		the selected time	of the member's		the selected time
	condition or on		period using DRG,	condition or on		period using DRG,
	necessary treatment		Revenue Code, or	necessary treatment		Revenue Code, or
	and discharge		CPT-level analytics	and discharge		CPT-level analytics
	planning activity (i.e.,		down to the provider	planning activity (i.e.,		down to the provider

CONCURRENT REVIEW REQUIREMENTS – INPATIENT SERVICES	Mental Hea	Ith/Substance Use Disorc	der Services		Medical/Surgical Services	
	not routinely	inity substance use Disort	level.	not routinely		level.
	conducted on a daily		In addition, this	conducted on a daily		In addition, this
	basis).		information is	basis).		information is
	During the review		reviewed monthly by	During the review		reviewed monthly by
	process, as needed,		the business owners	process, as needed,		the business owners
	the clinical reviewer		and presented to the	the clinical reviewer		and presented to the
	has access to		medical directors and	has access to		medical directors and
	consultation with a		utilization managers	consultation with a		utilization managers
	licensed doctor of		for discussion and	licensed doctor of		for discussion and
	medicine or		evaluation, as	medicine or		evaluation, as
	osteopathic medicine.		necessary, to	osteopathic medicine.		necessary, to
	Clinical reviewers and		recommend	Clinical reviewers and		recommend
	licensed mental		appropriate action	licensed mental		appropriate action
	health clinicians do		and follow-up. This	health clinicians do		and follow-up. This
	not deny cases for		team discusses both	not deny cases for		team discusses both
	medical necessity;		over- and under-	medical necessity;		over- and under-
	physicians render all		utilization	physicians render all		utilization
	medical necessity		occurrences and	medical necessity		occurrences and
	denials. Any decision		develops plans to	denials. Any decision		develops plans to
	to deny a service		address them as	to deny a service		address them as
	authorization request		needed.	authorization request		needed.
	or to authorize a		Members identified	or to authorize a		Members identified
	service in an amount,		as inappropriately	service in an amount,		as inappropriately
	duration, or scope		using services are	duration, or scope		using services are
	that is less than		referred to the	that is less than		referred to the
	requested and cannot		appropriate Care	requested and cannot		appropriate Care
	be approved by the		Coordination Program	be approved by the		Coordination Program
	nurse reviewer are		for management.	nurse reviewer are		for management.
	referred to internal			referred to internal		
	physicians who have			physicians who have		
	received orientation			received orientation		
	and extensive training			and extensive training		
	in the principles and			in the principles and		
	procedures of UM			procedures of UM		
	and hold a current,			and hold a current,		
	active non-restricted			active non-restricted		
	license of Doctor of			license of Doctor of		

CONCURRENT REVIEW REQUIREMENTS – INPATIENT SERVICES	Montal Hoolth /Substance Use Disc	rdor Somicos	Moo	dical/Surgical Services	
	Mental Health/Substance Use Diso Medicine or Doctor of	Tuer Services	Medicine or Doctor of	uicai/Surgicai Services	
	Osteopathic Medicine		Osteopathic Medicine		
	in the State of		in the State of		
	Tennessee.		Tennessee.		
	Board certified		Board certified		
	physicians,		physicians,		
	psychiatrists and		psychiatrists and		
	psychologists are		psychologists are		
	available as needed to		available as needed to		
	assist with medical		assist with medical		
	necessity		necessity		
	determinations. The		determinations. The		
	physician reviewer		physician reviewer		
	evaluates all referred		evaluates all referred		
	case documentation		case documentation		
	to determine if		to determine if		
	coverage for the care		coverage for the care		
	is medically necessary		is medically necessary		
	for the diagnosis		for the diagnosis		
	and/or if care is being		and/or if care is being		
	performed in the		performed in the		
	appropriate setting.		appropriate setting.		
	If the request is		If the request is		
	received via		received via		
	telephone, the		telephone, the		
	approval is provided		approval is provided		
	verbally and by		verbally and by		
	written notification to		written notification to		
	the attending		the attending		
	physician or other		physician or other		
	ordering provider, the		ordering provider, the		
	facility rendering		facility rendering		
	service, and member.  If the request is		service, and member.  If the request is		
	received via fax or		received via fax or		
	web, written		web, written		
	notification is mailed		notification is mailed		

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

# NQTL Analysis Module 2: Concurrent Review – OUTPATIENT SERVICES

CONCURRENT REVIEW REQUIREMENTS – OUTPATIENT SERVICES						
	Mental Health/Substance Use Disorder Services				Medical/Surgical Service	S
	Outpatient Therapy (Ou	t of Network Providers O	nly)	Ongoing Out of Networ	k Outpatient services	
	Transcranial Magnetic Stimulation			Ongoing Outpatient The occupational, and spee	erapies over 21 years of a	ge (Physical,
	Partial Hospitalization P	rogram			•	
List all outpatient benefits requiring	Intensive Outpatient Program			Ongoing Chiropractic se	ervices under 19 years of	age
concurrent review.				Ongoing hyperbaric oxygen therapy		
	BH Psych Testing					
	BH Psych Consult					
	BH ECT Outpatient					
	Processes:	Strategies:	Evidentiary	Processes:	Strategies:	Evidentiary
	Explain the process,	WHY does your MCO	Standards:	Explain the process,	WHY does your MCO	Standards:
	both in writing and in	require concurrent	What evidence	both in writing and in	require concurrent	What evidence
Processes, Strategies,	practice, for	review for these	supports the use of	practice, for	review for these	supports the use of
and Evidentiary	concurrent review	services, and why do	concurrent review for	concurrent review	services, and why do	concurrent review for
Standards	that your MCO uses.	you use the process	the listed benefits?	that your MCO uses.	you use the process	the listed benefits?
Standards		described? What is	Evidence may include		described? What is	Evidence may include
		the rationale and/or	practice guidelines		the rationale and/or	practice guidelines
		goal you are trying to	and internal health		goal you are trying to	and internal health
		achieve?	plan utilization data.		achieve?	plan utilization data.

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

CONCURRENT REVIEW REQUIREMENTS –						
OUTPATIENT SERVICES	Mental Hea	alth/Substance Use Disor	der Services		Medical/Surgical Services	s
	appropriateness and	Refer	changes, UM policy	appropriateness and	• Refer	changes, UM policy
	medical necessity.	potentially complex	changes, and claims	medical necessity.	potentially complex	changes, and claims
	Concurrent reviews	or long term cases to	data analysis. Another	Concurrent reviews	or long term cases to	data analysis. Another
	validate the necessity	medical and	key agenda item is	validate the necessity	medical and	key agenda item is
	for continued	behavioral care	presented by our	for continued	behavioral care	presented by our
	stay/services and	management	Actuarial department	stay/services and	management	Actuarial department
	monitors quality of	programs	of a detailed cost and	monitors quality of	programs	of a detailed cost and
	care.	<ul> <li>Identify and</li> </ul>	utilization analysis	care.	<ul> <li>Identify and</li> </ul>	utilization analysis
	All reviews are	refer potential quality	called the Surveillance	All reviews are	refer potential quality	called the Surveillance
	screened on initial	of care issues to	Report. The	screened on initial	of care issues to	Report. The
	review for discharge	Clinical Risk	Surveillance Report is	review for discharge	Clinical Risk	Surveillance Report is
	planning needs and	Management	refreshed monthly to	planning needs and	Management	refreshed monthly to
	ongoing management		reflect the most	ongoing management		reflect the most
	intervention.		recent data and the	intervention.		recent data and the
	Proactive discharge		latest rolling 12-	Proactive discharge		latest rolling 12-
	planning on initial		month trends related	planning on initial		month trends related
	review assists the		to 25 cost categories.	review assists the		to 25 cost categories.
	hospital and the		Included in the data	hospital and the		Included in the data
	member with the		are unit cost,	member with the		are unit cost,
	provision of		utilization, and total	provision of		utilization, and total
	appropriate inpatient		per member per	appropriate inpatient		per member per
	hospital services and		month (PMPM)	hospital services and		month (PMPM)
	a smooth transition to		trends. Unit cost and	a smooth transition to		trends. Unit cost and
	the next level of care		utilization trends are	the next level of care		utilization trends are
	needed.		reviewed by cost	needed.		reviewed by cost
	For concurrent		category and overall	For concurrent		category and overall
	reviews, the		to identify where	reviews, the		to identify where
	frequency of reviews		further analysis is	frequency of reviews		further analysis is
	for the extension of		required. The Medical	for the extension of		required. The Medical
	initial determinations		Informatics	initial determinations		Informatics
	is based on the		department conducts	is based on the		department conducts
	severity or complexity		detailed analysis over	severity or complexity		detailed analysis over
	of the member's		the selected time	of the member's		the selected time
	condition or on		period using DRG,	condition or on		period using DRG,
	necessary treatment		Revenue Code, or	necessary treatment		Revenue Code, or
	and discharge		CPT-level analytics	and discharge		CPT-level analytics
	planning activity (i.e.,		down to the provider	planning activity (i.e.,		down to the provider

CONCURRENT REVIEW REQUIREMENTS – OUTPATIENT SERVICES	Mental Hea	Ith/Substance Use Disorc	der Services		Medical/Surgical Services	
	not routinely	,	level.	not routinely	, , , , , , , , , , , , , , , , , , , ,	level.
	conducted on a daily		In addition, this	conducted on a daily		In addition, this
	basis).		information is	basis).		information is
	During the review		reviewed monthly by	During the review		reviewed monthly by
	process, as needed,		the business owners	process, as needed,		the business owners
	the clinical reviewer		and presented to the	the clinical reviewer		and presented to the
	has access to		medical directors and	has access to		medical directors and
	consultation with a		utilization managers	consultation with a		utilization managers
	licensed doctor of		for discussion and	licensed doctor of		for discussion and
	medicine or		evaluation, as	medicine or		evaluation, as
	osteopathic medicine.		necessary, to	osteopathic medicine.		necessary, to
	Clinical reviewers and		recommend	Clinical reviewers and		recommend
	licensed mental		appropriate action	licensed mental		appropriate action
	health clinicians do		and follow-up. This	health clinicians do		and follow-up. This
	not deny cases for		team discusses both	not deny cases for		team discusses both
	medical necessity;		over- and under-	medical necessity;		over- and under-
	physicians render all		utilization	physicians render all		utilization
	medical necessity		occurrences and	medical necessity		occurrences and
	denials. Any decision		develops plans to	denials. Any decision		develops plans to
	to deny a service		address them as	to deny a service		address them as
	authorization request		needed.	authorization request		needed.
	or to authorize a		Members identified	or to authorize a		Members identified
	service in an amount,		as inappropriately	service in an amount,		as inappropriately
	duration, or scope		using services are	duration, or scope		using services are
	that is less than		referred to the	that is less than		referred to the
	requested and cannot		appropriate Care	requested and cannot		appropriate Care
	be approved by the		<b>Coordination Program</b>	be approved by the		<b>Coordination Program</b>
	nurse reviewer are		for management.	nurse reviewer are		for management.
	referred to internal			referred to internal		
	physicians who have			physicians who have		
	received orientation			received orientation		
	and extensive training			and extensive training		
	in the principles and			in the principles and		
	procedures of UM			procedures of UM		
	and hold a current,			and hold a current,		
	active non-restricted			active non-restricted		
	license of Doctor of			license of Doctor of		

CONCURRENT REVIEW REQUIREMENTS – OUTPATIENT SERVICES	Montal Hoalth/Substance Use Disease	lor Somicos	Modi	cal/Surgical Services	
	Mental Health/Substance Use Disord Medicine or Doctor of	ier services	Medicine or Doctor of	cal/ Surgical Services	
	Osteopathic Medicine		Osteopathic Medicine		
	in the State of		in the State of		
	Tennessee.		Tennessee.		
	Board certified		Board certified		
	physicians,		physicians,		
	psychiatrists and		psychiatrists and		
	psychologists are		psychologists are		
	available as needed to		available as needed to		
	assist with medical		assist with medical		
	necessity		necessity		
	determinations. The		determinations. The		
	physician reviewer		physician reviewer		
	evaluates all referred		evaluates all referred		
	case documentation		case documentation		
	to determine if		to determine if		
	coverage for the care		coverage for the care		
	is medically necessary		is medically necessary		
	for the diagnosis		for the diagnosis		
	and/or if care is being		and/or if care is being		
	performed in the		performed in the		
	appropriate setting.		appropriate setting.		
	If the request is		If the request is		
	received via		received via		
	telephone, the		telephone, the		
	approval is provided		approval is provided		
	verbally and by		verbally and by		
	written notification to		written notification to		
	the attending		the attending		
	physician or other		physician or other		
	ordering provider, the		ordering provider, the		
	facility rendering		facility rendering		
	service, and member.		service, and member.		
	If the request is		If the request is		
	received via fax or		received via fax or		
	web, written		web, written		
	notification is mailed		notification is mailed		

CONCURRENT REVIEW REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Dis	sorder Services		Medical/Surgical Service	3	
	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	application of concurrent review is in parity.  If concurrent review requirements are not co	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	N/A – No modifications required to comply with parity.	
Explain how concurrent review processes for MH/SUD and/or M/S benefits will be modified to comply with parity.		

# NQTL Analysis Module 2: Concurrent Review – EMERGENCY SERVICES

CONCURRENT REVIEW REQUIREMENTS – EMERGENCY SERVICES	Mental Hea	olth/Substance Use Disor	der Services		Medical/Surgical Service	s
List all emergency benefits requiring concurrent review.				N/A No Concurrent Review of Emergency Services		
	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.
Processes, Strategies, and Evidentiary Standards	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	Emergency service concurrent review processes, strategies and evidentiar stringently applied than emergency service concurrent review processes,	
Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied to M/S benefits.		
Evaluation of Processes, Strategies, and Evidentiary Standards	If concurrent review requirements are applied comparably between MH application of concurrent review is in parity. No additional information  If concurrent review requirements are not comparably applied between application of concurrent review is not in parity. Proceed to the following	MH/SUD and M/S benefits, or are applied more stringently, then the
Modifications	N/A – No modifications required to comply with parity.	
Explain how concurrent review processes for MH/SUD and/or M/S benefits will be modified to comply with parity.		

# NQTL Analysis Module 3: Medical Necessity – INPATIENT SERVICES

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

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

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

MEDICAL NECESSITY				
REQUIREMENTS –				
INPATIENT SERVICES	-	tance Use Disorder Services	1	lical/Surgical Services
	item or service is	College of Cardiology)	item or service is	College of Cardiology)
	medically necessary.	Medical	medically necessary.	Medical
	The UM program uses	technology	The UM program uses	technology
	the CRA inclusive of	assessment center	the CRA inclusive of	assessment center
	exclusion lists and non-	evaluations (e.g.,	exclusion lists and non-	evaluations (e.g.,
	covered lists, BCBST	Hayes, ECRI, AHRQ)	covered lists, BCBST	Hayes, ECRI, AHRQ)
	Medical Policy, and MCG	Federal and	Medical Policy, and MCG	Federal and
	as significant resources	state mandates	as significant resources	state mandates
	for review of medical	Nationally	for review of medical	<ul> <li>Nationally</li> </ul>
	and behavioral health	recognized	and behavioral health	recognized
	determinations. UM	pharmaceutical	determinations. UM	pharmaceutical
	clinical decision tools are	compendia	clinical decision tools are	compendia
	applied based on the	U.S. Food and	applied based on the	U.S. Food and
	member's individual	Drug Administration	member's individual	Drug Administration
	needs.	(FDA)	needs.	(FDA)
		Once a new or revised		Once a new or revised
		BCBST medical policy		BCBST medical policy
		or guideline document		or guideline document
		is written, it is posted		is written, it is posted
		on BCBST's Draft		on BCBST's Draft
		Medical Policies site		Medical Policies site
		for 30 days for		for 30 days for
		provider review and		provider review and
		comments. After that		comments. After that
		30 day period the new		30 day period the new
		or revised policy or		or revised policy or
		guideline is presented		guideline is presented
		to BCBST Medical		to BCBST Medical
		Technology		Technology
		Assessment		Assessment
		Committee (MTAC) for		Committee (MTAC) for
		review and approval.		review and approval.
		All MTAC voting		All MTAC voting
		members are MDs and		members are MDs and
		when mental health		when mental health
		topics are presented		topics are presented
		at MTAC there is a		at MTAC there is a
		behavioral health MD		behavioral health MD
		who takes part in the		who takes part in the

MEDICAL NECESSITY REQUIREMENTS –						
INPATIENT SERVICES	Mental Health	n/Substance Use Disord	er Services	Medical/Surgical Services		3
			review and approval			review and approval
			process. All revised			process. All revised
			pharmacy policies			pharmacy policies
			(there are no BCBST			(there are no BCBST
			pharmacy guidelines)			pharmacy guidelines)
			are presented to			are presented to
			BCBST's Medical			BCBST's Medical
			Technology			Technology
			Assessment			Assessment
			Committee and			Committee and
			BCBST's Pharmacy &			BCBST's Pharmacy &
			Therapeutics			Therapeutics
			Subcommittee for			Subcommittee for
			review and approval.			review and approval.
			New pharmacy			New pharmacy
			policies are approved			policies are approved
			via an Executive			via an Executive
			Decision process in			Decision process in
			order for the medical			order for the medical
			policy document to be			policy document to be
			approved and			approved and
			available for use more			available for use more
			quickly.			quickly.
Comparability and	-			 //guideline source document zed to administer the medica		
Stringency			•		· · · · · · · · · · · · · · · · · · ·	
- 1.1.1				t the inpatient medical nece nore stringently applied thar		. •
Explain how the	processes, strategies and e	•	•	nore stringently applied that	i inpatient medical nece	essity requirement
processes, strategies,	processes, strategies and e	viuentiary stanuarus dp	plied to ivi/3 beliefits.			
and evidentiary						
standards applied to						
MH/SUD benefits are						
comparable and no						
more stringently						
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	N/A – No modifications required to comply with parity.						
Explain how medical necessity processes for MH/SUD and/or M/S benefits will be modified to comply with parity.							

# NQTL Analysis Module 3: Medical Necessity – OUTPATIENT SERVICES

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

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

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

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

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

MEDICAL NECESSITY REQUIREMENTS – OUTPATIENT		
SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Comparability and Stringency	The medical necessity criteria contained within four different types of policy outpatient services. The processes, strategies, and evidentiary standards uti both MH/SUD and M/S outpatient benefits. Therefore, it has been determined to the contained by the conta	lized to administer the medical necessity requirement are the same for ned that the outpatient medical necessity requirement processes, strategies
Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are	processes, strategies and evidentiary standards applied to M/S benefits.	no more stringently applied than outpatient medical necessity requirement
comparable and no more stringently applied to M/S benefits.		
Evaluation of Processes, Strategies,	If medical necessity requirements are applied comparably between MH/SI application of medical necessity is in parity. No additional information is r	• • • • • • • • • • • • • • • • • • • •
and Evidentiary Standards	If medical necessity requirements are not comparably applied between M application of medical necessity is not in parity. Proceed to the following r	
Modifications	N/A – No modifications required to comply with parity.	
Explain how medical necessity processes for MH/SUD and/or		
M/S benefits will be modified 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: 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.
Processes, Strategies, and Evidentiary Standards	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	Medical Necessity Requirements- Emergency Services processes, strategies and no more stringently applied than Medical Necessity Requirements- Er to M/S benefits.	s and evidentiary standards applied to MH/SUD benefits are comparable
Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied to M/S benefits.		
Evaluation of Processes, Strategies, and Evidentiary Standards	If medical necessity requirements are applied comparably between MH/application of medical necessity is in parity. No additional information is a lift medical necessity requirements are not comparably applied between application of medical necessity is not in parity. Proceed to the following	MH/SUD and M/S benefits, or are applied more stringently, then the
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 Hea	lth/Substance Use Disore	der Services		Medical/Surgical Service	s
	N/A – The plan does not have "fail first" or step therapy policies and procedures for inpatient services.			N/A – The plan does not have "fail first" or step therapy policies and procedures for inpatient services.		
Does the plan apply "fail first" requirements or step therapy protocols? List the inpatient services to which these requirements apply.	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.			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 Hea	lth/Substance Use Disor	der Services		Medical/Surgical Service	s
	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	the application of these If fail first/step therapy	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	N/A – No modifications required to comply with parity.	
Explain how fail first or step therapy requirements for MH/SUD and/or M/S benefits will be modified 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 Hea	llth/Substance Use Disor	der Services		Medical/Surgical Service	S
	N/A – The plan does not have "fail first" or step therapy policies and procedures for outpatient services.			N/A – The plan does not have "fail first" or step therapy policies and procedures for outpatient services.		
Does the plan apply "fail first" requirements or step therapy protocols? List the outpatient services to which these requirements apply.	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.		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 Hea	Ith/Substance Use Disor	der Services		Medical/Surgical Service	s
	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	the application of these If fail first/step therapy	f fail first/step therapy requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then he 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	N/A – No modifications required to comply with parity.	
Explain how fail first or step therapy requirements for MH/SUD and/or M/S benefits will be modified 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 Hea	llth/Substance Use Disor	der Services		Medical/Surgical Service	s
	N/A – The plan does not have "fail first" or step therapy policies and procedures for emergency services.			N/A – The plan does not have "fail first" or step therapy policies and procedures for emergency services.		
Does the plan apply "fail first" requirements or step therapy protocols? List the emergency services to which these requirements apply.	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.			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		
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 Hea	Ith/Substance Use Disor	der Services		Medical/Surgical Service	s
	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 medical necessity or medical/surgical service utilization management Department. The MCG Therefore, it is determine standards applied to MF	riteria utilized by BlueCro s are contained within fo guidelines (UMGs) and N Care Guidelines are purc ned that emergency servi H/SUD benefits are comp	J y policies and procedures oss BlueShield of Tennesse our different groups of doo MCG Care Guidelines. BCE hased for company use fro ces "fail first" requirement arable and no more string entiary standards applied	ee (BCBST) in determining cuments: Contractor Risk BST medical policies and U om MCG Health, Inc. MCG ats or step therapy protoc gently applied than emerg	Agreement, BCBST medic JMGS are developed by E G develops those guidelin cols processes, strategies	cal policies, BCBST BCBST's Medical Policy nes. and evidentiary
Evaluation of Processes, Strategies, and Evidentiary Standards	the application of these If fail first/step therapy	f 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.  f 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	N/A – No modifications required to comply with parity.	
requirements for MH/SUD and/or M/S benefits will be modified 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
	Mental Health/Substance Use Disorder Services  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 reapplication 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	Medical/Surgical Services  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 reapplication 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
inpatient providers?	<ul> <li>OPEN: The network is open and available to new providers seeking to join regardless of provider type and network need,</li> </ul>	seeking to join regardless of provider type and network need, so long as the provider meets the minimum network

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.	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	BCT Network
	The 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 multispecialty 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	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
	consideration and a decision on inclusion in the BCT network.	Any provider, who applies to join a BCT network that does not fall into
	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.	one of these categories, may be presented to BCT senior leadership for consideration and a decision on inclusion in the BCT network.
	Credentialing Requirements	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.
	In order to establish consistent standards for network participation, and to meet regulatory requirements,  BCBST/BlueCare Tennessee developed Network Participation	Credentialing Requirements
	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	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 Facility application information. Utilizing the CAQH application or Organizational Provider	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
app for r app and part Veri Prof inte inco serv Prof BCB	Mental Health/Substance Use Disorder Services  Dication, BCBST/BlueCare conducts a preliminary evaluation network participation. Practitioners must complete the Dication in its entirety, submit the required documentation, I complete the credentialing process prior to network ticipation.  Ifying credentials of Practitioners and other Health Care fessionals/Providers is an essential component of an egrated health care system. The Credentialing process proporates an ongoing assessment of the quality-of-care vices provided by those Practitioners and other Health Care fessionals/Providers who wish to participate in the BST/BlueCare Tennessee network. Major components of the dentialing 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
	The BCT provider network was developed and is monitored to meet the availability and accessibility standards of the Contractor Risk Agreement (CRA) and the TennCareSelect Agreement (TSA).	The BCT provider network was developed and is monitored to meet the availability and accessibility standards of the Contractor Risk Agreement (CRA) and the TennCareSelect Agreement (TSA).
Are there any geographic limitations on provider inclusion in	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.	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 network (e.g., requirements for accessing out-of-state providers)? If so, describe these limitations.	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.	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.	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.
	BlueCare Tennessee does not have out of network (OON) benefits except in the case of a medical emergency.	BlueCare Tennessee does not have out of network (OON) benefits except in the case of a medical emergency.
Describe the criteria	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:	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:
applied in determining standards for access to out-of-network providers.	<ul> <li>Is the request a covered service?</li> <li>Is it an emergency?</li> <li>Is the service medically necessary?</li> <li>Is there a participating provider available in the member's area?</li> </ul>	<ul> <li>Is the request a covered service?</li> <li>Is it an emergency?</li> <li>Is the service medically necessary?</li> <li>Is there a participating provider available in the member's area?</li> </ul>
	If OON service is approved, an authorization will be loaded and provider will be reimbursed for services at OON reimbursement rates.	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	If provider requests negotiated rates, once the authorization is

NETWORK STANDARDS - INPATIENT SERVICES	Mental Hea	Ith/Substance Use Disore	der Services	Medical/Surgical Services		
	rate negotiations once the rate is agreed upon by both parties, a single			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.			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?	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			<ul><li>Percentage of CMS</li><li>Underlying knowled</li><li>Provider research</li></ul>	dge of the market cost effective rates that s	
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  – INPATIENT SERVICES	Mental Hea	lth/Substance Use Disor	der Services		Medical/Surgical Service	
- INPATIENT 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 TennCareSelect 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	The BCT provider network was developed and is monitored to meet the availability and accessibility standards of the Contractor Risk Agreement (CRA) and the TennCareSelect 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
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.	guidelines. Network sta	ndards processes, strateg	•	ards applied to MH/SUD	cedures for network stan providers are comparable providers.	

NETWORK STANDARDS	Mantal Hadikh / Cuhatan as Has Disaudan Camilas	Madical/Courties Courties
- INPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Evaluation of Processes, Strategies, and	If network standards are applied comparably between MH/SUD and M/Sthese standards is in parity. No additional information is needed.	
Evidentiary Standards	If network standards are not comparably applied between MH/SUD and these standards is not in parity. Proceed to the following row.	M/S benefits, or are applied more stringently, then the application of
	N/A – No modifications required to comply with parity.	
Modifications		
Explain how network standards for MH/SUD and/or M/S benefits will be modified 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
	The Network Standards procedures encompass all provider types as	The Network Standards procedures encompass all provider types as
	Network Standards are not specific to any one provider type.	Network Standards are the not specific to any one provider type.
	Blue Cross and BlueShield of Tennessee, Inc. (BCBST) and BlueCare	Blue Cross and BlueShield of Tennessee, Inc. (BCBST) and BlueCare
	Tennessee (BCT) have established network participation criteria	Tennessee (BCT) have established network participation criteria
	detailing the terms and conditions for participation in the BCBST and	detailing the terms and conditions for participation in the BCBST and
	BCT networks. These terms and conditions will be consistently applied	BCT networks. These terms and conditions will be consistently applied
	to any provider who:	to any provider who:
	Is recruited by the Plan	Is recruited by the Plan
	Requests participation or re-applies for participation	Requests participation or re-applies for participation
	<ul> <li>Re-applies following voluntary or involuntary termination of provider's participation</li> </ul>	<ul> <li>Re-applies following voluntary or involuntary termination of provider's participation</li> </ul>
	Has a significant change in practice, which initiates a re-	Has a significant change in practice, which initiates a re-
	application and/or reconsideration of the provider's current	application and/or reconsideration of the provider's current
	participation status	participation status
	Definitions:	Definitions:
What are the plan's	Network status is defined for consistency and treatment of the network	Network status is defined for consistency and treatment of the network
network admission	and is administered by the Behavioral Health Provider Network	and is administered by Provider Network Management (PNM).
requirements for	Management Team (BHPNMT).	PNM has established network status classifications as follows:
outpatient providers?	BHPNMT has established network status classifications as follows:	OPEN: The network is open and available to new providers
	OPEN: The network is open and available to new providers	seeking to join regardless of provider type and network need,
	seeking to join regardless of provider type and network need,	so long as the provider meets the minimum network
	so long as the provider meets the minimum network	participation criteria, credentialing, and has not been otherwise
	participation criteria, credentialing, and has not been otherwise	recommended for exclusion from a network. For OPEN
	recommended for exclusion from a network. For OPEN	networks, contract requests are received and implemented
	networks, contract requests are received and implemented	without additional consideration.
	without additional consideration.	PARTIALLY CLOSED: The network is closed to certain new
	PARTIALLY CLOSED: The network is closed to certain new	providers seeking to join, including without limitation,
	providers seeking to join, including without limitation,	providers of a certain provider type or providers located in a
	providers of a certain provider type or providers located in a	defined location. For PARTIALLY CLOSED networks, contract
	defined location. For PARTIALLY CLOSED networks, contract	requests that are received are denied summarily, the provider
	requests that are received are denied summarily, the provider	is notified of the network status, and the provider is not sent
	is notified of the network status, and the provider is not sent	contracts for such network(s).
	contracts for such network(s).	CLOSED: The network is closed to new providers seeking to
	CLOSED: The network is closed to new providers seeking to	join. For CLOSED networks, contract requests that are received
	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.	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.	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 multispecialty 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	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
	credentialing process, which follows NCQA standards.	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
	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 TennCareSelect 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 Tanapasson 8 Contiguous Counties is required. BCT does	The BCT provider network was developed and is monitored to meet the availability and accessibility standards of the Contractor Risk Agreement (CRA) and the TennCareSelect 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.	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.

NETWORK STANDARDS  – OUTPATIENT						
SERVICES)	Mental Hea	Ith/Substance Use Disor	der Services		Medical/Surgical Service	es
	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:			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:		
Describe the criteria applied in determining standards for access to	<ul> <li>Is the request a covered service?</li> <li>Is it an emergency?</li> <li>Is the service medically necessary?</li> <li>Is there a participating provider available in the member's area?</li> </ul>			<ul> <li>Is the request a covered service?</li> <li>Is it an emergency?</li> <li>Is the service medically necessary?</li> <li>Is there a participating provider available in the member's area?</li> </ul>		
providers.	ut-of-network roviders.  If OON service is approved, an authorization will be loaded and provider will be reimbursed for services at OON reimbursement rates.			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 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.			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?	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			<ul><li>Percentage of CMS</li><li>Underlying knowle</li><li>Provider research</li></ul>	dge of the market cost effective rates that	
Processes, Strategies, and Evidentiary Standards	Processes: Explain the process, both in writing and in	Strategies: WHY does your MCO use these processes	Evidentiary Standards: What evidence	Processes: Explain the process, both in writing and in	Strategies: WHY does your MCO use these processes	Evidentiary Standards: What evidence

NETWORK STANDARDS							
- OUTPATIENT							
SERVICES)	Mental Hea	Ith/Substance Use Disor	der Services		Medical/Surgical Services		
	practice, for setting	and standards? What	supports the use of	practice, for setting	and standards? What	supports the use of	
	and implementing	is the rationale and/or	these processes and	and implementing	is the rationale and/or	these processes and	
	network admission	goal you are trying to	standards? Evidence	network admission	goal you are trying to	standards? Evidence	
	standards.	achieve?	may include practice	standards.	achieve?	may include practice	
			guidelines and			guidelines and	
			internal health plan			internal health plan	
			utilization data.			utilization data.	
	The BCT provider	To ensure network	BCT maintains an	The BCT provider	To ensure network	BCT maintains an	
	network was	sufficiency and an	adequate network of	network was	sufficiency and an	adequate network of	
	developed and is	appropriate mix of	providers and is	developed and is	appropriate mix of	providers and is	
	monitored to meet	providers to meet the	currently meeting all	monitored to meet	providers to meet the	currently meeting all	
	the availability and	member's needs.	access and availability	the availability and	member's needs.	access and availability	
	accessibility standards	These guidelines are	requirements as set	accessibility standards	These guidelines are	requirements as set	
	of the Contractor Risk	used to develop and	forth in the CRA. BCT	of the Contractor Risk	used to develop and	forth in the CRA. BCT	
	Agreement (CRA) and	maintain our provider	along with Provider	Agreement (CRA) and	maintain our provider	along with Provider	
	the TennCareSelect	network selection and	Resolutions monitors	the TennCareSelect	network selection and	Resolutions monitors	
	Agreement (TSA).	retention process	our network to	Agreement (TSA).	retention process	our network to	
	BHPNMT will ensure		ensure adherence to	PNM will ensure		ensure adherence to	
	proper selection and		all geographic access	proper selection and		all geographic access	
	retention of providers		standards by utilizing	retention of providers		standards by utilizing	
	by requiring all		industry standard	by requiring all		industry standard	
	applicable providers		network accessibility	applicable providers		network accessibility	
	to apply and pass a		analysis software,	to apply and pass a		analysis software,	
	rigorous credentialing		GeoAccess, along with	rigorous credentialing		GeoAccess, along with	
	process, which		other tools to monitor	process, which		other tools to monitor	
	follows NCQA		network adequacy	follows NCQA		network adequacy	
	standards.		and access for	standards.		and access for	
			physical and			physical and	
			behavioral health			behavioral health	
			services.			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 a guidelines. Network standards processes, strategies and evidentiary stands stringently applied than network standards processes, strategies and evidentially more open to providers than medical networks.	and M/S, policies and procedures for network standards follow the same ards applied to MH/SUD providers are comparable and no more
Evaluation of Processes, Strategies, and Evidentiary Standards	If network standards are applied comparably between MH/SUD and M/S these standards is in parity. No additional information is needed.  If network standards are not comparably applied between MH/SUD and 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 reapplication 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 such 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	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	Mantal Haalth /Cubatan as Haa Disaudan Camisas	Madical/Countries Countries
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.	Mental Health/Substance Use Disorder Services  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 TennCareSelect 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 Hea	llth/Substance Use Disor	der Services		Medical/Surgical Service	s
- EINIERGEINCY SERVICES	incital regiting distance oscillations and a second control of the			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.			<ul><li>Percentage of CMS</li><li>Underlying knowle</li><li>Provider research</li></ul>	dge of the market ecost effective rates that	-
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 Service	s
- EIVIERGENCY 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 TennCareSelect 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 Service policies and procedures		ostance Abuse Disorders a	are integrated in Emerger	ncy Medical Services, ther	re is only one set of

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 these standards is in parity. No additional information is needed.  If network standards are not comparably applied between MH/SUD and these standards is not in parity. Proceed to the following row.	
	N/A – No modifications required to comply with parity.	
Modifications		
Explain how network standards for MH/SUD and/or M/S benefits will be modified to comply with parity.		



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

PRIOR AUTHORIZATION REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services	s Medical/Surgical Services				
	Determina (NCDs) an Coverage Determina (LCDs). The Guidelines annually unreflect characteristics and provide the significant in service current reserved.	ations service. A specific clinical template based on nationally recognized practice guidelines must be completed.  updated to anges to the regulatory ents, t advances delivery, esearch, and portunities to				
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.	· · · · · · · · · · · · · · · · · · ·	s, it is determined that the prior authorization requirements are applied comparably rategies and standards. Therefore, there are no processes, strategies or standards hose 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	NA	, , , , , , , , , , , , , , , , , , , ,
Explain how prior authorization processes for MH/SUD and/or M/S benefits will be modified to comply with parity.		

# NQTL Analysis Module 1: Prior Authorization – OUTPATIENT SERVICES

PRIOR AUTHORIZATION REQUIREMENTS – OUTPATIENT SERVICES	Mental Hea	ılth/Substance Use Disor	der Services		Medical/Surgical Service	s
List all outpatient benefits requiring prior authorization.	Comprehensive Child and Family Treatment, Continuous Treatment,			Please see the attached document titled <i>UnitedHealthcare Community Plan Prior Authorization TN effective 7 -1-2017</i> for a complete list of Outpatient benefits requiring prior authorization.		
	Processes:	Strategies:	Evidentiary	Processes:	Strategies:	Evidentiary
	Explain the process, both in writing and in practice, for prior authorization that your MCO uses.	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?	Standards: What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.	Explain the process, both in writing and in practice, for prior authorization that your MCO uses.	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?	Standards: What evidence supports the use of prior authorization for the listed benefits? Evidence may include practice guidelines and internal health plan utilization data.
	The identified OP LOC's are subject to	To ensure that the service is in	The LOC Guidelines support this and were	The identified OP LOC's are subject to	The MCO applies a prior authorization	See attached policy HS UM 01 Medical
Processes, Strategies, and Evidentiary Standards	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	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.	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	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	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	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 –					
OUTPATIENT SERVICES	Mental Health/Substance Use Diso	rder 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 across all OP levels of care and utilize the same applied to MH/SUH benefits more stringently applied to	processes, strategies and	standards. Therefore, the		

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 MI- application of prior authorization is in parity. No additional information If prior authorization requirements are not comparably applied between application of prior authorization is not in parity. Proceed to the following	is needed.  MH/SUD and M/S benefits, or are applied more stringently, then the
	NA	
Modifications		
Explain how prior authorization processes for MH/SUD and/or M/S benefits will be modified		
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.				NA – Prior authorization	n is not required for emer	gency services.
	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.
Processes, Strategies, and Evidentiary Standards	NA	NA	NA	NA	NA	NA

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

# NQTL Analysis Module 2: Concurrent Review – INPATIENT SERVICES

CONCURRENT REVIEW REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disorder Services				Medical/Surgical Service	s
List all inpatient benefits requiring concurrent review.	Substance Abuse Residential, Mental Health Residential, Sex Offender Residential, Social Detox, Substance Abuse Rehab and Sub Acute Inpatient.			maternity	gical, Level 2 through Level of	·
Processes, Strategies, and Evidentiary Standards	Processes: Explain the process, both in writing and in practice, for concurrent review that your MCO uses.  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	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? 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	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. 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	Processes: Explain the process, both in writing and in practice, for concurrent review that your MCO uses.  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,	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? 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	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. 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
	utilization reviewer. Relevant clinical information is matched to a specific MNC guideline to determine if approval	Generally Accepted Standards of Medical Practice. • Clinically appropriate, in terms of type, frequency,	other clinical staff, members, and regulators. The evidence-base for the LOC Guidelines includes generally	health plan coverage guidelines and Milliman Care Guidelines (MCG) are all used to determine the medical necessity	health care provider required to identify and treat a member's illness or injury including all of the	all used to support the use of concurrent review for these services.

CONCURRENT REVIEW REQUIREMENTS –					
	tal Health/Substance Use Disor	rder Services	Medical/Surgical Services		
	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 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.	S
requiring a med necessity review follow the same	and				

CONCURRENT REVIEW REQUIREMENTS – INPATIENT SERVICES	Mental Health/Substance Use Disc		Medical/Surgical Service		
INPATIENT 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.	order services		wiedical/Surgical Service	
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 MH/SUD benefits are applied no more stringen		l levels of care. As evidenc	I ed above and in the refer	enced policies, the
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

CONCURRENT REVIEW REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		
List all outpatient benefits requiring concurrent review.	·			Private Duty Nursing So	ervices	
	Processes:	Strategies:	Evidentiary	Processes:	Strategies:	
	Explain the process,	WHY does your MCO	Standards: What evidence	Explain the process, both in writing and in	WHY does your MCO	Evidentiary Standards:
	both in writing and in practice, for	require concurrent review for these	supports the use of	practice, for	require concurrent review for these	What evidence supports the use of concurrent
	concurrent review	services, and why do	concurrent review for	concurrent review	services, and why do	review for the listed
	that your MCO uses.	you use the process	the listed benefits?	that your MCO uses.	you use the process	benefits? Evidence may
		described? What is	Evidence may include	lines year mos asser	described? What is	include practice guidelines
		the rationale and/or	practice guidelines		the rationale and/or	and internal health plan
		goal you are trying to	and internal health		goal you are trying to	utilization data.
		achieve?	plan utilization data.		achieve?	
	The identified OP	Medical Necessity is	The criteria to	Home Health Aide	The MCO is seeking	See attached document
	LOC's are subject to	defined as Services	determine medical	Services are	to ensure the	Private_Duty_Nursing_UM
Processes, Strategies,	medical necessity	provided for the	necessity are	reviewed with the	member is still in	SOP
and Evidentiary	review when an	purpose of	embedded in the	medical director	need of the medical	
Standards	authorization is	preventing,	Level of Care	every 6 months or	services provided in	
	required. It is applied during the during	evaluating,	Guidelines (LOC). The LOC Guidelines were	more frequently for	an effort to provide the most appropriate	
	concurrent facility	diagnosing or treating a mental	developed utilizing	any change in condition	care for the member	
	review (CFRs).	illness or substance	literature reviews as	Skilled Nursing	and help control	
	Teview (critis).	use disorder, or its	well as input solicited	Service is reviewed	costs by reducing	
	Each OP LOC has a	symptoms that are all	from providers,	with the medical	services as medically	
	specific clinical	of the following:	Medical Directors and	director every 8	appropriate.	
	template that must	In accordance with	other clinical staff,	weeks or more		
	be completed by	Generally Accepted	members, and	frequently for any	The plan defines	
	provider or utilization	Standards of Medical	regulators. The	change in condition.	medical necessity as	
	reviewer. Relevant	Practice.	evidence-base for the		services provided by	
	clinical information is	Clinically	LOC Guidelines	Nationally recognized	an institution,	

CONCURRENT REVIEW						
REQUIREMENTS –						
OUTPATIENT SERVICES		th/Substance Use Disor		1	Medical/Surgical Servi	ces
	matched to a specific	appropriate, in terms	includes generally	clinical guidelines	physician or other	
	MNC guideline to	of type, frequency,	accepted standards	and evidence are	health care provider	
	determine if approval	extent, site and	of clinical practice, as	used to assist	required to identify	
	is appropriate.	duration, and	well as governmental	clinicians in making	and treat a member's	
	F	considered effective	standards such as	informed decisions,	illness or injury	
	Frequency of	for the mental illness,	CMS' National	including the	including all of the	
	concurrent review is	substance use	Coverage	frequency of the next	following:	
	determined by	disorder, or its	Determinations	required review.	In accordance with	
	diagnosis, clinical	symptoms.	(NCDs) and Local		Generally Accepted	
	review, provider	Not mainly for the	Coverage		Standards of Medical	
	recommendations,	member's	Determinations		Practice.	
	support systems,	convenience or that	(LCDs). The LOC		Clinically	
	history of treatment	of the member's	Guidelines are		appropriate, in terms	
	and review of medical	doctor or other	annually updated to		of type, frequency,	
	necessity level of care	health care provider.	reflect changes to the		extent, site and	
	guidelines.	Not more costly	network, regulatory		duration, and	
	Consurrent reviews	than an alternative	requirements,		considered effective	
	Concurrent reviews	drug, service or supply that is at least	significant advances		for the illness or	
	may occur more		in service delivery,		injury	
	frequently if factors are present that	as likely to produce	current research, and other opportunities		Not mainly for the	
	require a case to be	equivalent therapeutic or	to improve its quality.		member's	
	escalated to staffing	diagnostic results as	to improve its quality.		convenience or that	
	or clinical rounds.	to the diagnosis or			of the member's	
	Also will take into	treatment of the			doctor or other	
	consideration average	member's mental			health care provider.	
	length of stay.	illness, substance use			Not more costly	
	length of stay.	disorder, or its			than an alternative	
	ASAM is used for all	symptoms.			drug, service or	
	SA OP services	Symptoms.			supply that is at least	
	requiring a medical				as likely to produce	
	necessity review.				equivalent	
					therapeutic or	
	Nationally recognized				diagnostic results as	
	clinical guidelines and				to the diagnosis or	
	evidence are used to				treatment of the	
	assist clinicians in				illness or injury.	
	making informed					
	decisions, including					
	the frequency of the					
	next required review.					

CONCURRENT REVIEW REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use D		Medical/Surgical Servi	ices	
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 au Nursing), there is no ability to evaluate for coreview 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 –		
<b>OUTPATIENT SERVICES</b>	Mental Health/Substance Use Disorder Services	Medical/Surgical Services
Modifications	NA	
Explain how concurrent review processes for MH/SUD and/or M/S benefits will be modified 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.					do not require Concurre	
	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.
Processes, Strategies, and Evidentiary Standards	NA	NA	NA	NA	NA	NA

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

# NQTL Analysis Module 3: Medical Necessity – INPATIENT SERVICES

MEDICAL NECESSITY REQUIREMENTS - INPATIENT SERVICES  What criteria are applied to make medical necessity/appropriateness determinations for inpatient services?	review.			Medical/Surgical Services  TennCare Rules Chapter 1200-13-1605 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 He	alth/Substance Use Disord	ler 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	As evidenced above and in the cited policies and procedures, it is determined t	
and Stringency	levels of care and utilize the same processes, strategies and standards. Therefore	
and carrigency	benefits more stringently applied that those for M/S benefits.	,
Explain how the		
processes,		
strategies, and		
evidentiary		
standards		
applied to		
MH/SUD		
benefits are		
comparable and		
no more		
stringently		
applied to M/S		
benefits.		
Evaluation of	If medical necessity requirements are applied comparably between MH/SUD	and NA/S handlife and are not applied more stringently, then the application
Processes,	of medical necessity is in parity. No additional information is needed.	and w/3 benefits and are not applied more stringently, then the application
Strategies, and	of medical necessity is in parity. No additional information is needed.	
Evidentiary	If medical necessity requirements are not comparably applied between MH/S	SUD and M/S henefits or are applied more stringently, then the application
Standards	of medical necessity is not in parity. Proceed to the following row.	and my a benefits, or the applied more stringently, then the application
Standards	of medical necessity is not in parity. Troceed to the following row	
Modifications	N/A	
Explain how		
medical		
necessity		
processes for		
MH/SUD and/or		
M/S benefits will		
be modified 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?	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 1200-13-1605  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 1200-13-1605 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.

REQUIREMENTS -			
OUTPATIENT SERVICES Mental Health/Substance Use Disorder Services	Medical/Surgical Services		
Mental Health/Substance Use Disorder 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.  We apply MNC for all authorized services at the time of each request. Relevant clinical is matched to MNC guidelines to determine medical necessity are embedded in the Level of Care Guidelines.  Mental Health/Substance Use Disorder Services  The plan defines medical necessity as evice 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 subs	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 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.  Medical/Surgical Services Seeking to ensure appropriate cost utilization and reduce over-utilization and policies no medical necessity 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, cost utilization and during concurrent review.		

MEDICAL NECESSITY REQUIREMENTS – OUTPATIENT SERVICES	Mental Health/Substance Use Disorder Services	Medical/Surgical Services					
Comparability and Stringency	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.						
Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied to M/S benefits.							
Evaluation of Processes, Strategies, and Evidentiary Standards	If medical necessity requirements are applied comparably between MH/S application of medical necessity is in parity. No additional information is  If medical necessity requirements are not comparably applied between N application of medical necessity is not in parity. Proceed to the following	needed.  1H/SUD and M/S benefits, or are applied more stringently, then the					
Modifications	N/A						
Explain how medical necessity processes for MH/SUD and/or M/S benefits will be modified 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 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.				es for MH/SUD or M/S be ied that those for M/S be	enefits. Therefore, there a	are no processes,
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
	N/A	
Modifications		
Explain how medical necessity processes for MH/SUD and/or M/S benefits will be modified 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 Hea	olth/Substance Use Disor	der Services		Medical/Surgical Service	5
	No, we do not apply a f	ail first requirement.			ries would require failure al for surgical interventio	
Does the plan apply "fail				Guidelines have embed	es and UnitedHealthcare of the dealthcare of the	d requirements for
first" requirements or step therapy protocols? List the inpatient				There is not a complete opening each individua	e all-inclusive list that can I guideline.	be provided without
services to which these requirements apply.				· ·	ent services would be hys leeding requiring hormon ntion.	•
				and physical therapy pr	d be failure of conservativior to consideration of anotal knee or total hip repla	elective joint
	Processes:	Strategies:	Evidentiary	Processes:	Strategies:	Evidentiary
Processes, Strategies, and Evidentiary Standards	Explain the process, both in writing and in practice, for fail first and/or step therapy protocols that your MCO uses.	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?	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.	Explain the process, both in writing and in practice, for fail first and/or step therapy protocols that your MCO uses.	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?	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 fi	rst 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	NA	
Explain how fail first or step therapy requirements for MH/SUD and/or M/S benefits will be modified 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 Hea	lth/Substance Use Disore	der Services	Medical/Surgical Services		
	No, we do not apply a fa	ail first requirement.		Guidelines have embed various fail-first therapi approval of more invasion.  There is not a complete opening each individua	•	nd requirements for s/devices before vices. be provided without
Does the plan apply "fail first" requirements or step therapy protocols? List the outpatient services to which these requirements apply.				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 Hea	Ith/Substance Use Disord	der 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 fi	rst 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	NA	
Explain how fail first or step therapy requirements for MH/SUD and/or M/S benefits will be modified 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.	·			NA – There are no fail fi	rst requirement for emer	gency M/S services.
	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.
Processes, Strategies, and Evidentiary Standards	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	NA – There are no fail first requirements for MH/SUD benefits or for Emer	gency M/S benefits.
Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied to M/S benefits.		
Evaluation of Processes, Strategies, and Evidentiary Standards	If fail first/step therapy requirements are applied comparably between I the application of these requirements is in parity. No additional information of these requirements are not comparably applied between the application of these requirements is not in parity. Proceed to the following	en MH/SUD and M/S benefits, or are applied more stringently, then the
Modifications	NA	
Explain how fail first or step therapy requirements for MH/SUD and/or M/S benefits will be modified 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?	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 <i>C_02_Clinician_Credentialing_Process</i> and <i>TennCare Addendum to Credentialing Policies</i> .	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 <i>Credentialing-Plan-2017</i> and <i>Credentialing_PlanState_and_Federal_Regulatory_Addendum</i> .
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  What methods are used to determine usual, customary, and reasonable charges?	Mental Health/Substance Use Disorder Services  UCR is determined by FairHealth, which is an outside vendor, to determine percentiles of average rates by region.			Reimbursement Program (I	Medical/Surgical Services imbursement Program (ENRP), MNRP) and shared savings pro que services by the provider, k	gram. For in network, the
Processes, Strategies, and	Processes: Explain the process, both in writing and in practice, for setting and implementing network admission standards.  Our network is reviewed for access and availability based on GEO	Strategies: WHY does your MCO use these processes and standards? What is the rationale and/or goal you are trying to achieve? We prefer to not contract using UCR methodology, instead we	Evidentiary Standards: What evidence supports the use of these processes and standards? Evidence may include practice guidelines and internal health plan utilization data. Geo Access reporting.	Processes: Explain the process, both in writing and in practice, for setting and implementing network admission standards.  Provider admission into network is based on geographic need, their agreement with contract	Strategies: WHY does your MCO use these processes and standards? What is the rationale and/or goal you are trying to achieve?  The goal is establishment of mutually beneficial partnerships that provide efficient quality care	Evidentiary Standards: What evidence supports the use of these processes and standards? Evidence may include practice guidelines and internal health plan utilization data.  We would seek to establish partnerships with inpatient providers that are the facilities of choice of our
Evidentiary Standards	access standards set forth with our risk agreement with TennCare.	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.		terms and rates. Our network is reviewed for access and availability based on GeoAccess standards set forth with our risk agreement with TennCare.	choices for health plan members. We also seek to ensure adequate access to services, and to ensure that qualified providers deliver services.	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	As evidenced above and in the referenced policies, all members shall be	e provided care in the same manner, on the same basis, and in accordance with the
and Stringency	same standards offered to all other patients of the provider. Covered so MH/SUD benefits applied more stringently than the M/S benefits.	ervices will be available and accessible to all members. Therefore, there are no IP
Explain how		
the processes,		
strategies, and		
evidentiary		
standards		
applied to		
MH/SUD		
benefits are		
comparable		
and no more stringently		
applied to M/S		
benefits.		
beliefits.		
<b>Evaluation of</b>	If network standards are applied comparably between MH/SUD and N	/I/S benefits and are not applied more stringently, then the application of these
Processes,	standards is in parity. No additional information is needed.	
Strategies, and		
Evidentiary		nd M/S benefits, or are applied more stringently, then the application of these
Standards	standards is not in parity. Proceed to the following row.	
Modifications	No modification needed.	
Explain how		
network		
standards for		
MH/SUD		
and/or M/S		
benefits will be		
modified 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?	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 <i>Credentialing-Plan-2017</i> .
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  What methods are used to determine usual, customary, and reasonable charges?	average rates by region.			Non-Network Reimb program for out of n	ursement Program (MN	gram (ENRP), Maximum IRP) and shared savings , the rates are based on
	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.
Processes, Strategies, and Evidentiary Standards	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	As evidenced above and in the referenced policies, all members shall be provided care same standards offered to all other patients of the provider. Covered services will be a MH/SUD benefits applied more stringently than the M/S benefits.	in the same manner, on the same basis, and in accordance with the
Explain how the processes, strategies, and evidentiary standards applied to MH/SUD benefits are comparable and no more stringently applied to M/S benefits.?		
Evaluation of Processes, Strategies, and Evidentiary Standards	If network standards are applied comparably between MH/SUD and M/S benefits an standards is in parity. No additional information is needed.  If network standards are not comparably applied between MH/SUD and M/S benefit standards is not in parity. Proceed to the following row.	
Standards	standards is not in parity. Proceed to the following row.	
Modifications  Explain how network	No modification needed.	
standards for MH/SUD and/or M/S benefits will be		
modified 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?	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 <i>Credentialing-Plan-2017</i> .
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  What methods are used to determine usual, customary, and reasonable charges?	Mental Health/Substance Use Disorder Services  NA  BH benefits for emergency services are covered under Medical/Surgical Services Benefits.				<b>Medical/Surgical Services</b> Reimbursement Program (E nt Program (MNRP) and shar	NRP), Maximum Non-
Processes, Strategies, and Evidentiary Standards	Processes: Explain the process, both in writing and in practice, for setting and implementing network admission standards.  NA  BH benefits for emergency services are covered under Medical/Surgical Services Benefits.	Strategies: WHY does your MCO use these processes and standards? What is the rationale and/or goal you are trying to achieve? NA BH benefits for emergency services are covered under Medical/Surgical	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.	Processes: Explain the process, both in writing and in practice, for setting and implementing network admission standards.  Provider admission into network is based on their agreement with contract terms and rates and geographic need. No written policies	Strategies: WHY does your MCO use these processes and standards? What is the rationale and/or goal you are trying to achieve?  The goal is establishment of mutually beneficial partnerships that provide efficient quality care choices for health plan members.	Evidentiary Standards: What evidence supports the use of these processes and standards? Evidence may include practice guidelines and internal health plan utilization data. We would seek to establish partnerships with emergency care providers that are the providers of choice of our members and network providers
		Services Benefits.		outline selection process.		whenever possible.

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



# NQTL Analysis Module: PHARMACY – Prior Authorization

PRIOR AUTHORIZATION REQUIREMENTS				N	Nedical/Surgical Services	S
Does TennCare require prior authorization for any covered pharmacy services? Which ones?	Disoder services. For a complete listing of services that require prior authorization, please see the links below: <a href="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.</a>		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: <a href="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</a>			
	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.
Processes, Strategies, and Evidentiary Standards	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		
REQUIREIVIENTS	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	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	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	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/or medical necessity criteria, the PBM shall document the request in		and Quality (AHRQ);  Canadian Agency for	document the request in the PBM pharmacy case management system and		and Quality (AHRQ);  Canadian Agency for

PRIOR AUTHORIZATION REQUIREMENTS	Mental Health/Substance Use Disorder Services		Medical/Surgical Services	
AUTHORIZATION	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.	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	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	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
	Additionally, some PA requirements can be bypassed for certain	outcomes; • FDA review documents; • Guidelines	bypassed for certain medications when specific medical conditions exist. Those	outcomes; • FDA review documents; • Guidelines

PRIOR	Mental Health/Substance Use Disorder Services		Medical/Surgical Services			
AUTHORIZATION REQUIREMENTS						
REQUIREIVIENTS						
	medications when		developed using an	specific medications and		developed using an
	specific medical		explicit evidence	diagnoses are available at		explicit evidence
	conditions exist. Those		evaluation process.	https://tenncare.magella		evaluation process
	specific medications and			nhealth.com. Prescribers		
	diagnoses are available			are encouraged to		
	at			include the applicable		
	https://tenncare.magell			diagnosis code on written		
	anhealth.com.			for on the electronic		
	Prescribers are			pharmacy claim.		
	encouraged to include					
	the applicable diagnosis					
	code on written for on					
	the electronic pharmacy					
	claim.					
Comparability		•		me for both MH/SUD and M/	•	
and Stringency				JD benefits are comparable a	and no more stringently a	pplied than prior
	authorization processes, st	trategies,and evidentiary s	tandards applied to M/S be	enefits.		
Explain how the						
processes,						
strategies, and						
evidentiary						
standards						
applied to						
MH/SUD						
benefits are						
comparable and						
no more						
stringently						
applied to M/S benefits.						
benefits.						
Evaluation of				and M/S benefits and are n	ot applied more stringen	tly, then the application
Processes,	of prior authorization is in	parity. No additional info	ormation is needed.			
Strategies, and						
Evidentiary	_	-		SUD and M/S benefits, or ar	e applied more stringent	y, then the application
Standards	of prior authorization is no	ot in parity. Proceed to the	e following row.			

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

# NQTL Analysis Module: PHARMACY – USE OF MEDICAL NECESSITY

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

USE OF MEDICAL	Mental Health/Substance Use Disorder Services			Medical/Surgical Services		S
NECESSITY						
REQUIREMENTS						
	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,	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	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,	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
	medical necessity determinations will be made by the prescribing physician or by the prescribing physician and		Guidelines;     Agency for     Healthcare     Research and     Quality (AHRQ);     Canadian Agency	medical necessity determinations will be made by the prescribing physician or by the prescribing physician and		Guidelines;     Agency for     Healthcare     Research and     Quality (AHRQ);     Canadian Agency

USE OF MEDICAL	Mental Health/Substance Use Disorder Services		Medical/Surgical Services		
NECESSITY					
REQUIREMENTS					
REQUIREMENTS	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	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	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 enrolled appeal or	e p	systematic reviews from validated, evidence-based medical sources.  The following types of vidence are ireferred and may be
	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	considered if they have been independently evaluated and determined to be of high quality:  Systematic reviews of randomized controlled trials (RCTs); Individual comparative effectiveness	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	h: in ev d	reviews of randomized controlled trials (RCTs);
	made in the context of medical/behavioral history information	RCTs evaluating clinically important	made in the context of medical/behavioral history information		RCTs evaluating clinically important

USE OF MEDICAL	Mental Health/Substance Use Disorder Services		Medical/Surgical Services			
NECESSITY						
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.				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.  Denefits are comparable to e not more stringently app		
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	N/A – No modifications	required to comply with	parity.			
Explain how medical necessity processes for MH/SUD and/or M/S benefits will be modified to comply with parity.						

# 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 Service	es
Does TennCare use fail first or step therapy protocols for any pharmacy services?	services. For a complete listing, please see links below:  https://tenncare.magellanhealth.com/static/docs/Preferred Drug List and Drug Criteria/TennCare PDL.pdf			Yes, step therapy protocols are utilized for some M/S pharmacy services. For a complete listing, please see links below: <a href="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/TennCare PDL.pdf</a>		
Which ones?	Drug Criteria/Criteria PD on	DL.pdf#nameddest=smoki	ng cessation agents secti	Drug Criteria/Criteria PI	DL.pdf#nameddest=smoki	ng cessation agents secti
	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.
Processes, Strategies, and Evidentiary Standards	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 costeffective 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 costeffective 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

USE OF FAIL FIRST OR STEP THERAPY PROTOCOLS			urgical 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	
	<ul> <li>Accept or reject the review and recommendations as written; or</li> <li>Make edits to the review and recommendations and accept as modified; or</li> <li>Request additional information from the TennCare Pharmacy staff on the topic; and</li> <li>If additional information is requested, findings may be presented to the PAC at the next scheduled meeting.</li> </ul>	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.	<ul> <li>Health (CADTH);</li> <li>The Cochrane Collaboration;</li> <li>National Institute for Clinical Evidence (NICE);</li> <li>Institute for Clinical and Economic Review (ICER);</li> <li>Published systematic reviews from validated, evidence- based medical sources.</li> <li>The following types of evidence are preferred and may be considered if they have been independently evaluated and determined to be of high quality:</li> <li>Systematic reviews of randomized controlled trials (RCTs);</li> <li>Individual comparative effectiveness RCTs evaluating clinically important outcomes;</li> <li>FDA review documents;</li> <li>Guidelines developed using an</li> </ul>

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.	
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 ber first/step therapy. The processes, strategies, and evidentiary standards are a	nefits are comparable to those applied to M/S benefits as applicable to the fail 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	If prior authorization requirements are applied comparably between MH/SUD and M/S benefits and are not applied more stringently, then the				
Processes,	application of prior authorization is in parity. No additional information is needed.				
Strategies, and					
Evidentiary	If prior authorization requirements are not comparably applied between MH/SUD and M/S benefits, or are applied more stringently, then the				
Standards	application of prior authorization is not in parity. Proceed to the following row.				
Modifications	N/A				
Explain how					
concurrent					
review processes					
for MH/SUD					
and/or M/S					
benefits will be					
modified to					
comply with					
parity.					