2024 Parity Evaluation for NJ FamilyCare Plan A and ABP

NJFamilyCare requires all recipients, regardless of their eligibility and or population group, to be enrolled into one of five Medicaid managed care plans. The available service packages include Plans A, ABP, B, C and D. Plans A and ABP are an identical service package and are the only service packages for which the State and its contracted managed care plans are required to complete a parity analysis. The three CHIP plans B, C and D (beginning 7/1/18) provide Early Periodic Screening, Diagnosis and Treatment (EPSDT) coverage and are therefore deemed compliant with parity requirements. At present, all physical health services are provided by Managed Care Organizations (MCOs) while the majority of mental health and substance use disorder (SUD) services are provided Fee-For-Service (FFS). This applies to Medicaid and CHIP programs. Therefore, the State has completed the narrative portion for this parity analysis with input collected from each of the managed care plans.

The State's FFS program only allows prior and retro-authorization in three circumstances. The first is with programs that require treatment planning. The authorization requires a properly completed treatment plan be submitted prior to authorization for payment for services. The treatment plan is reviewed for completeness, required signatures and clinical appropriateness. An example would be community support services. Services provided and billed must match the services listed and approved in the treatment plan. The second use of prior authorization is to ensure that services are being provided at the appropriate clinical level so that the individual will best benefit from the service being offered. An example would be transportation services. The client is eligible for transportation, but may not be appropriate for the level of transport requested. Lastly, authorization is used when multiple providers may be involved in treatment. Authorization ensures fiscal responsibility and reduces the ability for two providers to bill for the same service at the same time. An example where this is utilized is private duty nursing.

For 2023, NJ ended our state of emergency. All Prior Authorization (PA) and copayments for medical-surgical and behavioral health were reinstated. This reinstatement of PA applied to managed care and FFS products.

The MCOs are contractually required to meet the requirements listed for any service authorized through the State plan or through the Comprehensive waiver. Additionally, unless otherwise stated in the contract, the MCOs are required to follow any applicable rules published in the New Jersey administrative code. As for Non-Quantitative Treatment Limits (NQTLs), the plans are free to utilize measures to ensure fiscal appropriateness and medical necessity. Plans may not otherwise limit services authorized by the State and must ensure that any NQTL may be overridden when determined medically necessary or as required under EPSDT. All plans have demonstrated that their prior authorization requirements meet these standards and that the concurrent or retrospective review of the member's records demonstrated that the services are appropriate and based on medical necessity criteria.

For both FFS and MCOs, all cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the individual's unique clinical situation as applied to national best practice guidelines to assure that all medically necessary services are authorized. Any provider or recipient may request a second appeal to an independent medical peer for a final determination.

Within NJ FamilyCare, there are three sub-population groups for which MCOs cover the majority of MH/SUD services for Plan A and ABP. They are recipients receiving Managed Long Term Services and Supports (MLTSS), Division of Developmental Disabilities (DDD) involved recipients and individuals enrolled in a Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNP). Each sub-population receives the majority of their behavioral health and all of their physical health services from the managed care plan. The limited behavioral health services not covered by the MCO are programs include those that involve targeted case management and Programs for Assertive Community Treatment (PACT) and community support services which are provided FFS. The remaining subpopulations of Plan A and ABP receive all of their behavioral health services through FSS. All acute inpatient admissions, regardless of the admitting diagnosis, are covered by the recipient's managed care plan for all population groups. In addition, independent practitioners providing Medication Assisted Treatment (MAT) and navigator services are reimbursed under their managed care contract.

For the purposes of this parity analysis, behavioral health shall consist of mental health and substance use disorder services and is identified as MH/SUD and defined as those conditions listed in ICD-10-CM, Chapter 5 (with the exception of subchapter 1, "Mental disorders due to known physiological conditions"), including a subset of mental health conditions listed in ICD-10-Chapter 5 identified with the diagnosis codes F10-F19. This subset identifies conditions in which the use of one or more substances leads to a clinically significant impairment. Medical and surgical benefits shall be those services associated with the diagnosis and treatment of Medical Surgical conditions listed in ICD-10-CM, Chapters 1 through 4, and Chapter 5, subchapter 1 only, as well as Chapters 6 through 20. These services shall be identified as M/S.

For the purposes of this Parity analysis, MH/SUD and M/S services have been listed under one of four benefit classifications consisting of inpatient, outpatient, prescription drugs and emergency care. The categories have been defined as follows:

> "Inpatient" shall consist of all covered services or items provided to a beneficiary when a physician has written an order for admission to a facility. Those services provided in a facility may be for MH/SUD treatment as well as M/S services as defined above.
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> "Outpatient" shall consist of all covered services or items that are provided to a beneficiary in a setting that does not require a physician's order for admission and do not meet the definition of emergency care.
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> "Emergency Care" shall consist of all covered services or items delivered in an Emergency Department (ED) setting or outside of an ED setting but provided to stabilize an emergency/crisis, other than in an inpatient setting.
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> "Pharmacy" shall consist of durable medical equipment and covered medications, drugs, and associated supplies that require a prescription as well as services delivered by a pharmacist working in a free standing pharmacy.

The core services within these categories are attached for comparison.

Under NJ FamilyCare guidelines, and in compliance with the Mental Health Parity and Addictions Equity Act of 2008 (MHPAEA), neither the State nor the contracted Managed Care Organizations (MCOs) may impose:

- an aggregate lifetime dollar limit on any MH/SUD or M/S benefits
- an annual dollar limit on any MH/SUD or M/S benefits
- any financial requirements to MH/SUD benefits in the Inpatient classification
- any financial requirements to MH/SUD benefits in the Outpatient classification
- any financial requirements to MH/SUD benefits in the Emergency classification
- any financial requirements to MH/SUD benefits in the Pharmacy classification

Through regulations and contract language, NJ FamilyCare does not allow for any aggregate lifetime dollar limits on any benefits, M/S or MH/SUD. Since there are no annual dollar limits or any financial requirements on any M/S or MH/SUD services, NJ FamilyCare meets MHPAEA parity requirements for this section.

Under NJ FamilyCare contract guidelines and regulations, New Jersey's contracted MCOs cannot impose:

- Financial requirements—Payment by beneficiaries for services received that are in addition to payments made by the state or the MCO for those services. This includes copayments, coinsurance, and deductibles.
- Quantitative treatment limitations—Limits on the scope or duration of a benefit that are expressed numerically that are applied in a manner that is more restrictive than those that apply to M/S benefits in the same classification. This includes day or visit limits.
- Aggregate lifetime or annual dollar limits—Dollar limits on the total amount of a specified benefit over a lifetime or on an annual basis.

Therefore, since the State (or any of the five contracted MCOs) cannot impose any of the above limitations, NJ FamilyCare (Medicaid and CHIP) is determined to be compliant with the parity requirements listed in MHPAEA for this section.

A detailed analysis was also completed for Non-Quantitative Treatment Limits (NQTL) to ensure compliance with parity guidelines. This detailed analysis includes the State FFS system as well as individual analyses provided by each contracted plan. The MCO NQTL analyses can be seen in the attached appendices. An NQTL is defined as a limit on the scope or duration of benefits that may be extended if determined medically necessary; thus making it a "soft" limit. Parity prohibits New Jersey and its contracted MCOs from imposing an NQTL on MH/SUD benefits in any of the four classifications unless, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the classification. The factors used in applying the identified NQTLs are not applied more stringently for MH/SUD benefits than the factors used to apply the NQTL in the M/S benefits in the same classification.

To allow comparison between MS and BH/SUD and to assist with the analysis, each service group was assigned to one of the four categories (inpatient, outpatient, pharmacy and emergency). Several BH/SUD NQTLs have been identified that span across categories. First, and most prominent, is the medical management criteria utilized by both the State and the contracted MCOs in all four categories for both MH/SUD and M/S services. Medical management criteria are intended to ensure services are provided at the appropriate level of care. However, they may have the effect of limiting or denying services that fail to meet medical necessity. Prior authorization, a subcomponent of applying the criteria, is required to

ensure that service requests are being provided at the clinically appropriate level. This reduces fraud and abuse for the State while ensuring recipients receive the proper level of care. Prior authorizations are based solely on Medicaid eligibility and clinical necessity and may be overridden at any time if determined medically necessary. They are NJ FamilyCare's way to ensure service requests have been evaluated and to allow payment for those services. None of the medical management criteria, including prior authorizations, that is utilized by the State or MCO for MH/SUD services require any processes, strategies, evidentiary standards or other factors that are applied more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in each of the M/S classifications.

The State of New Jersey does have a regulation requiring the use of less expensive services if the other services are considered equivalent. This requirement is generally not applied to MH/SUD services since Mental Health services, other than acute inpatient services and SUD (ASAM), do not use medical management criteria. An example of how this law could be applied in a medical situation would be a client requesting a power wheelchair when they are capable of utilizing a manual chair. The request for the higher cost device would be denied unless medical necessity for a power chair could be provided. For MH/SUD, an example would be an individual seeking partial care services on a daily basis without demonstrating a need for this service. The State would approve individual or group therapy 2 days a week if the same outcome would be expected and treatment is determined medically appropriate by a medical professional. However, In the event this situation did arise, and it was determined medically appropriate by the State's Medical Director, the service would be approved at the higher level. For MH/SUD services, clients may choose between available services provided those services meet evidentiary standards that demonstrate an appropriate level of care. All services may be approved if medically necessary. The standard for applying restrictions to levels of care is not applied more stringently for MH/SUD than for M/S services in equivalent categories.

Geographical limitations could possibly span all four categories. However, NJ FamilyCare does not have any geographic limitations on provider inclusion. Both FFS and the MCOs contract with providers outside of New Jersey. Fee-for-service is open to any provider in any state. The MCOs limit their providers to the contiguous states surrounding New Jersey. However, both the State and MCOs offer "one time" provider agreements to providers who are outside of the network who provide urgent or emergent services outside of New Jersey. These agreements are easy to complete and ensure individuals travelling outside of New Jersey, but within the United States, can receive urgent medical care as needed. In support of the primary care model of care, the MCO contract requires routine or well care be provided by the individual's primary care physician. All providers follow the same guidelines and there are no differences between providers for MH/SUD and M/S services.

Rate setting for professional services have the potential to involve all four categories. Professional services are generally set at a specific percentage of Medicare rates. Rates do not increase with Medicare increases unless that requirement is part of the rate setting methodology. Therefore, rates across all specialties and provider types may vary. Factors such as a shortage of providers have resulted in specific rates being increased. APNs are paid 85% of the physician rate. Managed care plans generally set initial rates at the FFS rate but are free to negotiate rates independently. For professional services, rates vary depending on provider saturation and contracting needs. The rate setting process is the same for other professionals including PhDs and MA professionals. The majority of M/S service providers are reimbursed by the MCOs and the majority of BH/SUD providers are reimbursed by FFS. However, reimbursement

rates are determined in an equable manner for MH/SUD and M/S providers with both sides reacting to supply and demand as well as an examination of commercial rates for similar services.

Practitioner types are limited to those that are approved through regulation and through the State plan. Under FFS, which covers the majority of MH/SUD services, the State only recognizes physicians, APNs and psychologists as billable BH providers. However, any provider may practice within their licensure when their services are billed through an outpatient hospital, homecare provider or independent clinic. Most of the MH/SUD services within FFS are provided by clinic providers. Other than psychiatrists, there does not appear to be an unusual shortage of providers. To help attract psychiatrists, FFS has worked with programs to increase rates and billing opportunities to help offset the high cost of these providers.

The managed care contract allows MCOs to contract with any provider if the service they provide is covered in the State plan. These providers can practice as an "in lieu of service". Practitioner types, facility types, or specialty providers are not excluded in writing or in operation from providing covered benefits if they complete the enrollment and contracting requirements of the managed care plan. However, the provider must be contracted with the managed care plan in order to provide services to covered beneficiaries.

The network requirements for FFS and MCOs are different. With the exception of any lawfully imposed moratoriums on provider enrollment, NJ FFS offers an "any willing provider" environment. Any willing provider can apply, and if they meet eligibility requirements (license, accreditation, no debarment history, etc.), they may enroll as a FFS provider. Managed care plans contract with networks of qualified health care providers and home and community-based service providers (as applicable to state) to the enrolled membership in its Plan. The plan performs initial and ongoing assessments of its organizational providers in compliance with applicable local, state, and federal accreditation requirements. Information and documentation on organizational providers is collected, verified, reviewed, and evaluated in order to achieve a decision to approve or deny network participation. Neither the State nor the MCOs employ different criteria for MH/SUD or M/S provider enrollment.

With the exception of a few provider groups that the State mandates be open to enrollment, MCOs are not an open provider network. However, MCOs are contractually required to contract with providers for new recipients who require continuity of care with their present provider. They are also required to cover services for specialists who offer a unique specialty or area of expertise not available within the network, such as a "center of excellence". MCOs must also have adequate providers who can meet the recipient's needs. Therefore, MCOs must also allow for out of network providers when there are no equivalent contracted providers available within the network. The provider enrollment process for the State and for MCOs does not apply different standards between M/S and MH/SUD providers.

With the exception of limited MCO pharmacy services (addressed below), neither the State nor the contracted MCOs apply requirements for the completion of a particular service prior to approval for another. This process is commonly referred to as "step therapy". Evidentiary standards are utilized to determine what service is medically appropriate based on national care guidelines. This process may resemble step therapy at times, but evidentiary guidelines are case by case, taking multiple client specific factors into account to determine the most appropriate plan of care. Any of the guideline recommendations may be overridden if determined medically necessary by providers or the MCO/FFS medical director. Each provider is entitled to speak with the medical director regarding a negative decision. This affords the provider the opportunity to provide evidentiary standards or new clinical

information that may result in a revised decision. This process utilizing physician interaction and evidentiary standards are applied evenly across M/S and MH/SUD services and are not applied more stringently for MH/SUD.

Category specific NQTLs are identified and addressed below. With only minimal time periods as an exception, all M/S services are covered by the managed care plans. For examples of national standards of care utilized by the managed care plans, and applied to M/S services, please see attached appendices.

OUTPATIENT BH/SUD

Parity allows states to apply "soft limits" which are benefit limits that allow for an individual to exceed numerical limits for M/S or MH/SUD benefits on the basis of medical necessity. These benefits are considered to be an NQTL. Mental health partial care has an example of a soft limit and is listed under the "outpatient" category of service. The MH partial care benefit is a psychiatric day care program limited to 5 hours a day, 25 hours a week. This limit was imposed based on nationally accepted standards of care and recognition of an individual's limited ability to participate in active therapy beyond five hours a day. However, if determined medically necessary, services can be authorized to exceed the program limits. This limitation does not exceed the M/S Outpatient limit imposed on medical day care which is also 5 hours a day, 5 days a week.

There are two other soft limits utilized for BH/SUD services; the American Society of Addiction Medicine (ASAM) criteria and Pre-Admission Screening and Resident Review (PASARR) criteria. ASAM is a set of nationally recognized criteria developed to provide outcome oriented and results-based care in the treatment of SUD. The M/S equivalent would be Milliman Care Guidelines (MCG) used to evaluate necessity for outpatient M/S services such as physical therapy. PASARR is an advocacy program mandated by CMS to ensure that nursing home applicants and residents with mental illness and intellectual/developmental disabilities are appropriately placed and receive necessary services to meet their needs. Neither is to be utilized to limit medically necessary services based on financial or cost-based rationale. MCOs may not impose any Non-Quantitative Treatment Limitations (NQTLs) on MH/SUD services in the inpatient classification beyond the utilization of the American Society of Addiction Medicine (ASAM) criteria or the Pre-Admission Screening and Resident Review (PASARR) criteria authorized and required in the State Plan.

All SUD services provided by independent clinics or outpatient hospital programs, including MCO and FFS covered services, must meet ASAM criteria to ensure they are providing the appropriate level of care. These services include SUD partial care, Intensive Out-Patient services (IOP), Medically Assisted Treatment (MAT), short term rehabilitation and non-acute detoxification. Services that are determined to meet the appropriate level of care are given an authorization number which will allow the provider to bill for the service. Authorization numbers are an essential component of utilizing ASAM criteria as they ensure that the recipient was evaluated by the State (or a state contracted entity) and determined clinically appropriate for the service being billed. ASAM criteria is unique to SUD services, however, an equivalent practice would be authorization of physical therapy services. As long as the individual is making progress toward their goals, the authorization will continue. The process is clinically driven. Neither prior authorization is used for length of stay. There are no length-of-stay limits for BH/SUD or M/S services as long as the therapy is determined medically necessary.

Several SUD services have soft limits beyond the use of ASAM criteria. Outpatient psychotherapy MH/SUD services provided by independent practitioners or independent clinics (including Federally Qualified Health Centers (FQHC)) do not require any authorization. These services include initial assessments as well as individual, group or family psychotherapy. Providers are required to ensure the service provided is medically appropriate. These services are limited to one service modality (individual, group or family) per day up to a total of five services per week. This limit is based on nationally recognized practice standards. If an individual requires more frequent or more intensive service, these limits may be overridden. However, exceeding these limits indicate individuals should be reassessed under ASAM criteria and would likely require a higher level of care.

Outpatient mental health programs such as partial care and Community Support Services (CSS) utilize prior authorization to ensure that a completed individual rehabilitation plan is properly completed and signed in addition to medical necessity. Authorization is not used to limit admission or continuation of medically necessary services. This practice was necessitated by failure of the provider types to complete an appropriate treatment plan. A proper treatment plan is essential to provide quality, patient focused services to these mental health services. This is a unique use of prior authorization limited to BH/SUD. While M/S rehab services require prior authorization, that authorization is based on medical necessity only and not the successful completion of treatment planning prior to the provision of a service.

Outpatient IOP SUD partial care services also have additional soft limits. IOP is defined as a bundled service requiring 3 hours of therapy per day, 3 days per week. While IOP is a defined service, services provided within that definition can be provided in additional quantities if medically necessary. Similarly, SUD partial care is a bundled service requiring 20 hours of psychoeducational therapy per week. Services can be provided in addition to the services included in the description of partial care. Again, if there is a need for additional services, ASAM criteria may indicate a higher level of service is required. The soft limit associated with SUD partial care is equivalent to the limit imposed on medical day care in the outpatient M/S category. As the NQTLs meet the definition of a soft limit and the identified limits on outpatient MH/SUD services do not require any processes, strategies, evidentiary standards or other factors that are applied more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the outpatient M/S classification, Outpatient MH/SUD services are compliant with the parity requirements in MHPAEA.

INPATIENT MH/SUD

All inpatient mental health and SUD inpatient admissions are now covered by managed care for all managed care members. MCOs may not impose prior authorization on any emergent mental health admission. Concurrent review is allowable. Those who are FFS do not require prior authorization if in state and are still required to meet medical necessity criteria determined through concurrent review. This applies to M/S and BH/SUD inpatient hospitalization and short term rehabilitation. FFS providers self-attest that they are providing utilization review of Medicaid clients and they are sampled throughout the year by a contracted vendor to ensure compliance. Managed care plans provide ongoing utilization reviews to prevent fraud and abuse as well as to ensure appropriate utilization to control cost while ensuring appropriate care. Services beyond the recommendations of the approved guideline criteria, New Jersey policy or accepted industry guidelines may be approved as long as documentation supports that decision.

For both M/S and mental health admissions, medical necessity may be determined by utilizing Milliman criteria. Inpatient substance use disorder follows ASAM criteria. Both are a nationally recognized set of best practice guidelines utilized to ensure medical necessity and appropriateness of treatment. Managed care plans provide ongoing utilization reviews to prevent fraud and abuse. In addition, utilization review ensures appropriate utilization, controls cost and ensures appropriate care. The use of Milliman criteria and ASAM criteria represent soft NQTL limits since services can be extended beyond criteria guidelines. Both clinical management criteria are utilized by MCOs and the State equally for M/S inpatient and BH/SUD inpatient services. These services do not require any processes, strategies, evidentiary standards or other factors that are applied more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S inpatient benefits.

Beyond acute care facilities, MH/SUD inpatient services include admissions to a Psychiatric Residential Treatment Facility (PRTF) for children up to 21 years of age, Adult Mental Health Rehabilitation (AMHR), admissions to a short term SUD rehabilitation facility or admission for non-acute detoxification. PRTF and AMHR services currently do not require authorization under FFS. AMHR under an MCO does require authorization based on the presence of a mental health diagnosis and the regulatory requirements for this program. MCOs utilize this authorization to ensure fiduciary appropriateness and to evaluate individuals for less restrictive services in the community. All facility based SUD inpatient services that are FFS covered are no longer subject to the Institution for Mental Diseases (IMD) exclusion. These services have been added to the continuum of SUD services available under ASAM guidelines. Short term rehabilitation and non-acute detoxification are now authorized when determined appropriate by ASAM criteria. This is equivalent to M/S authorization for subacute rehabilitation services which are provided without limit for as long as medically necessary. There are no associated day or unit limits for any of these services. There are no processes, strategies, evidentiary standards or other factors applied more stringently than equivalent services in inpatient M/S.

All of the identified NQTLs meet the definition of a soft limit and the identified limits on inpatient MH/SUD services may be exceeded if medically necessary. Therefore, since none of the identified NQTLs require any processes, strategies, evidentiary standards or other factors that are applied more stringently than, the processes, strategies, evidentiary standards, or other factors used when applying the NQTL to M/S benefits in the inpatient M/S classification, this category of service meets the Parity standard established by MHPAEA.

Pharmacy BH/SUD

All pharmaceutical products provided through a specialty care or traditional pharmacy, are covered by MCOs for all populations in NJ FamilyCare. Contracted managed care plans utilize a preferred drug formulary that ensures access to all drug classes. Certain drugs routinely require prior authorization including those for the treatment of addiction. The requirement for prior authorization is based on utilization, safety and the Drug Utilization Review Board (DURB) recommendations. These recommendations ensure safe and appropriate usage of certain drug classes. The State DURB program and all its managed care partners have established effective quality assurance measures and systems to reduce medication errors and adverse drug reactions while improving medication utilization.

Managed care plans should not require the completion of a course of action or failure of another treatment plan (step therapy) before approving a service for mental health or SUD treatments. Pharmaceutical services are covered by the MCO for all population groups for both M/S and BH/SUD

services. Managed care entities utilize step therapy when there are several different drugs available on the Preferred Drug List (PDL) for treating a particular medical condition. A step therapy guideline that is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line therapy) before "stepping up" to more expensive alternatives is permissible if medically appropriate. For commonly prescribed drugs, the adjudication process may systematically assume a failed treatment based on previous claims history. This automated process reduces the need for prior authorization requests. To see how plans apply Step Therapy (ST) protocols, please refer to the attached appendices.

1) Step Therapy (ST) protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period.
2) At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the Drug Evaluation Review ("DER") process and will receive the ST medication.
3) Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval.

NJ FamilyCare MCOs rely on ST and do not have prescription "tiers". The use of tiers is commonly used in commercial plans as a way for MCOs to separate the drugs they cover within classes based on safety and cost. Generally, secondary tiers require higher copayment amounts for prescription drugs in addition to the need for prior authorization. NJ FamilyCare does not allow copayments. Therefore, the MCOs rely on Step therapy. If a prescription for mental health drugs has not met the fail requirements, or the prescriber wants to bypass the lower step drug(s), a prior authorization is required. As per an executive order, substance use medication assisted treatment may not be prior authorized with the exception of non-formulary medications. The prescriber must contact the MCO and provide the required information supporting a non-formulary drug. If the correct information is received, the MCO has 24 hours to make a decision. If the decision supports the prescriber, the authorization is given and the beneficiary receives their drug. If the decision does not, the prescriber may prescribe the alternative in formulary medication. These decisions are required to be based on medical necessity. However, ST is not applied any more stringently for BH/SUD than it is for M/S prescriptions. All adverse determinations are appealable based on best practice guidelines and medical necessity. All prescribers have the right to call and speak with the medical director at the plan responsible for the negative decision. If unsuccessful, they may go to an outside peer for an independent decision.

Managed Care providers use this utilization management tool for drugs that have a high potential for inappropriate use. Step therapy is essential to maintain our recipients' safety and health. To ensure step therapy protocol remains current, these protocols are developed and reviewed at least annually. They indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.).

Pharmacy services contain several measures beyond step therapy which include prior authorization. Authorization for certain pharmaceutical products ensures that providers comply with pharmacy practice standards, drug utilization review, internal medication error identification systems, medical therapy management programs, and pharmacy and therapeutics committee recommendations. This helps to ensure that recipients receive safe, high-quality, cost-effective pharmaceutical therapy. All prior authorizations, requirements, and edit restrictions can be overridden by the State or MCO pharmacy department staff once medical necessity is established and safety is assured. Therefore this NQTL is a soft limit which is applied equally for M/S and BH/SUD pharmaceutical services. There is no dollar or quantity

limit and usage can be extended beyond DURB limits if clinically indicated. Therefore, this category of service meets the parity standard established by MHPAEA.

Emergency BH/SUD

Emergency services provided for diagnoses defined as a BH/SUD service do not have any prior authorization or service limits. There are no NQTLs, financial requirements or service limits on any BH/SUD services other than transportation in the BH/SUD Emergency category. For transportation, authorization is used to determine if the transport is emergent or non-emergent. This is the same requirement as for M/S services. Emergent transportation is the responsibility of the MCO and non-emergency transportation is the responsibility of a contracted broker. Prior authorization is used strictly to ensure proper billing to the correct payer. There is no service limitation. Emergency services in an emergency department are evaluated for medical necessity for billing purposes only. The Emergency Medical Treatment and Labor Act (EMTALA) requires that emergency screening and stabilization services cannot be denied to anyone who reasonably thinks their condition is potentially life threatening. While services are screened for medical appropriateness, the client is not assessed a copayment if the service does not meet an emergency level of care. Therefore, there are no identified financial or service limits in MH/SUD Emergency. All services are applied equally among M/S emergency and BH/SUD emergency categories. Therefore, this category meets parity requirements in MHPEA.

Conclusion:

NJ FamilyCare meets parity in each of the four required categories listed under BH/SUD. No MH/SUD service requires any processes, strategies, evidentiary standards or other factors that are applied more stringently than those applied to M/S services.

Availability

The criteria for any medical necessity determination for all MH/SUD benefits, whether provided FFS or by an MCO, will be identified. However, most evidentiary standards and treatment criteria guidelines are licensed products and reproduction of the criteria is prohibited. However, as outlined in 42 CFR 438.236(c), MCOs are required to provide, upon request, practice guidelines to all affected providers and recipients. These practice guidelines identify the criteria utilized and explain how the criteria is applied. As required by 438.915(a) the MCO shall make the criteria for medical necessity determinations available to enrollees, potential enrollees and providers upon request. Providers of MH/SUD and all Medicaid recipients are sent an initial denial letter citing the criteria utilized to make the medical necessity determination. The denial letter includes both levels of appeal available to the recipient.

The State of New Jersey is actively working on making Medicaid (including CHIP) information available to all interested parties by listing that information online.

NJ FamilyCare Plan A/ABP recipients with mental health and substance use disorder services covered by their selected managed care plan:

- Managed Long Term Services and Supports (MLTSS) recipients
- Division of Developmental Disabilities (DDD) involved recipients

- Fully Integrated Dual Eligible Special Needs Plans (FIDE SNP) recipients

All NJ FamilyCare plan A/ABP mental health and substance use disorder benefits are covered by managed care under the NJ State Plan for each classification below. No mental health or SUD benefits were added to the Managed Care Plan (MCP) benefit package to meet the requirement in 42 CFR 438.910(b)(2). Inpatient psychiatric hospitalizations may be provided in an Institution of Mental Disease (IMD) as an "in lieu of" service.

MCOs are responsible to provide any medically necessary service to any individuals under the age of 21 that is identified during an EPSDT evaluation.

Definitions for the Purposes of Parity Analysis

Mental Health (MH)- Those conditions listed in ICD-10-CM, Chapter 5 with the exception of subchapter 1, "Mental Disorders due to know physiological conditions".

Substance Use Disorder SUD-a subset of mental health conditions listed in ICD-10-chapter 5 and identified with the diagnosis codes F10-F19, which identify conditions in which the use of one or more substances leads to a clinically significant impairment.

Medical and Surgical benefits- those services associated with the diagnosis and treatment of Medical Surgical conditions listed in ICD-10-CM, Chapters 1-4, Chapters 5 subchapter 1 and chapters 6 through 20.

Standards Used for the Classification of Benefits

Inpatient: All covered services or items provided to a beneficiary when a physician has written an order for admission to a facility. Those services provided in a facility may be for MH and/or SUD treatment as well as for Medical/Surgical services as defined above under "Definitions for the Purposes of Parity Analysis"

Outpatient: All covered services or items that are provided to a beneficiary in a setting that does not require a physician's order for admission and do not meet the definition of emergency care. Outpatient MH/SUD services are those services provided for those conditions listed in ICD-10-CM Chapter 5 (with the exception of subchapter 1) while Medical/Surgical services are those services associated with the diagnosis and treatment of those conditions listed in ICD-10-CM, Chapters 1-4, Chapter 5 (subchapter 1) and Chapters 6 through 20.

Emergency Care: All covered services or items delivered in an emergency department (ED) setting or to stabilize an emergency/crisis, other than in an inpatient setting. Those services delivered for treatment, stabilization or diagnosis of a MH/SUD as defined in the "Definitions for Purposes of Parity Analysis" above shall be considered emergency care for the treatment MH/SUD. Those services provided for the treatment, stabilization or diagnosis of a medical or surgical service as defined above in "definitions for Purposes of Parity Analysis" shall be considered emergency care for medical and surgical benefit.

Pharmacy: Durable medical equipment and covered medications, drugs and associated supplies that require a prescription, and services delivered by a pharmacist who works in a free-standing pharmacy. Those medications, drugs and associated supplies used for the treatment of a condition listed in ICD-10-CM Chapter 5, with the exception of subchapter 1) shall be applied to and considered MH/SUD. Those medications, drugs and associated supplies used for the treatment of a condition listed in ICD-10-CM Chapters 1-4, Chapter 5 subchapter 1, and Chapters 6-20 shall be applied to and considered medical/surgical services.

Aggregate lifetime limits, Annual Dollar Limits and financial requirements

a) MCOs may not impose an aggregate lifetime dollar limit on any MH/SUD benefit.
b) MCOs may not impose an annual dollar limit on any MH/SUD benefit.
c) MCOs may not impose any financial requirements to any MH/SUD benefits in the inpatient classification.
d) MCOs may not impose any financial requirements to any MH/SUD benefits in the outpatient classification.
e) MCOs may not impose any financial requirements to any MH/SUD benefits in the emergency care classification.
f) MCOs may not impose any financial requirements to any MH/SUD benefits in the pharmacy classification.

Quantitative Treatment Limitations

a) MCOs may not impose any quantitative treatment limitations to MH/SUD benefits in the inpatient classification.
b) MCOs may not impose any quantitative treatment limitations to MH/SUD benefits in the outpatient classification.
c) MCOs may not impose any quantitative treatment limitations to MH/SUD benefits in the emergency care classification.
d) MCOs may not impose any quantitative treatment limitations to MH/SUD benefits in the pharmacy classification.
e) MCOs may not implement different tiers of prescription drug benefits.

Non-Quantitative Treatment Limitations

a) MCOs may not impose any Non-Quantitative Treatment Limitations (NQTLs) on MH/SUD services in the inpatient classification beyond the utilization of the American Society of Addiction Medicine (ASAM) criteria or the nationally accepted medical criteria they have identified on their health plan's website. ASAM is a set of nationally recognized criteria developed to provide outcome oriented and results-based care in the treatment of SUD and is required for use by the health plan in contract language. Health plans are also required to follow state PASAAR criteria which determines if residents with mental illness and intellectual/developmental disabilities are appropriate to be placed in long term care and able to receive and benefit from necessary services intended to meet their needs. No medical criteria is to be utilized to limit medically necessary services based on financial or cost-based rationale.
b) MCOs may not impose any Non-Quantitative Treatment Limitations (NQTLs) beyond prior authorization on MH/SUD services in the outpatient classification. MCOs must follow those limits in the State Plan/Regulations or ASAM criteria. Physician and outpatient services have regulatory limits in place that are based on established practice models and used to limit billing errors and limit fraud and abuse. All limits can be overridden if medical necessity is established. All prior authorizations are based on clinical necessity and are not based on fiscal limitations.
c) MCOs may not impose any Non-Quantitative Treatment Limitations (NQTLs) on MH/SUD services in the emergency care classification. As per contract language, MCOs cannot impose a prior authorization on emergency services.
d) MCOs may not impose any Non-Quantitative Treatment Limitations (NQTLs) on MH/SUD services in the pharmacy classification beyond step therapy and prior authorization limits utilized to ensure safety and care that is clinically appropriate and based on nationally recognized guidelines. All pharmacy services are available and prior authorization decisions and step therapy requirements can be overridden if medically necessary. Providers can appeal directly to the pharmacy unit or medical director at the MCO in addition to the required appeals and grievance requirements.

Benefit Type	Inpatient	Outpatient	Prescription Drugs	Emergency Care
	- Surgery (established medical criteria) - Anesthesia - Medical/Surgical bed (medical criteria) - Medication administered during the admission - Lab - Radiology - Acute medical detox (ASAM criteria) - Short term rehab (medical criteria) - Custodial Nursing (PAS)	- Physician visit urgent - Physician well visit (limits) - gyn/obstetrics Doulas- no PA - Outpatient surgical center and endoscopy (auth) - optometry- limits - Home-based skilled nursing (medical criteria) - home based rehab and respiratory tx (medical criteria) - Home infusion Prior authorized - PDN-(tool with auth) - PT/OT/ST (auth) - Lab - Radiology (some services authed) - Personal care provided in the beneficiary's home (Unit limit, PA) - Medical day care (limit units per day per week, PA) - Subacute acute rehab services (Criteria) - assisted living (authorized) - group homes (DCP&P) - Opioid Overdose Recovery Program (no PA) Lactation consultants	- Generic and name brand medications - Narcotic meds (may require prior auth.) - Prescription medication required prior to a radiology study - Nicotine reduction therapy - Hep C Tx (PA) - Prosthetics and Orthotics (PA) - Hearing aids (PA) - DME supply (limits and PA for beds, wheelchairs, pumps, lifts, standers, molded braces, vents, incontinence products). Breast pumps- no PA - eyewear/contacts- (limits)	- Ambulance/ALS - Air ambulance/SCT (authorized) - Consultation delivered in an ED - Medications administered during an ED visit - Lab - Radiology provided in an ED - bedside surgical tx

Benefit Type MH/SUD	Inpatient	Outpatient	Prescription Drugs	Emergency Care
	- Psychiatric hospitalization (medical criteria) - PRTF - Psychotropic medication administered in hospital - Short term SUD rehab (ASAM) - Long term SUD rehab (ASAM) - residential withdrawal management (ASAM)	- MH psychiatrist visit - SUD physician visit - MH Psychotherapy (limits) - OP MH clinic psychotherapy (limits) - Partial care/PH (PA with limits units per day/wk) - IOP (ASAM) - MAT (no PA) - Non-acute detox ambulatory (ASAM) - OP SUD psychotherapy (no PA) - AMHR group homes - PACT/ICMS - Rehabilitation services - Peer support (children PA) Care management (no PA)	- Generic and name brand medications (e.g., SSRIs, antipsychotics) - Vivitrol (No PA) - Suboxone -Sublocade (No PA) - Nicotine reduction therapy (limited PA)	- Crisis stabilization (FFS) - Psychotropic medication administered in an ED - mobile crisis

NJ FamilyCare Plan A CHIP Pregnant Women recipients with mental health and substance use disorder services covered by FFS and M/S services by their selected managed care plan

All NJ FamilyCare plan A CHIP Pregnant women mental health and substance use disorder benefits, other than acute hospital services, are covered by FFS Medicaid under the NJ State Plan for each classification below. Inpatient psychiatric and acute substance abuse detoxification are the responsibility of the MCO. No mental health or SUD benefits were added to the Managed Care Plan (MCP) benefit package to meet the requirement in 42 CFR 438.910(b)(2). Inpatient psychiatric hospitalizations may be provided in an Institution of Mental Disease (IMD) as an "in lieu of" service.

MCOs and FFS are responsible to provide any medically necessary service to any individuals under the age of 21 that is identified during an EPSDT evaluation.

Definitions for the Purposes of Parity Analysis

Mental Health (MH)- Those conditions listed in ICD-10-CM, Chapter 5 with the exception of subchapter 1, "Mental Disorders due to know physiological conditions".

Substance Use Disorder SUD-a subset of mental health conditions listed in ICD-10-chapter 5 and identified with the diagnosis codes F10-F19, which identify conditions in which the use of one or more substances leads to a clinically significant impairment.

Medical and Surgical benefits- those services associated with the diagnosis and treatment of Medical Surgical conditions listed in ICD-10-CM, Chapters 1-4, Chapters 5 subchapter 1 and chapters 6 through 20.

Standards Used for the Classification of Benefits

Inpatient: All covered services or items provided to a beneficiary when a physician has written an order for admission to a facility. Those services provided in a facility may be for MH and/or SUD treatment as well as for Medical/Surgical services as defined above under "Definitions for the Purposes of Parity Analysis"

Outpatient: All covered services or items that are provided to a beneficiary in a setting that does not require a physician's order for admission and do not meet the definition of emergency care. Outpatient MH/SUD services are those services provided for those conditions listed in ICD-10-CM Chapter 5 (with the exception of subchapter 1) while Medical/Surgical services are those services associated with the diagnosis and treatment of those conditions listed in ICD-10-CM, Chapters 1-4, Chapter 5 (subchapter 1) and Chapters 6 through 20.

Emergency Care: All covered services or items delivered in an emergency department (ED) setting or to stabilize an emergency/crisis, other than in an inpatient setting. Those services delivered for treatment, stabilization or diagnosis of a MH/SUD as defined in the "Definitions for Purposes of Parity Analysis" above shall be considered emergency care for the treatment MH/SUD. Those services provided for the treatment, stabilization or diagnosis of a medical or surgical service as defined above in "definitions for Purposes of Parity Analysis" shall be considered emergency care for medical and surgical benefit.

Pharmacy: Durable medical equipment and covered medications, drugs and associated supplies that require a prescription, and services delivered by a pharmacist who works in a free-standing pharmacy. Those medications, drugs and associated supplies used for the treatment of a condition listed in ICD-10-CM Chapter 5, with the exception of subchapter 1) shall be applied to and considered MH/SUD. Those medications, drugs and associated supplies used for the treatment of a condition listed in ICD-10-CM Chapters 1-4, Chapter 5 subchapter 1, and Chapters 6-20 shall be applied to and considered medical/surgical services.

Aggregate lifetime limits, Annual Dollar Limits and financial requirements

g) MCOs may not impose an aggregate lifetime dollar limit on any MH/SUD benefit.
h) MCOs may not impose an annual dollar limit on any MH/SUD benefit.
i) MCOs may not impose any financial requirements to any MH/SUD benefits in the inpatient classification.
j) MCOs may not impose any financial requirements to any MH/SUD benefits in the outpatient classification.
k) MCOs may not impose any financial requirements to any MH/SUD benefits in the emergency care classification.
l) MCOs may not impose any financial requirements to any MH/SUD benefits in the pharmacy classification.

Quantitative Treatment Limitations

f) MCOs may not impose any quantitative treatment limitations to MH/SUD benefits in the inpatient classification.
g) MCOs may not impose any quantitative treatment limitations to MH/SUD benefits in the outpatient classification.
h) MCOs may not impose any quantitative treatment limitations to MH/SUD benefits in the emergency care classification.
i) MCOs may not impose any quantitative treatment limitations to MH/SUD benefits in the pharmacy classification.
j) MCOs may not implement different tiers of prescription drug benefits.

Non-Quantitative Treatment Limitations

e) MCOs may not impose any Non-Quantitative Treatment Limitations (NQTLs) on MH/SUD services in the inpatient classification beyond the utilization of the American Society of Addiction Medicine (ASAM) criteria or the nationally accepted medical criteria they have identified on their health plan's website for M/S inpatient or rehabilitative residential services. ASAM is a set of nationally recognized criteria developed to provide outcome oriented and results-based care in the treatment of SUD and is required for use by the health plan in contract language. Health plans are also required to follow state PASAAR criteria which determines if residents with mental illness and intellectual/developmental disabilities are appropriate to be placed in long term care and able to receive and benefit from necessary services intended to meet their needs. No medical criteria is to be utilized to limit medically necessary services based on financial or cost-based rationale.
f) MCOs may not impose any Non-Quantitative Treatment Limitations (NQTLs) beyond the use of ASAM criteria for inpatient acute medical detoxification or their own established medical criteria (identified on each plan's website). Physician and outpatient services have regulatory limits in place that are based on established practice models and used to limit billing errors and limit fraud and abuse. All limits can be overridden if medical necessity is established. All prior authorizations are based on clinical necessity and are not based on fiscal limitations.
g) MCOs may not impose any Non-Quantitative Treatment Limitations (NQTLs) on MH/SUD services in the emergency care classification. As per contract language, MCOs cannot impose a prior authorization on emergency services.
h) MCOs may not impose any Non-Quantitative Treatment Limitations (NQTLs) on MH/SUD services in the pharmacy classification beyond step therapy and prior authorization limits utilized to ensure safety and care that is clinically appropriate and based on nationally recognized guidelines. All pharmacy services are available and prior authorization decisions and step therapy requirements can be overridden if medically necessary. Providers can appeal directly to the pharmacy unit or medical director at the MCO in addition to the required appeals and grievance requirements.

FFS benefit Comparison

Benefit Type	Inpatient	Outpatient	Prescription Drugs	Emergency Care
M/S	- Surgery (established medical criteria) - Anesthesia - Medical/Surgical bed (medical criteria) - Medication administered during the admission - Lab - Radiology - Acute medical detox (ASAM criteria) - Short term rehab (medical criteria) - Custodial Nursing (PAS)	- Physician visit urgent - Physician well visit (limits) - gyn/obstetrics - Outpatient surgical center and endoscopy (auth) - optometry- limits - Home-based skilled nursing (medical criteria) - home based rehab and respiratory tx (medical criteria) - Home infusion Prior authorized - PDN-(tool with auth) - PT/OT/ST (auth) - Lab - Radiology (some services authed) - Personal care provided in the beneficiary's home (Unit limit, PA) - Medical day care (limit units per day per week, PA) - Subacute acute rehab services (Criteria) - assisted living (authorized) - group homes (DCP&P) -Doulas -lactation consultants	- Generic and name brand medications - Narcotic meds (prior auth.) - Prescription medication required prior to a radiology study - Nicotine reduction therapy - Hep C Tx (PA) - Prosthetics and Orthotics (PA) - Hearing aids (limits and PA) - DME supply (limits and PA for beds, wheelchairs, pumps, lifts, standers, molded braces, vents, incontinence products). - eyewear/contacts- (limits)	- Ambulance/ALS - Air ambulance/SCT (authorized) - Consultation delivered in an ED - Medications administered during an ED visit - Lab - Radiology provided in an ED - bedside surgical tx

Benefit Type MH/SUD	**Inpatient**	**Outpatient**	**Prescription Drugs**	**Emergency Care**
	- Psychiatric hospitalization (medical criteria) - PRTF - Psychotropic medication administered in hospital - Short term SUD rehab (ASAM) - Long term SUD rehab (ASAM) - residential withdrawal management (ASAM)	- MH psychiatrist visit - SUD physician visit - MH Psychotherapy (soft limits) - OP MH clinic psychotherapy (soft limits) - Partial care/PH (PA with limits units per day/wk) - IOP (ASAM) - MAT (ASAM) - Non-acute detox ambulatory (ASAM) - OP SUD psychotherapy - AMHR group homes -Community Support Services (CSS) - PACT/ICMS - Rehabilitation services - Peer support (children PA, adults no PA) -SUD care management	- Generic and name brand medications (e.g., SSRIs, antipsychotics) - Vivitrol (No PA) - Suboxone Methadone (no PA) -Sublocade (No PA) - Nicotine reduction therapy (limited PA)	- Crisis stabilization (FFS) - Psychotropic medication administered in an ED - mobile crisis

Federal Mental Health Parity and Addiction Equity Filing Table 5: Non-

Quantitative Treatment Limitations

Submit a separate form for each benefit plan design.

A. Plan Name: Aetna Better Health of NJ		B. Date: 03/01/2025
C. Contact Name: Dr. Sadijah Husain	D. Telephone Number: 609-282-8230	E. Email: husains@aetna.com
F. Line of Business (HMO, EPO, POS, PPO): HMO		
G. Contact Type (large group, small group, individual): large group		
H. Benefit Plan Effective Date: 01/01/2015		I. Benefit Plan Design(s) Identifier(s):[1]

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
A. Definition of Medical Necessity What is the definition of medical necessity?	Medical necessity is defined as a service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the provider in accordance with Aetna Better Health of New Jersey's guidelines, policies or procedures, for the diagnosis or treatment of a covered illness, condition or injury, for the prevention of future disease, to assist in the member's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth. Medically necessary services are those for	Medical necessity is defined as a service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the provider in accordance with Aetna Better Health of New Jersey's guidelines, policies or procedures, for the diagnosis or treatment of a covered illness, condition or injury, for the prevention of future disease, to assist in the member's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth. Medically necessary services are those for which there is no other equally	

	which there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the member. A decision about coverage for a requested service based on whether the service is clinically appropriate and/or needed based on a member's circumstances. MCG Guidelines (formerly Milliman Care Guidelines), including Chronic Care Guidelines, are evidence-based clinical guidelines that are updated annually. They support prospective, concurrent, and retrospective reviews; proactive care management; discharge planning; patient education, and quality initiatives. Aetna Clinical Policy Bulletins (CPBs) are based on evidence in the peer-reviewed published medical literature, technology assessments and structured evidence reviews, evidence-based consensus statements, expert opinions of health care practitioners/providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies.	effective, more conservative or substantially less costly course of treatment available or suitable for the member. A decision about coverage for a requested service based on whether the service is clinically appropriate and/or needed based on a member's circumstances. MCG Guidelines (formerly Milliman Care Guidelines), including Chronic Care Guidelines, are evidence-based clinical guidelines that are updated annually. They support prospective, concurrent, and retrospective reviews; proactive care management; discharge planning; patient education, and quality initiatives. Aetna Clinical Policy Bulletins (CPBs) are based on evidence in the peer-reviewed published medical literature, technology assessments and structured evidence reviews, evidence-based consensus statements, expert opinions of health care practitioners/providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies. Behavioral Health Medications for members prescribed by Behavioral Health Providers are Gold-Carded in NJ. Meaning, unless they have some sort of safety issue, for instance, above Max dose, Drug to Drug Interaction, Duplication, out of the normal FDA age guidelines it will pay at Point of Sale without disruption. Any Behavioral Health medications that are prescribed by Non-Behavioral Health Providers will be subject to Aetna Behavior Health guidelines which describes Medical Necessity. Medical Necessity is determined by FDA guidelines. SUD in NJ is dictated by a State mandated protocol. Once again there is no DUR to prove Medical Necessity unless again the claim has some sort of safety issue at POS. At that point the claim will stop for clinical justification to override the FDAs guidelines.	

[1] Use the same benefit plan design identifier(s) as for Tables 1-4.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
B. Prior-authorization Review Process Include all services for which prior- authorization is required. Describe any step- therapy or "fail first" requirements and requirements for submission of treatment request forms or treatment plans. Inpatient, In-Network:	All elective inpatient service requires an authorization. Emergency admission to a hospital does not require prior authorization. Inpatient care requires authorization, which is entered in the course of concurrent review, not prior to admission. All inpatient benefits are reviewed against MCG guidelines. No benefit requires fail first therapy;	All inpatient service require an authorization. Emergency admission to a hospital does not require prior authorization. Inpatient care requires authorization, which is entered in the course of concurrent review, not prior to admission. All inpatient benefits are reviewed against MCG and ASAM guidelines. No benefit requires fail first therapy; Behavioral Health Medications prescribed by a Behavioral Health Prescriber along with Substance Use Disorder Medications (MAT) in NJ are not subjected to Prior Authorization unless there is a safety issue. At that point, a PA will be required to Clinically Justify why FDA guidelines are not being followed	All elective inpatient service requires an authorization. Emergency admission to a hospital does not require prior authorization. Inpatient care requires authorization, which is entered in the course of concurrent review, not prior to admission. All inpatient benefits are reviewed against MCG or ASAM guidelines. No benefit requires fail first therapy;
Outpatient, In-Network: Office Visits:	No authorization required	No authorization required	
Outpatient, In-Network: Other Outpatient Items and Services:	Outpatient Services that require prior authorization vary, based upon the code, and are not location specific. We encourage providers to utilize the ProPAT system to check the code specific listings for details. The following services are examples of selected services requiring precertification; Surgical services, Home based services including hospice, Therapies (PT, OT, speech), Imaging such as MRI and MRA, DME (wheelchairs/hospital beds), Orthotics / Prosthetics.	Outpatient Services that require prior authorization vary, based upon the code, and are not location specific. We encourage providers to utilize the ProPAT system to check the code specific listings for details. The following services are examples of selected outpatient services requiring precertification: substance use disorder partial care, substance use disorder intensive outpatient programs, mental health partial care, and adult mental health rehabilitation. All	All outpatient benefits are reviewed against guidelines. Many guidelines include first steps that should be failed before the service of interest would be considered medically necessary. No benefit requires fail first therapy. There are no requirements for fail first therapy. When a request for an outpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a

	Evidence based guidelines are utilized to make all clinical decisions.	codes are reviewed by legal at the National level for parity compliance. Evidence based guidelines are utilized to make all clinical decisions.	request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.
Inpatient, Out-of-Network:	All elective inpatient service requires an authorization. Emergency admission to a hospital does not require prior authorization. Inpatient care requires authorization, which is entered in the course of concurrent review (see below), not prior to admission.	All inpatient services require an authorization. Emergency admission to a hospital does not require prior authorization. Inpatient care requires authorization, which is entered in the course of concurrent review (see below), not prior to admission	When a request for an inpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized. We do not require fail first therapy; we require that the request meets clinical necessity per evidence based guidelines.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
Outpatient, Out-of-Network: Office Visits:	All Out-Of-Network services require prior authorization	All Out-Of-Network services require prior authorization	All outpatient benefits are reviewed against guidelines. We do not require fail first therapy; we require that the request meets clinical necessity per evidence-based guidelines.
Outpatient, Out-of-Network: Other Items and Services:	All Out-Of-Network services require prior authorization	All Out-Of-Network services require prior authorization	All outpatient benefits are reviewed against guidelines. There are no requirements for fail first therapy. When a request for an outpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.
C. Concurrent Review Process, including frequency and penalties for all services. Describe any step-therapy or "fail first" requirements and requirements for submission of treatment request forms or treatment plans. Inpatient, In-Network:	Concurrent reviews of acute hospitalizations are conducted as dictated by the member's clinical condition, either on-site or by telephone, facsimile or provider portal, and may occur up to seven (7) days a week on a schedule dictated by the member's diagnosis or condition or contractual obligation. If the initial request includes enough clinical information to render a decision, the request is completed within twenty-four (24) hours. If additional information is required, that is requested within 24 hours of receipt of initial request, and a decision is rendered no more than 72 hours from receipt of	Concurrent reviews of acute hospitalizations are conducted as dictated by the member's clinical condition, either on-site or by telephone, facsimile or provider portal, and may occur up to seven (7) days a week on a schedule dictated by the member's diagnosis or condition or contractual obligation. If the initial request includes enough clinical information to render a decision, the request is completed within twenty-four (24) hours. If additional information is required, that is requested within 24 hours of receipt of initial request, and a decision is rendered no more than 72 hours from receipt of	When a request for a continued inpatient services is received it is reviewed against evidence based clinical guidelines by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.

	original request The facility providing the inpatient services should notify the Aetna Better Health Prior Authorization department within twenty-four (24) hours of the member's admission. Aetna Better Health may authorize covered and medically necessary inpatient services provided that the following criteria are met: The member is enrolled and eligible on the date(s) of service, Aetna Better Health's notification and prior authorization requirements are met and the concurrent or retrospective review of the member's records indicates that the inpatient placement is appropriate based on medical necessity criteria. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.	original request. The facility providing the inpatient services should notify the Aetna Better Health Prior Authorization department within twenty-four (24) hours of the member's admission. Aetna Better Health may authorize covered and medically necessary inpatient services provided that the following criteria are met: The member is enrolled and eligible on the date(s) of service, Aetna Better Health's notification and prior authorization requirements are met and the concurrent or retrospective review of the member's records indicates that the inpatient placement is appropriate based on medical necessity criteria. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.	
Outpatient, In-Network: Office Visits:	No authorization required	No authorization required	
Outpatient, In-Network: Other Outpatient Items and Services:	Outpatient Services that require prior authorization vary, based upon the code, and are not location specific. We encourage providers to utilize the ProPAT system to check the code specific listings for details. The following services are examples of selected services requiring precertification; Surgical services, Home based services including hospice, Therapies (PT, OT, speech), Imaging such as MRI and MRA, DME (wheelchairs/hospital beds), Orthotics /	Outpatient Services that require prior authorization vary, based upon the code, and are not location specific. We encourage providers to utilize the ProPAT system to check the code specific listings for details. The following services are examples of selected outpatient services requiring precertification: substance use disorder partial care, substance use disorder intensive outpatient programs, mental health partial care, and adult mental health rehabilitation. All codes	All outpatient benefits are reviewed against guidelines. There are no requirements for fail first therapy. When a request for an outpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services

	Prosthetics. Evidence based guidelines are utilized to make all clinical decisions.	are reviewed by legal at the National level for parity compliance. Evidence based guidelines are utilized to make all clinical decisions.	are authorized.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
Inpatient, Out-of-Network:	Prior Authorization is not required for emergency admission to a hospital. Concurrent reviews of acute hospitalizations are conducted as dictated by the member's clinical condition, either on-site or by telephone, facsimile or provider portal and may occur up to seven (7) days a week on a schedule dictated by the member's diagnosis or condition or contractual obligation. If the initial request includes enough clinical information to render a decision, the request is completed within twenty-four (24) hours. If additional information is required, that is requested within 24 hours of receipt of initial request, and a decision is rendered no more than 72 hours from receipt of original request The facility providing the inpatient services should notify the Aetna Better Health Prior Authorization department within twenty-four (24) hours of the member's admission. Aetna Better Health may authorize covered and medically necessary inpatient services provided that the following criteria are met: The member is enrolled and eligible on the date(s) of service, Aetna Better Health's notification and prior authorization requirements are met and the concurrent or retrospective review of the member's records indicates that the inpatient placement is appropriate based on	Prior Authorization is not required for emergency admission to a hospital. Concurrent reviews of acute hospitalizations are conducted as dictated by the member's clinical condition, either on-site or by telephone, facsimile, or provider portal, and may occur up to seven (7) days a week on a schedule dictated by the member's diagnosis or condition or contractual obligation. If the initial request includes enough clinical information to render a decision, the request is completed within twenty-four (24) hours. If additional information is required, that is requested within 24 hours of receipt of initial request, and a decision is rendered no more than 72 hours from receipt of original request The facility providing the inpatient services should notify the Aetna Better Health Prior Authorization department within twenty-four (24) hours of the member's admission. Aetna Better Health may authorize covered and medically necessary inpatient services provided that the following criteria are met: The member is enrolled and eligible on the date(s) of service, Aetna Better Health's notification and prior authorization requirements are met and the concurrent or retrospective review of the member's records indicates that the inpatient placement is appropriate based on	When a request for continued inpatient services is received it is reviewed against evidence based clinical guidelines by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.

	medical necessity criteria. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.	medical necessity criteria. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.	
Outpatient, Out-of-Network: Office Visits:	All Out-Of-Network services require prior authorization	All Out-Of-Network services require prior authorization	There are no requirements for fail first therapy. When a request for an outpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.
Outpatient, Out-of-Network: Other Items and Services:	All Out-Of-Network services require prior authorization	All Out-Of-Network services require prior authorization	There are no requirements for fail first therapy. When a request for an outpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.
D. Retrospective Review Process, including timeline and penalties. Inpatient, In Network:	All elective inpatient service requires an authorization. Emergency admission to a hospital does not require prior authorization. Inpatient care requires authorization, which is entered in the course of concurrent review, not prior to admission. All inpatient benefits are reviewed against MCG	All inpatient services require an authorization. Emergency admission to a hospital does not require prior authorization. Inpatient care requires authorization, which is entered in the course of concurrent review, not prior to admission. All inpatient benefits are reviewed against MCG	When a request for an inpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all

	guidelines. Many guidelines include first steps that should be failed before the service of interest should be considered medically necessary. No benefit requires fail first therapy; however clinical guidelines may include a series of steps prior to meeting medical necessity. Retrospective requests must be submitted within 90 days of the discharge. Retrospective determinations must be issued within 30 days of the authorization request.	and ASAM guidelines. No benefit requires fail first therapy; however clinical guidelines may include a series of steps prior to meeting medical necessity. Retrospective requests must be submitted within 90 days of the discharge. Retrospective determinations must be issued within 30 days of the authorization request.	medically necessary services are authorized. We do not require fail first therapy; we require that the request meets clinical necessity as per evidence-based guidelines
Outpatient, In-Network: Office Visits:	No authorization required	No authorization required	
Outpatient, In-Network: Other Outpatient Items and Services:	Outpatient Services that require prior authorization vary, based upon the code, and are not location specific. We encourage providers to utilize the ProPAT system to check the code specific listings for details. The following services are examples of selected services requiring precertification; Surgical services, Home based services including hospice, Therapies (PT, OT, speech), Imaging such as MRI and MRA, DME (wheelchairs/hospital beds), Orthotics / Prosthetics. Evidence based guidelines are utilized to make all clinical decisions, see below response. Retrospective reviews must be submitted within 90 days of the date of service. Retrospective determinations must be issued within 30 days of the receipt date.	Outpatient Services that require prior authorization vary, based upon the code, and are not location specific. We encourage providers to utilize the ProPAT system to check the code specific listings for details. The following services are examples of selected outpatient services requiring precertification: substance use disorder partial care, substance use disorder intensive outpatient programs, mental health partial care, and adult mental health rehabilitation. All codes are reviewed by legal at the National level for parity compliance. Evidence based guidelines are utilized to make all clinical decisions, see below response. Retrospective reviews must be submitted within 90 days of the date of service. Retrospective determinations must be issued within 30 days of the receipt date.	There are no requirements for fail first therapy. When a request for an outpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
Inpatient, Out-of-Network:	All elective inpatient service requires an authorization. Emergency admission to a hospital does not require prior authorization. Inpatient care requires authorization, which is entered in the course of concurrent review (see below), not prior to admission. Retrospective requests must be submitted within 90 days of the discharge. Retrospective determinations must be issued within 30 days of the authorization request.	All inpatient services require an authorization. Emergency admission to a hospital does not require prior authorization. Inpatient care requires authorization, which is entered in the course of concurrent review (see below), not prior to admission. Retrospective requests must be submitted within 90 days of the discharge. Retrospective determinations must be issued within 30 days of the authorization request.	When a request for an inpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized. We do not require fail first therapy; we require that the request meets clinical necessity per evidence-based guidelines.
Outpatient, Out-of-Network: Office Visits:	All Out-Of-Network services require prior authorization. Retrospective reviews must be submitted within 90 days of the date of service. Retrospective determinations must be issued within 30 days of the receipt date.	All Out-Of-Network services require prior authorization. Retrospective reviews must be submitted within 90 days of the date of service. Retrospective determinations must be issued within 30 days of the receipt date.	There are no requirements for fail first therapy. When a request for an outpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.
Outpatient, Out-of-Network: Other Items and Services:	All Out-Of-Network services require prior authorization. Retrospective reviews must be submitted within 90 days of the date of service. Retrospective	All Out-Of-Network services require prior authorization. Retrospective reviews must be submitted within 90 days of the date of service. Retrospective	There are no requirements for fail first therapy. When a request for an outpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet

	determinations must be issued within 30 days of the receipt date.	determinations must be issued within 30 days of the receipt date. Pharmacy has weekly and monthly reports retrospectively review the Behavioral Health Claims along with the Substance Use Disorder (MAT) claims.	established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.
E. Emergency Services	No authorization required	No authorization required	
F. Pharmacy Services Include all services for which prior-authorization is required, any step-therapy or "fail first" requirements, any other NQTLs. Tier 1:		Behavioral Health Medication prescribed by a Behavioral Health Prescriber along with Substance Use Disorder Medications (MAT) in NJ are not subjected to Prior Authorization unless there is a safety issue. At that point, a PA will be required to Clinically Justify why FDA guidelines are not being followed. Behavioral Health medications are Gold Carded, and SUD (MAT) are not subjected to Drug Utilization Review. ABHNJ does not have a tiered formulary.	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
Tier 2:		x	
Tier 3:		x	
Tier 4:		x	
G. Prescription Drug Formulary Design- How are formulary decisions made for the diagnosis and medical necessary treatment of medical, mental health and substance use disorder conditions?		Behavioral Health Medication prescribed by a Behavioral Health Prescriber along with Substance Use Disorder Medications (MAT) in NJ are not subjected to Prior Authorization unless there is a safety issue. At that point, a PA will be required to Clinically Justify why FDA guidelines are not being followed. All Behavioral Health medications not prescribed by a BH provider are subjected to Aetna National Guidelines which are based on FDA Guidelines These are very few and far between since most BH claims are prescribed by BH providers.	

Describe the pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step therapy.		Pharmacy is governed by State mandates in NJ for BH and SUD so no Pharmacy Mgmt is needed except for the very few BH claims that are not prescribed by BH providers.	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
What disciplines, such as primary care physicians (internists and pediatricians) and specialty physicians (including psychiatrists) and pharmacologists, are involved in the development of the formulary for medications to treat medical, mental health and substance use disorder conditions.		All medications that are added to the formulary are done through the Pharmacy and Therapeutics Committee. This service has been delegated to CVS /Caremark. However, Aetna Better Health does have a formulary workgroup. The Medicaid Formulary Workgroup is comprised of pharmacists and physicians with different specialties. This workgroup reviews the formulary recommendations that are presented to the CVS Caremark P&T. The CVS Caremark National P and T Committee consist of at least ten voting members. These are External Clinical Experts from a variety of medical specialties including high-volume specialty physicians and pharmacist. A majority of CVS Caremark National P and T Committee members are actively practicing pharmacists and physicians. At least one P and T Committee practicing pharmacist and one practicing physician is an expert in the care of elderly or disabled persons. The CVS Caremark National P and T Committee is comprised of members representing a sufficient number of clinical specialties to	

		adequately meet the needs of the member, including psychiatrist, pediatricians, and/ or other mental Health prescribing practitioners. Aetna Better Health of NJ does also have a dedicated Mailbox (ABHNJNationalPandTCommittee@AETNA.com for Providers to provide input into the Formulary. This mailbox is monitored by the Plan's Pharmacy Director. The input from the Providers is forwarded to the Formulary workgroup where it is reviewed. If it is felt to be relative it is then added to the workgroup's comments provided to the CVS/Caremark P and T committee.	
H. Case Management What case management services are available?		Case management is integrated, and staff are trained on physical health and behavioral health. In addition, the health plan has 2 behavioral health case managers to assist and support the members with complex needs. The health plan also has a peer support specialist who assists members with substance use issues.	
What case management services are required?		Aetna must provide coordination of behavioral health services that are covered under the health plan with other clinically appropriate behavioral health services that are funded through Medicaid State Plan	

What are the eligibility criteria for case management services?		Any member enrolled in the health plan is eligible for case management services along with their consent.	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
I. Process for Assessment of New Technologies Definition of experimental/investigational:	The definition of experimental and investigational: <u>Definitions</u> The following words and phrases when used in this Certificate shall have, unless the context clearly indicates otherwise, the meaning given to them below: Experimental or Investigational Procedures. Services or supplies that are, as determined by HMO, experimental. A drug, device, procedure or treatment will be determined to be experimental if: 1. there is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or 2. required FDA approval has not been granted for marketing; or 3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or 4. the written protocol or protocol(s) used by the	The definition of experimental and investigational: <u>Definitions</u> The following words and phrases when used in this Certificate shall have, unless the context clearly indicates otherwise, the meaning given to them below: Experimental or Investigational Procedures. Services or supplies that are, as determined by HMO, experimental. A drug, device, procedure or treatment will be determined to be experimental if: 1. there is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or 2. required FDA approval has not been granted for marketing; or 3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or 4. the written protocol or protocol(s) used by the	

	treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or 5. it is not of proven benefit for the specific diagnosis or treatment of a Member's particular condition; or 6. it is not generally recognized by the Medical Community as effective or appropriate for the specific diagnosis or treatment of a Member's particular condition; or 7. it is provided or performed in special settings for research purposes. Also, this exclusion will not apply with respect to drugs that: • Have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or • are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute. • If Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.	treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or 5. it is not of proven benefit for the specific diagnosis or treatment of a Member's particular condition; or 6. it is not generally recognized by the Medical Community as effective or appropriate for the specific diagnosis or treatment of a Member's particular condition; or 7. it is provided or performed in special settings for research purposes. Also, this exclusion will not apply with respect to drugs that: • Have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or • are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute. • If Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.	
Qualifications of individuals evaluating new technologies:	The Aetna Clinical Policy Council reviews and approves the CPBs. The Clinical Policy Council is comprised of Aetna pharmacists and medical directors from the various clinical areas of the company that uses the CPBs.	The Aetna Clinical Policy Council reviews and approves the CPBs. The Clinical Policy Council is comprised of Aetna pharmacists and medical directors from the various clinical areas of the company that uses the CPBs.	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
Evidence consulted in evaluating new technologies:	Summarize the plan's applicable NQTLs, including any variations by benefit. Aetna's Clinical Policy Bulletins (CPBs) are based on evidence in the peer-reviewed published medical literature, technology assessments and structured evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies.	Summarize the plan's applicable NQTLs, including any variations by benefit. Aetna's Clinical Policy Bulletins (CPBs) are based on evidence in the peer-reviewed published medical literature, technology assessments and structured evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*. Authorization requests that do not meet criteria for the requested service, or for which there are no established medical necessity criteria, are presented to a medical director for review. The medical director conducting the review must have clinical expertise in treating the member's condition or disease and be qualified by training, experience and certification/licensure to conduct the prior authorization functions in accordance with state and federal regulations. The medical director reviews the service request, the member's need, and the clinical information presented. Using the approved criteria and medical director's clinical judgment, a determination is made to approve, deny or reduce the service. Only a medical director can reduce or deny a request for service based on a medical necessity review.8 If all applicable medical necessity criteria are not clear enough to make a determination or the requested service is not addressed by the standard criteria or Aetna CPBs, the medical director may submit an email request for a position determination to the Aetna Clinical Policy Review Unit [MAM2] The Aetna Clinical Policy Review Unit researches literature applicable to the specific request and, when a determination is reached, responds to the medical director.

J. Standards for provider credentialing and contracting			
Is the provider network open or closed?	Provider network is open	Provider network is open	
What are the credentialing standards for physicians?	We credential all physicians following NCQA, CMS and the state's credentialing standards. The following factors are considered and primary sources verified as necessary and required: • Licensure and/or certification verified through state licensing boards in geographical areas where network practitioners will care for our members • Board certifications (when applicable) • Loss of/limitation of hospital admitting privileges (when applicable) • Current professional liability coverage • Drug Enforcement Agency (DEA) and state controlled-drug substance registration, when applicable, through verification by the U.S. Department of Commerce National Technical Information Service (when applicable) • Disciplinary history or adverse actions related to licensure and DEA registration, which we query through state licensing boards and the National Practitioner Databank (NPDB) • Malpractice insurance claim history to examine any possible trends and to look for evidence that might suggest any probable substandard professional performance in the future • Mental and physical health to determine if the practitioner's history might suggest any probable substandard professional performance in the future • Participation in government programs such as	We credential all physicians following NCQA, CMS and the state's credentialing standards. The following factors are considered and primary sources verified as necessary and required: • Licensure and/or certification verified through state licensing boards in geographical areas where network practitioners will care for our members • Board certifications (when applicable) • Loss of/limitation of hospital admitting privileges (when applicable) • Current professional liability coverage • Drug Enforcement Agency (DEA) and state controlled-drug substance registration, when applicable, through verification by the U.S. Department of Commerce National Technical Information Service (when applicable) • Disciplinary history or adverse actions related to licensure and DEA registration, which we query through state licensing boards and the National Practitioner Databank (NPDB) • Malpractice insurance claim history to examine any possible trends and to look for evidence that might suggest any probable substandard professional performance in the future • Mental and physical health to determine if the practitioner's history might suggest any probable substandard professional performance in the future • Participation in government programs such as	

	Medicare or Medicaid • Professional education and training through verification by the American Medical Association (AMA) Masterfile, American Osteopathic Association (AOA) and specialty board or specific residency/training program (highest level of education, depending on practitioner type) • Work history	Medicare or Medicaid • Professional education and training through verification by the American Medical Association (AMA) Masterfile, American Osteopathic Association (AOA) and specialty board or specific residency/training program (highest level of education, depending on practitioner type) • Work history	
What are the credentialing standards for licensed non-physician providers? Specify type of provider and standards, e.g., nurse practitioners, physician assistants, psychologists, clinical social workers.	ABH New Jersey requires that all practitioners be credentialed. Thus, we also credential these individuals following NCQA, CMS and state guidelines. The following factors are considered and primary sources verified as necessary and required: • Licensure and/or certification verified through state licensing boards in geographical areas where network practitioners will care for our members • Board certifications (when applicable) • Loss of/limitation of hospital admitting privileges (when applicable) • Current professional liability coverage • Drug Enforcement Agency (DEA) and state controlled-drug substance registration, when applicable, through verification by the U.S. Department of Commerce National Technical Information Service (when applicable) • Disciplinary history or adverse actions related to licensure and DEA registration, which we query through state licensing boards and the National Practitioner Databank (NPDB) • Malpractice insurance claim history to examine any possible trends and to look for evidence that might suggest any probable substandard professional performance in the future • Mental and physical health to determine if the practitioner's history might suggest any probable	ABH New Jersey requires that all practitioners be credentialed. Thus, we also credential these individuals following NCQA, CMS and state guidelines. The following factors are considered and primary sources verified as necessary and required: • Licensure and/or certification verified through state licensing boards in geographical areas where network practitioners will care for our members • Board certifications (when applicable) • Loss of/limitation of hospital admitting privileges (when applicable) • Current professional liability coverage • Drug Enforcement Agency (DEA) and state controlled-drug substance registration, when applicable, through verification by the U.S. Department of Commerce National Technical Information Service (when applicable) • Disciplinary history or adverse actions related to licensure and DEA registration, which we query through state licensing boards and the National Practitioner Databank (NPDB) • Malpractice insurance claim history to examine any possible trends and to look for evidence that might suggest any probable substandard professional performance in the future • Mental and physical health to determine if the practitioner's history might suggest any probable	

	substandard professional performance in the future • Participation in government programs such as Medicare or Medicaid • Professional education and training through verification by the American Medical Association (AMA) Masterfile, American Osteopathic Association (AOA) and specialty board or specific residency/training program (highest level of education, depending on practitioner type) • Work history Additional information and specifics per provider type can be found in the attached QM policy 53	substandard professional performance in the future • Participation in government programs such as Medicare or Medicaid • Professional education and training through verification by the American Medical Association (AMA) Masterfile, American Osteopathic Association (AOA) and specialty board or specific residency/training program (highest level of education, depending on practitioner type) • Work history Additional information and specifics per provider type can be found in the attached QM policy 53	
What are the credentialing/contracting standards for unlicensed personnel; e.g., home health aides, qualified autism service professionals and paraprofessionals?	ABH New Jersey requires that all practitioners be credentialed. Thus, we also credential these individuals following NCQA, CMS and state guidelines. The following factors are considered, and primary sources verified as necessary and required: * Current unencumbered state license/certification or Certificate of Occupancy * Good standing with Medicare and Medicaid, as appropriate, on anyone (1) of the lists below: 1. Office of Inspector General (OIG) sanctions 2. Federal Excluded Parties List System (EPLS) 3. State or federal debarment lists * Business Requirements: * Business Criteria gathered during the credentialing process includes: 1. W-9 form 2. Disclosure of Ownership 3. Employment Qualification Attestation form	ABH New Jersey requires that all practitioners be credentialed. Thus, we also credential these individuals following NCQA, CMS and state guidelines. The following factors are considered, and primary sources verified as necessary and required: * Current unencumbered state license/certification or Certificate of Occupancy * Good standing with Medicare and Medicaid, as appropriate, on anyone (1) of the lists below: 1. Office of Inspector General (OIG) sanctions 2. Federal Excluded Parties List System (EPLS) 3. State or federal debarment lists * Business Requirements: * Business Criteria gathered during the credentialing process includes: 1. W-9 form 2. Disclosure of Ownership 3. Employment Qualification Attestation form	

	4. State business licenses 5. Current professional liability insurance in adequate amounts as specified by Aetna Medicaid Administrators 6. Business entity information (state tax certification or trade name registration) 7. Policies related to pre-employment criminal background checks 8. Policies for addressing complaints and grievances	4. State business licenses 5. Current professional liability insurance in adequate amounts as specified by Aetna Medicaid Administrators 6. Business entity information (state tax certification or trade name registration) 7. Policies related to pre-employment criminal background checks 8. Policies for addressing complaints and grievances	
K. Exclusions for Failure to Complete a			

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
Course of Treatment Does the Plan exclude benefits for failure to complete treatment?	There are no exclusions of benefits for the failure to complete treatment.	There are no exclusions of benefits for the failure to complete treatment.	
L. Restrictions that limit duration or scope of benefits for services Does the Plan restrict the geographic location in which services can be received, e.g., service area, within California, within the United States?	There are no geographic location restrictions for any emergency services, including emergency acute inpatient admissions. The state restrictions for non-emergency treatment include providers being enrolled with the state as a Medicaid provider. The member must live in NJ to be eligible for NJ Medicaid benefits. If the member is out of State for longer than 30 days, they will need to be reported to the State. Pharmacy does allow the member to fill their prescriptions at any CVS network pharmacies regardless of what State that Pharmacy is housed in. It also has recognized that some members choose to rehab out of State and continue to receive NJ benefits at that time. Based on medical needs, members can services provided in another state if pre-authorized	There are no geographic location restrictions for any emergency services, including emergency acute inpatient admissions. The state restrictions for non-emergency treatment include providers being enrolled with the state as a Medicaid provider. The member must live in NJ to be eligible for NJ Medicaid benefits. If the member is out of State for longer than 30 days, they will need to be reported to the State. Pharmacy does allow the member to fill their prescriptions at any CVS network pharmacies regardless of what State that Pharmacy is housed in. It also has recognized that some members choose to rehab out of State and continue to receive NJ benefits at that time. Based on medical needs, members can services provided in another state if pre-authorized	

Does the Plan restrict the type(s) of facilities in which enrollees can receive services?	No restrictions	No restrictions	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
M. Does the Plan restrict the types of provider specialties that can provide certain M/S and/or MH/SUD benefits?	Appropriate licensure is required to provide services within the scope of treatment being offered.	Appropriate licensure is required to provide services within the scope of treatment being offered.	

Federal Mental Health Parity and Addiction Equity Filing Table 5: Non-Quantitative Treatment Limitations

Submit a separate form for each benefit plan design.

A. Plan Name: Aetna Better Health of NJ		B. Date: 03/01/2025
C. Contact Name: Dr. Sadijah Husain	D. Telephone Number: 609-282-8230	E. Email: husains@aetna.com
F. Line of Business (HMO, EPO, POS, PPO): HMO		
G. Contract Type (large group, small group, individual): large group		
H. Benefit Plan Effective Date: 01/01/2015		I. Benefit Plan Design(s) Identifier(s):[1]

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
A. Definition of Medical Necessity What is the definition of medical necessity?	Medical necessity is defined as a service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the provider in accordance with Aetna Better Health of New Jersey's guidelines, policies or procedures, for the diagnosis or treatment of a covered illness, condition or injury, for the prevention of future disease, to assist in the member's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth. Medically necessary services are those for	Medical necessity is defined as a service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the provider in accordance with Aetna Better Health of New Jersey's guidelines, policies or procedures, for the diagnosis or treatment of a covered illness, condition or injury, for the prevention of future disease, to assist in the member's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth. Medically necessary services are those for which there is no other equally	

	which there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the member. A decision about coverage for a requested service based on whether the service is clinically appropriate and/or needed based on a member's circumstances. MCG Guidelines (formerly Milliman Care Guidelines), including Chronic Care Guidelines, are evidence-based clinical guidelines that are updated annually. They support prospective, concurrent, and retrospective reviews; proactive care management; discharge planning; patient education, and quality initiatives. Aetna Clinical Policy Bulletins (CPBs) are based on evidence in the peer-reviewed published medical literature, technology assessments and structured evidence reviews, evidence-based consensus statements, expert opinions of health care practitioners/providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies.	effective, more conservative or substantially less costly course of treatment available or suitable for the member. A decision about coverage for a requested service based on whether the service is clinically appropriate and/or needed based on a member's circumstances. MCG Guidelines (formerly Milliman Care Guidelines), including Chronic Care Guidelines, are evidence-based clinical guidelines that are updated annually. They support prospective, concurrent, and retrospective reviews; proactive care management; discharge planning; patient education, and quality initiatives. Aetna Clinical Policy Bulletins (CPBs) are based on evidence in the peer-reviewed published medical literature, technology assessments and structured evidence reviews, evidence-based consensus statements, expert opinions of health care practitioners/providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies. Behavioral Health Medications for members prescribed by Behavioral Health Providers are Gold-Carded in NJ. Meaning, unless they have some sort of safety issue, for instance, above Max dose, Drug to Drug Interaction, Duplication, out of the normal FDA age guidelines it will pay at Point of Sale without disruption. Any Behavioral Health medications that are prescribed by Non-Behavioral Health Providers will be subject to Aetna Behavior Health guidelines which describes Medical Necessity. Medical Necessity is determined by FDA guidelines. SUD in NJ is dictated by a State mandated protocol. Once again there is no DUR to prove Medical Necessity unless again the claim has some sort of safety issue at POS. At that point the claim will stop for clinical justification to override the FDAs guidelines.	

[1] Use the same benefit plan design identifier(s) as for Tables 1-4.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
B. Prior-authorization Review Process Include all services for which prior- authorization is required. Describe any step- therapy or "fail first" requirements and requirements for submission of treatment request forms or treatment plans. Inpatient, In-Network:	All elective inpatient service requires an authorization. Emergency admission to a hospital does not require prior authorization. Inpatient care requires authorization, which is entered in the course of concurrent review, not prior to admission. All inpatient benefits are reviewed against MCG guidelines. No benefit requires fail first therapy;	All inpatient service require an authorization. Emergency admission to a hospital does not require prior authorization. Inpatient care requires authorization, which is entered in the course of concurrent review, not prior to admission. All inpatient benefits are reviewed against MCG and ASAM guidelines. No benefit requires fail first therapy; Behavioral Health Medications prescribed by a Behavioral Health Prescriber along with Substance Use Disorder Medications (MAT) in NJ are not subjected to Prior Authorization unless there is a safety issue. At that point, a PA will be required to Clinically Justify why FDA guidelines are not being followed	All elective inpatient service requires an authorization. Emergency admission to a hospital does not require prior authorization. Inpatient care requires authorization, which is entered in the course of concurrent review, not prior to admission. All inpatient benefits are reviewed against MCG or ASAM guidelines. No benefit requires fail first therapy;
Outpatient, In-Network: Office Visits:	No authorization required	No authorization required	
Outpatient, In-Network: Other Outpatient Items and Services:	Outpatient Services that require prior authorization vary, based upon the code, and are not location specific. We encourage providers to utilize the ProPAT system to check the code specific listings for details. The following services are examples of selected services requiring precertification; Surgical services, Home based services including hospice, Therapies (PT, OT, speech), Imaging such as MRI and MRA, DME (wheelchairs/hospital beds), Orthotics / Prosthetics.	Outpatient Services that require prior authorization vary, based upon the code, and are not location specific. We encourage providers to utilize the ProPAT system to check the code specific listings for details. The following services are examples of selected outpatient services requiring precertification: substance use disorder partial care, substance use disorder intensive outpatient programs, mental health partial care, and adult mental health rehabilitation. All	All outpatient benefits are reviewed against guidelines. Many guidelines include first steps that should be failed before the service of interest would be considered medically necessary. No benefit requires fail first therapy. There are no requirements for fail first therapy. When a request for an outpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a

	Evidence based guidelines are utilized to make all clinical decisions.	codes are reviewed by legal at the National level for parity compliance. Evidence based guidelines are utilized to make all clinical decisions.	request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.
Inpatient, Out-of-Network:	All elective inpatient service requires an authorization. Emergency admission to a hospital does not require prior authorization. Inpatient care requires authorization, which is entered in the course of concurrent review (see below), not prior to admission.	All inpatient services require an authorization. Emergency admission to a hospital does not require prior authorization. Inpatient care requires authorization, which is entered in the course of concurrent review (see below), not prior to admission	When a request for an inpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized. We do not require fail first therapy; we require that the request meets clinical necessity per evidence based guidelines.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
Outpatient, Out-of-Network: Office Visits:	All Out-Of-Network services require prior authorization	All Out-Of-Network services require prior authorization	All outpatient benefits are reviewed against guidelines. We do not require fail first therapy; we require that the request meets clinical necessity per evidence-based guidelines.
Outpatient, Out-of-Network: Other Items and Services:	All Out-Of-Network services require prior authorization	All Out-Of-Network services require prior authorization	All outpatient benefits are reviewed against guidelines. There are no requirements for fail first therapy. When a request for an outpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.
C. Concurrent Review Process, including frequency and penalties for all services. Describe any step-therapy or "fail first" requirements and requirements for submission of treatment request forms or treatment plans. Inpatient, In-Network:	Concurrent reviews of acute hospitalizations are conducted as dictated by the member's clinical condition, either on-site or by telephone, facsimile or provider portal, and may occur up to seven (7) days a week on a schedule dictated by the member's diagnosis or condition or contractual obligation. If the initial request includes enough clinical information to render a decision, the request is completed within twenty-four (24) hours. If additional information is required, that is requested within 24 hours of receipt of initial request, and a decision is	Concurrent reviews of acute hospitalizations are conducted as dictated by the member's clinical condition, either on-site or by telephone, facsimile or provider portal, and may occur up to seven (7) days a week on a schedule dictated by the member's diagnosis or condition or contractual obligation. If the initial request includes enough clinical information to render a decision, the request is completed within twenty-four (24) hours. If additional information is required, that is requested within 24 hours of receipt of initial request, and a decision is	When a request for a continued inpatient services is received it is reviewed against evidence based clinical guidelines by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.

	rendered no more than 72 hours from receipt of original request The facility providing the inpatient services should notify the Aetna Better Health Prior Authorization department within twenty-four (24) hours of the member's admission. Aetna Better Health may authorize covered and medically necessary inpatient services provided that the following criteria are met: The member is enrolled and eligible on the date(s) of service, Aetna Better Health's notification and prior authorization requirements are met and the concurrent or retrospective review of the member's records indicates that the inpatient placement is appropriate based on medical necessity criteria. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.	rendered no more than 72 hours from receipt of original request. The facility providing the inpatient services should notify the Aetna Better Health Prior Authorization department within twenty-four (24) hours of the member's admission. Aetna Better Health may authorize covered and medically necessary inpatient services provided that the following criteria are met: The member is enrolled and eligible on the date(s) of service, Aetna Better Health's notification and prior authorization requirements are met and the concurrent or retrospective review of the member's records indicates that the inpatient placement is appropriate based on medical necessity criteria. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.	
Outpatient, In-Network: Office Visits:	No authorization required	No authorization required	
Outpatient, In-Network: Other Outpatient Items and Services:	Outpatient Services that require prior authorization vary, based upon the code, and are not location specific. We encourage providers to utilize the ProPAT system to check the code specific listings for details. The following services are examples of selected services requiring precertification; Surgical services, Home based services including hospice, Therapies (PT, OT, speech), Imaging such as MRI and MRA, DME	Outpatient Services that require prior authorization vary, based upon the code, and are not location specific. We encourage providers to utilize the ProPAT system to check the code specific listings for details. The following services are examples of selected outpatient services requiring precertification: substance use disorder partial care, substance use disorder intensive outpatient programs, mental health partial care,	All outpatient benefits are reviewed against guidelines. There are no requirements for fail first therapy. When a request for an outpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique

	(wheelchairs/hospital beds), Orthotics / Prosthetics. Evidence based guidelines are utilized to make all clinical decisions.	and adult mental health rehabilitation. All codes are reviewed by legal at the National level for parity compliance. Evidence based guidelines are utilized to make all clinical decisions.	clinical situation to assure that all medically necessary services are authorized.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
Inpatient, Out-of-Network:	Prior Authorization is not required for emergency admission to a hospital. Concurrent reviews of acute hospitalizations are conducted as dictated by the member's clinical condition, either on-site or by telephone, facsimile or provider portal and may occur up to seven (7) days a week on a schedule dictated by the member's diagnosis or condition or contractual obligation. If the initial request includes enough clinical information to render a decision, the request is completed within twenty-four (24) hours. If additional information is required, that is requested within 24 hours of receipt of initial request, and a decision is rendered no more than 72 hours from receipt of original request The facility providing the inpatient services should notify the Aetna Better Health Prior Authorization department within twenty-four (24) hours of the member's admission. Aetna Better Health may authorize covered and medically necessary inpatient services provided that the following criteria are met: The member is enrolled and eligible on the date(s) of service, Aetna Better Health's notification and prior authorization requirements are met and the concurrent or retrospective review of the member's records indicates that	Prior Authorization is not required for emergency admission to a hospital. Concurrent reviews of acute hospitalizations are conducted as dictated by the member's clinical condition, either on-site or by telephone, facsimile, or provider portal, and may occur up to seven (7) days a week on a schedule dictated by the member's diagnosis or condition or contractual obligation. If the initial request includes enough clinical information to render a decision, the request is completed within twenty-four (24) hours. If additional information is required, that is requested within 24 hours of receipt of initial request, and a decision is rendered no more than 72 hours from receipt of original request The facility providing the inpatient services should notify the Aetna Better Health Prior Authorization department within twenty-four (24) hours of the member's admission. Aetna Better Health may authorize covered and medically necessary inpatient services provided that the following criteria are met: The member is enrolled and eligible on the date(s) of service, Aetna Better Health's notification and prior authorization requirements are met and the concurrent or retrospective review of the member's records indicates that	When a request for continued inpatient services is received it is reviewed against evidence based clinical guidelines by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.

	the inpatient placement is appropriate based on medical necessity criteria. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.	the inpatient placement is appropriate based on medical necessity criteria. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.	
Outpatient, Out-of-Network: Office Visits:	All Out-Of-Network services require prior authorization	All Out-Of-Network services require prior authorization	There are no requirements for fail first therapy. When a request for an outpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.
Outpatient, Out-of-Network: Other Items and Services:	All Out-Of-Network services require prior authorization	All Out-Of-Network services require prior authorization	There are no requirements for fail first therapy. When a request for an outpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.
D. Retrospective Review Process, including timeline and penalties. Inpatient, In Network:	All elective inpatient service requires an authorization. Emergency admission to a hospital does not require prior authorization. Inpatient care requires authorization, which is entered in the course of concurrent review, not prior to admission.	All inpatient services require an authorization. Emergency admission to a hospital does not require prior authorization. Inpatient care requires authorization, which is entered in the course of concurrent review, not prior to admission.	When a request for an inpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of

	All inpatient benefits are reviewed against MCG guidelines. Many guidelines include first steps that should be failed before the service of interest should be considered medically necessary. No benefit requires fail first therapy; however clinical guidelines may include a series of steps prior to meeting medical necessity. Retrospective requests must be submitted within 90 days of the discharge. Retrospective determinations must be issued within 30 days of the authorization request.	All inpatient benefits are reviewed against MCG and ASAM guidelines. No benefit requires fail first therapy; however clinical guidelines may include a series of steps prior to meeting medical necessity. Retrospective requests must be submitted within 90 days of the discharge. Retrospective determinations must be issued within 30 days of the authorization request.	health as well as the unique clinical situation to assure that all medically necessary services are authorized. We do not require fail first therapy; we require that the request meets clinical necessity as per evidence-based guidelines
Outpatient, In-Network: Office Visits:	No authorization required	No authorization required	
Outpatient, In-Network: Other Outpatient Items and Services:	Outpatient Services that require prior authorization vary, based upon the code, and are not location specific. We encourage providers to utilize the ProPAT system to check the code specific listings for details. The following services are examples of selected services requiring precertification; Surgical services, Home based services including hospice, Therapies (PT, OT, speech), Imaging such as MRI and MRA, DME (wheelchairs/hospital beds), Orthotics / Prosthetics. Evidence based guidelines are utilized to make all clinical decisions, see below response. Retrospective reviews must be submitted within 90 days of the date of service. Retrospective determinations must be issued within 30 days of the receipt date.	Outpatient Services that require prior authorization vary, based upon the code, and are not location specific. We encourage providers to utilize the ProPAT system to check the code specific listings for details. The following services are examples of selected outpatient services requiring precertification: substance use disorder partial care, substance use disorder intensive outpatient programs, mental health partial care, and adult mental health rehabilitation. All codes are reviewed by legal at the National level for parity compliance. Evidence based guidelines are utilized to make all clinical decisions, see below response. Retrospective reviews must be submitted within 90 days of the date of service. Retrospective determinations must be issued within 30 days of the receipt date.	There are no requirements for fail first therapy. When a request for an outpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
Inpatient, Out-of-Network:	All elective inpatient service requires an authorization. Emergency admission to a hospital does not require prior authorization. Inpatient care requires authorization, which is entered in the course of concurrent review (see below), not prior to admission. Retrospective requests must be submitted within 90 days of the discharge. Retrospective determinations must be issued within 30 days of the authorization request.	All inpatient services require an authorization. Emergency admission to a hospital does not require prior authorization. Inpatient care requires authorization, which is entered in the course of concurrent review (see below), not prior to admission. Retrospective requests must be submitted within 90 days of the discharge. Retrospective determinations must be issued within 30 days of the authorization request.	When a request for an inpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized. We do not require fail first therapy; we require that the request meets clinical necessity per evidence-based guidelines.
Outpatient, Out-of-Network: Office Visits:	All Out-Of-Network services require prior authorization. Retrospective reviews must be submitted within 90 days of the date of service. Retrospective determinations must be issued within 30 days of the receipt date.	All Out-Of-Network services require prior authorization. Retrospective reviews must be submitted within 90 days of the date of service. Retrospective determinations must be issued within 30 days of the receipt date.	There are no requirements for fail first therapy. When a request for an outpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.
Outpatient, Out-of-Network: Other Items and Services:	All Out-Of-Network services require prior authorization. Retrospective reviews must be submitted within	All Out-Of-Network services require prior authorization. Retrospective reviews must be submitted within	There are no requirements for fail first therapy. When a request for an outpatient service is received it is reviewed against evidence based clinical guidelines through the prior auth process by clinical personnel. All cases are reviewed by

	90 days of the date of service. Retrospective determinations must be issued within 30 days of the receipt date.	90 days of the date of service. Retrospective determinations must be issued within 30 days of the receipt date. Pharmacy has weekly and monthly reports retrospectively review the Behavioral Health Claims along with the Substance Use Disorder (MAT) claims.	licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the unique clinical situation to assure that all medically necessary services are authorized.
E. Emergency Services	No authorization required	No authorization required	
F. Pharmacy Services Include all services for which prior-authorization is required, any step-therapy or "fail first" requirements, any other NQTLs. Tier 1:		Behavioral Health Medication prescribed by a Behavioral Health Prescriber along with Substance Use Disorder Medications (MAT) in NJ are not subjected to Prior Authorization unless there is a safety issue. At that point, a PA will be required to Clinically Justify why FDA guidelines are not being followed. Behavioral Health medications are Gold Carded, and SUD (MAT) are not subjected to Drug Utilization Review. ABHNJ does not have a tiered formulary.	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
Tier 2:		x	
Tier 3:		x	
Tier 4:		x	
G. Prescription Drug Formulary Design- How are formulary decisions made for the diagnosis and medical necessary treatment of medical, mental health and substance use disorder conditions?		Behavioral Health Medication prescribed by a Behavioral Health Prescriber along with Substance Use Disorder Medications (MAT) in NJ are not subjected to Prior Authorization unless there is a safety issue. At that point, a PA will be required to Clinically Justify why FDA guidelines are not being followed. All Behavioral Health medications not prescribed by a BH provider are subjected to Aetna National Guidelines which are based on FDA Guidelines These are very few and far between since most BH claims are prescribed by BH providers.	

Describe the pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step therapy.		Pharmacy is governed by State mandates in NJ for BH and SUD so no Pharmacy Mgmt is needed except for the very few BH claims that are not prescribed by BH providers.	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
What disciplines, such as primary care physicians (internists and pediatricians) and specialty physicians (including psychiatrists) and pharmacologists, are involved in the development of the formulary for medications to treat medical, mental health and substance use disorder conditions.		All medications that are added to the formulary are done through the Pharmacy and Therapeutics Committee. This service has been delegated to CVS /Caremark. However, Aetna Better Health does have a formulary workgroup. The Medicaid Formulary Workgroup is comprised of pharmacists and physicians with different specialties. This workgroup reviews the formulary recommendations that are presented to the CVS Caremark P&T. The CVS Caremark National P and T Committee consist of at least ten voting members. These are External Clinical Experts from a variety of medical specialties including high-volume specialty physicians and pharmacist. A majority of CVS Caremark National P and T Committee members are actively practicing pharmacists and physicians. At least one P and T Committee practicing pharmacist and one practicing physician is an expert in the care of elderly or disabled persons. The CVS	

		Caremark National P and T Committee is comprised of members representing a sufficient number of clinical specialties to adequately meet the needs of the member, including psychiatrist, pediatricians, and/ or other mental Health prescribing practitioners. Aetna Better Health of NJ does also have a dedicated Mailbox (ABHNJNationalPandTCommittee@AETNA.com for Providers to provide input into the Formulary. This mailbox is monitored by the Plan's Pharmacy Director. The input from the Providers is forwarded to the Formulary workgroup where it is reviewed. If it is felt to be relative it is then added to the workgroup's comments provided to the CVS/Caremark P and T committee.	
H. Case Management What case management services are available?		Case management is integrated, and staff are trained on physical health and behavioral health. In addition, the health plan has 2 behavioral health case managers to assist and support the members with complex needs. The health plan also has a peer support specialist who assists members with substance use issues.	
What case management services are required?		Aetna must provide coordination of behavioral health services that are covered under the health plan with other clinically appropriate behavioral health services that are funded through Medicaid State Plan	

What are the eligibility criteria for case management services?		Any member enrolled in the health plan is eligible for case management services along with their consent.	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
I. Process for Assessment of New Technologies Definition of experimental/investigational:	The definition of experimental and investigational: <u>Definitions</u> The following words and phrases when used in this Certificate shall have, unless the context clearly indicates otherwise, the meaning given to them below: Experimental or Investigational Procedures. Services or supplies that are, as determined by HMO, experimental. A drug, device, procedure or treatment will be determined to be experimental if: 1. there is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or	The definition of experimental and investigational: <u>Definitions</u> The following words and phrases when used in this Certificate shall have, unless the context clearly indicates otherwise, the meaning given to them below: Experimental or Investigational Procedures. Services or supplies that are, as determined by HMO, experimental. A drug, device, procedure or treatment will be determined to be experimental if: 1. there is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or	

	2. required FDA approval has not been granted for marketing; or 3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or 4. the written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or 5. it is not of proven benefit for the specific diagnosis or treatment of a Member's particular condition; or 6. it is not generally recognized by the Medical Community as effective or appropriate for the specific diagnosis or treatment of a Member's particular condition; or 7. it is provided or performed in special settings for research purposes. Also, this exclusion will not apply with respect to drugs that: • Have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or	2. required FDA approval has not been granted for marketing; or 3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or 4. the written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or 5. it is not of proven benefit for the specific diagnosis or treatment of a Member's particular condition; or 6. it is not generally recognized by the Medical Community as effective or appropriate for the specific diagnosis or treatment of a Member's particular condition; or 7. it is provided or performed in special settings for research purposes. Also, this exclusion will not apply with respect to drugs that: • Have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or	

	• are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute. • If Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.	• are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute. • If Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.	
Qualifications of individuals evaluating new technologies:	The Aetna Clinical Policy Council reviews and approves the CPBs. The Clinical Policy Council is comprised of Aetna pharmacists and medical directors from the various clinical areas of the company that uses the CPBs.	The Aetna Clinical Policy Council reviews and approves the CPBs. The Clinical Policy Council is comprised of Aetna pharmacists and medical directors from the various clinical areas of the company that uses the CPBs.	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
Evidence consulted in evaluating new technologies:	Summarize the plan's applicable NQTLs, including any variations by benefit. Aetna's Clinical Policy Bulletins (CPBs) are based on evidence in the peer-reviewed published medical literature, technology assessments and structured evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies.	Summarize the plan's applicable NQTLs, including any variations by benefit. Aetna's Clinical Policy Bulletins (CPBs) are based on evidence in the peer-reviewed published medical literature, technology assessments and structured evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*. Authorization requests that do not meet criteria for the requested service, or for which there are no established medical necessity criteria, are presented to a medical director for review. The medical director conducting the review must have clinical expertise in treating the member's condition or disease and be qualified by training, experience and certification/licensure to conduct the prior authorization functions in accordance with state and federal regulations. The medical director reviews the service request, the member's need, and the clinical information presented. Using the approved criteria and medical director's clinical judgment, a determination is made to approve, deny or reduce the service. Only a medical director can reduce or deny a request for service based on a medical necessity review.8 If all applicable medical necessity criteria are not clear enough to make a determination or the requested service is not addressed by the standard criteria or Aetna CPBs, the medical director may submit an email request for a position determination to the Aetna Clinical Policy Review Unit [MAM2] The Aetna Clinical Policy Review Unit researches literature applicable to the specific request and, when a determination is reached, responds to the medical director.

J. Standards for provider credentialing and contracting			
Is the provider network open or closed?	Provider network is open	Provider network is open	
What are the credentialing standards for physicians?	We credential all physicians following NCQA, CMS and the state's credentialing standards. The following factors are considered and primary sources verified as necessary and required: • Licensure and/or certification verified through state licensing boards in geographical areas where network practitioners will care for our members • Board certifications (when applicable) • Loss of/limitation of hospital admitting privileges (when applicable) • Current professional liability coverage • Drug Enforcement Agency (DEA) and state controlled-drug substance registration, when applicable, through verification by the U.S. Department of Commerce National Technical Information Service (when applicable) • Disciplinary history or adverse actions related to licensure and DEA registration, which we query through state licensing boards and the National Practitioner Databank (NPDB) • Malpractice insurance claim history to examine	We credential all physicians following NCQA, CMS and the state's credentialing standards. The following factors are considered and primary sources verified as necessary and required: • Licensure and/or certification verified through state licensing boards in geographical areas where network practitioners will care for our members • Board certifications (when applicable) • Loss of/limitation of hospital admitting privileges (when applicable) • Current professional liability coverage • Drug Enforcement Agency (DEA) and state controlled-drug substance registration, when applicable, through verification by the U.S. Department of Commerce National Technical Information Service (when applicable) • Disciplinary history or adverse actions related to licensure and DEA registration, which we query through state licensing boards and the National Practitioner Databank (NPDB) • Malpractice insurance claim history to examine	

	any possible trends and to look for evidence that might suggest any probable substandard professional performance in the future • Mental and physical health to determine if the practitioner's history might suggest any probable substandard professional performance in the future • Participation in government programs such as Medicare or Medicaid • Professional education and training through verification by the American Medical Association (AMA) Masterfile, American Osteopathic Association (AOA) and specialty board or specific residency/training program (highest level of education, depending on practitioner type) • Work history	any possible trends and to look for evidence that might suggest any probable substandard professional performance in the future • Mental and physical health to determine if the practitioner's history might suggest any probable substandard professional performance in the future • Participation in government programs such as Medicare or Medicaid • Professional education and training through verification by the American Medical Association (AMA) Masterfile, American Osteopathic Association (AOA) and specialty board or specific residency/training program (highest level of education, depending on practitioner type) • Work history	
What are the credentialing standards for licensed non-physician providers? Specify type of provider and standards, e.g., nurse practitioners, physician assistants, psychologists, clinical social workers.	ABH New Jersey requires that all practitioners be credentialed. Thus, we also credential these individuals following NCQA, CMS and state guidelines. The following factors are considered and primary sources verified as necessary and required: • Licensure and/or certification verified through state licensing boards in geographical areas where network practitioners will care for our members • Board certifications (when applicable) • Loss of/limitation of hospital admitting privileges (when applicable) • Current professional liability coverage • Drug Enforcement Agency (DEA) and state controlled-drug substance registration, when applicable, through verification by the U.S.	ABH New Jersey requires that all practitioners be credentialed. Thus, we also credential these individuals following NCQA, CMS and state guidelines. The following factors are considered and primary sources verified as necessary and required: • Licensure and/or certification verified through state licensing boards in geographical areas where network practitioners will care for our members • Board certifications (when applicable) • Loss of/limitation of hospital admitting privileges (when applicable) • Current professional liability coverage • Drug Enforcement Agency (DEA) and state controlled-drug substance registration, when applicable, through verification by the U.S.	

	Department of Commerce National Technical Information Service (when applicable) • Disciplinary history or adverse actions related to licensure and DEA registration, which we query through state licensing boards and the National Practitioner Databank (NPDB) • Malpractice insurance claim history to examine any possible trends and to look for evidence that might suggest any probable substandard professional performance in the future • Mental and physical health to determine if the practitioner's history might suggest any probable substandard professional performance in the future • Participation in government programs such as Medicare or Medicaid • Professional education and training through verification by the American Medical Association (AMA) Masterfile, American Osteopathic Association (AOA) and specialty board or specific residency/training program (highest level of education, depending on practitioner type) • Work history Additional information and specifics per provider type can be found in the attached QM policy 53	Department of Commerce National Technical Information Service (when applicable) • Disciplinary history or adverse actions related to licensure and DEA registration, which we query through state licensing boards and the National Practitioner Databank (NPDB) • Malpractice insurance claim history to examine any possible trends and to look for evidence that might suggest any probable substandard professional performance in the future • Mental and physical health to determine if the practitioner's history might suggest any probable substandard professional performance in the future • Participation in government programs such as Medicare or Medicaid • Professional education and training through verification by the American Medical Association (AMA) Masterfile, American Osteopathic Association (AOA) and specialty board or specific residency/training program (highest level of education, depending on practitioner type) • Work history Additional information and specifics per provider type can be found in the attached QM policy 53	
What are the credentialing/contracting standards for unlicensed personnel; e.g., home health aides, qualified autism service professionals and paraprofessionals?	ABH New Jersey requires that all practitioners be credentialed. Thus, we also credential these individuals following NCQA, CMS and state guidelines. The following factors are considered, and primary sources verified as necessary and required: * Current unencumbered state	ABH New Jersey requires that all practitioners be credentialed. Thus, we also credential these individuals following NCQA, CMS and state guidelines. The following factors are considered, and primary sources verified as necessary and required: * Current unencumbered state	

	license/certification or Certificate of Occupancy * Good standing with Medicare and Medicaid, as appropriate, on anyone (1) of the lists below: 1. Office of Inspector General (OIG) sanctions 2. Federal Excluded Parties List System (EPLS) 3. State or federal debarment lists * Business Requirements: * Business Criteria gathered during the credentialing process includes: 1. W-9 form 2. Disclosure of Ownership 3. Employment Qualification Attestation form 4. State business licenses 5. Current professional liability insurance in adequate amounts as specified by Aetna Medicaid Administrators 6. Business entity information (state tax certification or trade name registration) 7. Policies related to pre-employment criminal background checks 8. Policies for addressing complaints and grievances	license/certification or Certificate of Occupancy * Good standing with Medicare and Medicaid, as appropriate, on anyone (1) of the lists below: 1. Office of Inspector General (OIG) sanctions 2. Federal Excluded Parties List System (EPLS) 3. State or federal debarment lists * Business Requirements: * Business Criteria gathered during the credentialing process includes: 1. W-9 form 2. Disclosure of Ownership 3. Employment Qualification Attestation form 4. State business licenses 5. Current professional liability insurance in adequate amounts as specified by Aetna Medicaid Administrators 6. Business entity information (state tax certification or trade name registration) 7. Policies related to pre-employment criminal background checks 8. Policies for addressing complaints and grievances	
K. Exclusions for Failure to Complete a			

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
Course of Treatment Does the Plan exclude benefits for failure to complete treatment?	There are no exclusions of benefits for the failure to complete treatment.	There are no exclusions of benefits for the failure to complete treatment.	
L. Restrictions that limit duration or scope of benefits for services Does the Plan restrict the geographic location in which services can be received, e.g., service area, within California, within the United States?	There are no geographic location restrictions for any emergency services, including emergency acute inpatient admissions. The state restrictions for non-emergency treatment include providers being enrolled with the state as a Medicaid provider. The member must live in NJ to be eligible for NJ Medicaid benefits. If the member is out of State for longer than 30 days, they will need to be reported to the State. Pharmacy does allow the member to fill their prescriptions at any CVS network pharmacies regardless of what State that Pharmacy is housed in. It also has recognized that some members choose to rehab out of State and continue to receive NJ benefits at that time. Based on medical needs, members can services provided in another state if pre-authorized	There are no geographic location restrictions for any emergency services, including emergency acute inpatient admissions. The state restrictions for non-emergency treatment include providers being enrolled with the state as a Medicaid provider. The member must live in NJ to be eligible for NJ Medicaid benefits. If the member is out of State for longer than 30 days, they will need to be reported to the State. Pharmacy does allow the member to fill their prescriptions at any CVS network pharmacies regardless of what State that Pharmacy is housed in. It also has recognized that some members choose to rehab out of State and continue to receive NJ benefits at that time. Based on medical needs, members can services provided in another state if pre-authorized	

Does the Plan restrict the type(s) of facilities in which enrollees can receive services?	No restrictions	No restrictions	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
M. Does the Plan restrict the types of provider specialties that can provide certain M/S and/or MH/SUD benefits?	Appropriate licensure is required to provide services within the scope of treatment being offered.	Appropriate licensure is required to provide services within the scope of treatment being offered.	

NQTL ANALYSIS for MCOs	Horizon NJ Health (HNJH)	
Prior Authorization: Inpatient Services	**Behavioral Health (Mental Health and Substance Use Disorder Services)**	**Medical/Surgical Services**
List all inpatient benefits that require prior authorization	Per the State Contract, all inpatient benefits require prior authorization: Acute Inpatient Psychiatric Hospital - Short-term Care, Private Psychiatric Hospital, Acute General Hospital, Mental Health Residential, SUD Residential (ASAM 3.5) Adult Mental Health Rehabilitation Group Home (AMHR), Detoxification (ASAM 4.0), Sub-Acute Detoxification level (ASAM 3.7), Hospital-based Inpatient Withdrawal Management, Subacute Rehab.	Per the State Contract, all inpatient benefits for elective care require prior authorization: Acute Medical /Surgical elective Inpatient Hospital, Hospital-based Inpatient Withdrawal Management, Long term Acute Hospital ("LTACH"), Acute Rehabilitation, Sub-acute rehabilitation and Skilled nursing facility.
Processes, Strategies and Evidentiary Standards	**Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**	**Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**
	HNJH's process for prior authorization of Behavioral Health services is as follows: Clinical requests for the above services and levels of care are submitted to HNJH either telephonically, through an electronic portal, fax, or email. Licensed Behavioral Health clinicians evaluate against the appropriate evidenced-based clinical criteria guidelines: MCG®; American Society of Addiction Medicine ("ASAM") for Substance Use Disorder ("SUD") and Horizon Uniform Medical Policy to determine whether the requested level of care/service meets medical necessity. Cases that meet medical necessity criteria are approved by Behavioral Health clinicians. Cases that do not meet medical necessity criteria are referred to a medical director for organizational determination resulting in either an approval or adverse determination. HNJH's Behavioral Health utilization management department is comprised of licensed and non-licensed healthcare professionals including Psychiatrists, Registered Nurses, Licensed Clinical Social Workers, Licensed	HNJH's process for prior authorization of Medical/Surgical services is as follows: Clinical requests for the above services and levels of care are submitted to HNJH either telephonically or through an electronic portal, fax, or email. Licensed Registered nurses and licensed Physical Therapists evaluate against the appropriate evidenced-based clinical criteria guidelines: MCG®; Centers for Medicare and Medicaid Services ("CMS") - National Coverage Determinations ("NCD")/ Local Coverage Determinations ("LCD"), and Horizon Uniform Medical policy to determine whether the requested level of care/service meets medical necessity. Cases that meet medical necessity criteria are approved by licensed health care clinicians. Cases that do not meet medical necessity criteria are referred to a medical director for organizational determination resulting in either an approval or an adverse determination. HNJH's utilization management department is comprised of licensed and non-licensed healthcare

	Marriage and Family Therapists, Licensed Professional Counselors, Clinical Psychologists, BCBAs (Autism ABA Service), and Support Associates qualified to function within the utilization management program and the defined scope of their job descriptions. Physician Reviewers, known as Medical Directors are licensed and board certified. HNJH maintains compliance with the process and timeframes for medical necessity review and prior authorization consistent with state, federal, and NCQA accreditation requirements. In addition, Court mandated inpatient care is processed under the court order of the recommended treatment by the judge. HNJH's exceptions to the above process for prior authorization of Behavioral Health services are as follows: Exceptions are granted if there is a need for a service that our network providers/ hospitals cannot accommodate or there are geo access issues. Exceptions are granted when medically necessary to ensure there are no barriers to access to care.	professionals, including Physicians, Registered Nurses, Licensed Physical Therapists and Support Associates qualified to function within the utilization management program and the defined scope of their job descriptions. Physician Reviewers known as Medical Directors are licensed and board certified. HNJH maintains compliance with the process and timeframes for medical necessity review and prior authorization consistent with state, federal, and NCQA accreditation requirements. HNJH's exceptions to the above process for prior authorization of Medical/Surgical services are as follows: Exceptions are granted if there is a need for a service that our network providers/ hospitals cannot accommodate or there are geo access issues. Exceptions are granted when medically necessary to ensure there are no barriers to access to care.
	Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.	**Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.**
	Prior Authorization The Plan defines prior authorization as the process by which a request for coverage of health care services is assessed prior to a service or course of treatment, for appropriateness of the admission based upon the application of medical necessity. The prior authorization program is overseen by the following committees: Utilization Management/ Case Management Committee The Utilization Management/ Case Management Committee (UM/CMC) is responsible for the review of Medicare and Medicaid Management to support the Horizon vision statement of improving quality and enhancing patient experience. This committee is responsible for approving and providing direction	Prior Authorization The Plan defines prior authorization as the process by which a request for coverage of health care services is assessed prior to a service or course of treatment, for appropriateness of the admission based upon the application of medical necessity. The prior authorization program is overseen by the following committees: Utilization Management/ Case Management Committee The Utilization Management/ Case Management Committee (UM/CMC) is responsible for the review of Medicare and Medicaid Management to support the Horizon vision statement of improving quality and enhancing patient experience. This committee is responsible for approving and providing direction

	and recommendations for changes to Utilization Management (UM) policies, Care Management (CM) Policies, the UM and CM program descriptions, evaluations and work plans for the government programs line of business. The committee will promote the effective and efficient use of medical services. The committee will obtain important input from external participating providers on administrative and clinical issues The UM/CMC is charged with the review of the following, including, but not limited to: • Annual review and approval of the UM and CM Work Plans and evaluations • Annual review and approval of clinical criteria applied for medical necessity reviews • Monitoring of utilization/production data, including patterns of appropriate utilization including over and underutilization and overall performance • Annual review of administrative policies pertaining to UM and CM • Monitoring of UM and CM initiatives • Evaluation of medical director/physician advisor and nurse inter-rater reports • Monitoring of UM/CM compliance with external accreditation standards • Monitoring of UM/CM compliance with regulatory requirements • Monitoring of applicable patient safety data and initiatives • Update, review and approve Clinical Practice Guidelines • Quarterly review of UM Appeals Data The Utilization Management/Case Management Committee reports directly to the Quality Improvement Committee The Utilization Management/Case Management (UM/CM) Committee meets no less than 5 times per year and quarterly in joint sessions with the Physician Advisory Committee. Internal voting members on the committee to establish quorum include: • Medical Directors (5) • Director, Dental Operations • Director, Medicaid Care Management Programs • Director, Case Management and Clinical Operations,	and recommendations for changes to Utilization Management (UM) policies, Care Management (CM) Policies, the UM and CM program descriptions, evaluations and work plans for the government programs line of business. The committee will promote the effective and efficient use of medical services. The committee will obtain important input from external participating providers on administrative and clinical issues The UM/CMC is charged with the review of the following, including, but not limited to: • Annual review and approval of the UM and CM Work Plans and evaluations • Annual review and approval of clinical criteria applied for medical necessity reviews • Monitoring of utilization/production data, including patterns of appropriate utilization including over and underutilization and overall performance • Annual review of administrative policies pertaining to UM and CM • Monitoring of UM and CM initiatives • Evaluation of medical director/physician advisor and nurse inter-rater reports • Monitoring of UM/CM compliance with external accreditation standards • Monitoring of UM/CM compliance with regulatory requirements • Monitoring of applicable patient safety data and initiatives • Update, review and approve Clinical Practice Guidelines • Quarterly review of UM Appeals Data The Utilization Management/Case Management Committee reports directly to the Quality Improvement Committee The Utilization Management/Case Management (UM/CM) Committee meets no less than 5 times per year and quarterly in joint sessions with the Physician Advisory Committee. Internal voting members on the committee to establish quorum include: • Medical Directors (5) • Director, Dental Operations • Director, Medicaid Care Management Programs • Director, Case Management and Clinical Operations,

	Medicare • Director. Clinical Special Needs Plan • Director, Clinical Operations • Director, Clinical Behavioral Health Services • Director, Utilization Management • Director, Pharmacy • Director, Quality Management Clinical Operations GP External Voting members include: Board-certified participating physicians with diverse geographic and specialty representation and designated business leaders have been assigned voting privileges. Other medical and non-medical personnel may attend and participate without voting privileges. Physician Advisory Committee (PAC) The purpose of the Physician Advisory Committee (PAC) is to identify issues of concern to the physician community and opportunities for optimizing patient care. The function of PAC is to review and make recommendations to Horizon NJ Health's medical and administrative leadership concerning clinical and administrative issues of importance to the membership and participating practitioners of Horizon NJ Health. The committee will identify issues of concern to the participating medical community and assess clinical policies and programs in the context of current standards of care. This committee is defined by regulations of the New Jersey Office of Managed Health Care and is a subcommittee of the Quality Improvement Committee (QIC). This Committee reports its activities and recommendations to the QIC. The committee meets quarterly in joint sessions with the Utilization Management/Case Management (UM/CM) Committee. Additional meetings may be scheduled at the discretion of the chairperson to meet business needs. The committee is chaired by the Plan Executive Medical Director designated by the Chief Medical Officer. At least two providers on the committee shall maintain practices or provide services that predominantly serve Medicaid beneficiaries and other	Medicare • Director. Clinical Special Needs Plan • Director, Clinical Operations • Director, Clinical Behavioral Health Services • Director, Utilization Management • Director, Pharmacy • Director, Quality Management Clinical Operations GP External Voting members include: Board-certified participating physicians with diverse geographic and specialty representation and designated business leaders have been assigned voting privileges. Other medical and non-medical personnel may attend and participate without voting privileges. Physician Advisory Committee (PAC) The purpose of the Physician Advisory Committee (PAC) is to identify issues of concern to the physician community and opportunities for optimizing patient care. The function of PAC is to review and make recommendations to Horizon NJ Health's medical and administrative leadership concerning clinical and administrative issues of importance to the membership and participating practitioners of Horizon NJ Health. The committee will identify issues of concern to the participating medical community and assess clinical policies and programs in the context of current standards of care. This committee is defined by regulations of the New Jersey Office of Managed Health Care and is a subcommittee of the Quality Improvement Committee (QIC). This Committee reports its activities and recommendations to the QIC. The committee meets quarterly in joint sessions with the Utilization Management/Case Management (UM/CM) Committee. Additional meetings may be scheduled at the discretion of the chairperson to meet business needs. The committee is chaired by the Plan Executive Medical Director designated by the Chief Medical Officer. At least two providers on the committee shall maintain practices or provide services that predominantly serve Medicaid beneficiaries and other

	indigent populations, in addition to one or more other practicing providers on the committee who have experience and expertise in serving enrollees with long-term care and special needs. The committee meets at least quarterly. Its input and recommendations shall be employed to inform and direct Contractor quality management activities, policy, and operational changes. The physician committee members are all voting members, others may attend and participate without voting privileges. They include but are not limited to: • Medical Directors (5) • Director, Dental Operations • Director, Medicaid Care Management Programs • Director, Case Management and Clinical Operations, Medicare • Director. Clinical Special Needs Plan • Director, Clinical Operations • Director, Clinical Behavioral Health Services (2) • Director, Utilization Management • Director, Pharmacy • Director, Quality Management Clinical Operations GP External voting members include Board-certified participating physicians with diverse geographic and specialty representation and designated business leaders have been assigned voting privileges. Other medical and non-medical personnel may attend and participate without voting privileges. Why HNJH requires prior authorization: Horizon performs prospective review of select health care services to determine medical necessity and to ensure that service requests are being provided at the clinically appropriate level. Decisions on medical appropriateness are based on clinical/behavioral health criteria approved by Horizon. Why HNJH requires prior authorization: Certain non-emergency services require prior authorization based on medical appropriateness of the care requested as per the evidenced based medical necessity criteria MCG/ASAM. HNJH medical directors may have peer to peer discussions with	indigent populations, in addition to one or more other practicing providers on the committee who have experience and expertise in serving enrollees with long-term care and special needs. The committee meets at least quarterly. Its input and recommendations shall be employed to inform and direct Contractor quality management activities, policy, and operational changes. The physician committee members are all voting members, others may attend and participate without voting privileges. They include but are not limited to: • Medical Directors (5) • Director, Dental Operations • Director, Medicaid Care Management Programs • Director, Case Management and Clinical Operations, Medicare • Director. Clinical Special Needs Plan • Director, Clinical Operations • Director, Clinical Behavioral Health Services (2) • Director, Utilization Management • Director, Pharmacy • Director, Quality Management Clinical Operations GP External voting members include Board-certified participating physicians with diverse geographic and specialty representation and designated business leaders have been assigned voting privileges. Other medical and non-medical personnel may attend and participate without voting privileges. Why HNJH requires prior authorization: Horizon performs prospective review of select health care services to determine medical necessity and to ensure that service requests are being provided at the clinically appropriate level. Decisions on medical appropriateness are based on clinical/behavioral health criteria approved by Horizon. Why HNJH requires prior authorization: Certain non-emergency services require prior authorization based on medical appropriateness of the care as per the evidenced based medical necessity criteria- MCG/Horizon Uniform Medical Policy, CMS NCD/LCD. HNJH medical

	the servicing provider after an initial adverse determination is made for an HNJ H member. This review allows a medical director to obtain additional clinical information pertaining to a member's care to substantiate medical necessity and approve the services requested. The intent is to ensure our members have access to quality services appropriate to their needs. How the process may be modified to meet medical necessity: HNJH medical directors may have peer to peer discussions with the servicing provider after an initial adverse determination is made for a HNJH member in an attempt to obtain additional clinical information pertaining to the member's care to substantiate medical necessity and approve services requested. Prior authorizations are based solely on Medicaid eligibility and clinical necessity and may be overridden at any time if determined medically necessary.	directors may have peer to peer discussions with the servicing provider after an initial adverse determination is made for an HNJ H member. This review allows a medical director to obtain additional clinical information pertaining to a member's care to substantiate medical necessity and approve the services requested. The intent is to ensure our members have access to quality services appropriate to their needs. How the process may be modified to meet medical necessity: HNJH medical directors may have peer to peer discussions with the servicing provider after an initial adverse determination is made for a HNJH member in an attempt to obtain additional clinical information pertaining to the member's care to substantiate medical necessity and approve services requested. Prior authorizations are based solely on Medicaid eligibility and clinical necessity and may be overridden at any time if determined medically necessary.
	Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	**Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.**
	Evidence that supports the use of prior authorization: HNJH UM program uses the following objective, evidenced-based Clinical Criteria/Guidelines for services requiring medical necessity review: MCG®, Centers for Medicare and Medicaid Services ("CMS"), National Coverage Determinations/ Local Coverage Determinations, Horizon Uniform Medical Policies, and the American Society of Addiction Medicine ("ASAM") for SUD withdrawal management. The following factors considered when applying criteria to services received by a HNJH member include age, co-morbidities, complications, progress of treatment, psychosocial issues, culture, home environment and other situations as they arise. HNJH also considers the local delivery system available to members to ensure there are not barriers to care. These criteria sets are reviewed annually for appropriateness to	Evidence that supports the use of prior authorization: HNJH UM program uses the following objective, evidenced-based Clinical Criteria/Guidelines for services requiring medical necessity review: MCG®, Centers for Medicare and Medicaid Services ("CMS") National Coverage Determinations/ Local Coverage Determinations, and Horizon Uniform Medical Policies. The following factors considered when applying criteria to services received by a HNJH member include age, co-morbidities, complications, progress of treatment, psychosocial issues, culture, home environment and other situations as they arise. HNJH also considers the local delivery system available to members to ensure there are not barriers to care. These criteria sets are reviewed annually for appropriateness to the HNJH population need and updated as applicable when national and/or community-based clinical practice guidelines are

	the HNJH population's need and updated as applicable when national and/or community-based clinical practice guidelines are updated. The annual review process involves appropriate medical directors and community-based practitioners in developing, adopting and reviewing criteria. Members and providers are advised of the availability of criteria sets upon request, in notice of action / UM adverse determination letters, provider manuals, newsletters, the HNJH website, and member handbooks.	updated. The annual review process involves appropriate medical directors and community-based practitioners in developing, adopting and reviewing criteria. Members and providers are advised of the availability of criteria sets upon request, in notice of action / UM adverse determination letters, provider manuals, newsletters, the HNJH website, and member handbooks.

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Prior Authorization: Outpatient Services	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all outpatient benefits that require authorization	Outpatient services: • Partial Hospitalization (PHP) • Partial Care • Partial SUD (ASAM 2.5 • Intensive Outpatient (IOP) • IOP SUD (ASAM 2.1) • Adult Mental Health Rehabilitation (AMHR) Group Homes and Apartments • Applied Behavior Analysis (ABA) • Repetitive Transcranial Magnetic Stimulation (rTMS) • Electroconvulsive Therapy (ECT) • Psych Testing/Neuropsychological Testing • Medically Managed Detox (ASAM 4.0) • Medically Monitored Detox (SUD ASAM 3.7D) • Services by non-participating providers • OP Specialty Services	Outpatient Services: • Select outpatient elective surgery/procedures • Durable medical equipment • Home health services/home health aide, Assistant/Private Duty Nursing/Hospice • Home IV therapy • Chiropractic services after initial evaluation • Select chemotherapy (high dollar medical injectables including but not limited to chemotherapy, CarT and gene therapy • Radiation therapy • Radiology • Dialysis (excluding Medicare Advantage) • Outpatient therapies such as Cardiac rehab, Speech/Cognitive/Physical/Occupational Therapy • OB U/S not listed as part of GEMS program • Services requested by non-participating providers
	Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	**Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**
	HNJH's process for prior authorization of Behavioral Health services is as follows: Clinical requests for the above services and levels of care are submitted to HNJH either telephonically, through an electronic portal, fax, mail, which licensed Behavioral Health clinicians evaluate against the appropriate evidenced-based clinical criteria guidelines: MCG®; American Society of Addiction Medicine ("ASAM") for Substance Use Disorder ("SUD") and Horizon	HNJH's process for prior authorization of outpatient Medical/Surgical services is as follows: Clinical requests for the above services and levels of care are submitted to HNJH either telephonically or through an electronic portal, fax or email which licensed healthcare clinicians then evaluate the supporting clinical documentation provided against the appropriate evidenced-based clinical criteria guidelines: MCG® and Horizon Uniform Medical

	Uniform Medical Policy to determine whether the requested level of care/service meets medical necessity. HNJH maintains compliance with federal and state regulations and guidelines as well as NCQA health plan accreditation standards. Cases that meet medical necessity criteria are approved by Behavioral Health care clinicians. The cases that do not meet medical necessity criteria are referred to a medical director for organizational determination resulting in either an approval or adverse determination. HNJH's Behavioral Health utilization management department is comprised of licensed and non-licensed healthcare professionals including Psychiatrists, Registered Nurses, Licensed Clinical Social Workers, licensed Marriage and Family Therapists, licensed Professional Counselors, Clinical Psychologists, BCBAs (Autism ABA Service), and Support Associates qualified to function within the utilization management program and the defined scope of their job descriptions. Physician Reviewers, known as medical Directors are licensed and board certified. The process and timeframes for medical necessity review and prior authorization are consistent with state, federal, and NCQA accreditation requirements. HNJH's exceptions to the above process for prior authorization of Behavioral Health services are as follows: Exceptions are granted if there is a need for a service that our network providers/ hospitals cannot accommodate or there are geo access issues. Exceptions are granted when medically necessary to ensure there are no barriers to access to care. Prior authorizations are based solely on Medicaid eligibility and clinical necessity and may be overridden at any time if determined medically necessary.	Policy to determine whether the requested level of care/service meets medical necessity. HNJH maintains compliance with federal and state regulations andguidelines as well as NCQA health plan accreditation standards. The cases that meet medical necessity criteria are approved by licensed health care clinicians. Cases that do not meet medical necessity criteria are referred to a medical director for organizational determination resulting in either an approval or an adverse determination. HNJH's utilization management department is comprised of licensed and non-licensed healthcare professionals, including Physicians, Registered Nurses, licensed Physical Therapists and Support Associates qualified to function within the utilization management program and the defined scope of their job descriptions. Physician Reviewers known as medical directors are licensed and board certified. The process and timeframes for medical necessity review and prior authorization are consistent with the state, federal and accreditation requirements. HNJH's exceptions to the above process for prior authorization of Medical/Surgical services are as follows: Exceptions are granted if there is a need for a service our network providers/ hospitals cannot accommodate or there are geo access issues. Exceptions are granted when medically necessary to ensure there are no barriers to access of care. Prior authorizations are based solely on Medicaid eligibility and clinical necessity and may be overridden at any time if determined medically necessary.

Prior Authorization: Emergency Services	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all emergency benefits that require prior authorization and/or fail first therapy	Prior authorization for emergency services, either in-network or out-of network, is not required.	Prior authorization for emergency services, either in-network or out-of network, is not required.
List Processes, Strategies and Evidentiary Standards	**Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**	**Processes: Explain the process for prior authorization that isutilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**
	N/A	N/A
	Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.	**Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.**
	N/A	N/A
	Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized bythe plan.	**Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.**
	N/A	N/A

Prior Authorization: Pharmacy Services	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all Pharmacy benefits that require prior authorization	In regards only to Medicaid outpatient pharmacy benefit provided via retail pharmacies, prior authorization is applied for formulary exceptions and safety edits (e.g., quantity limits, therapeutic duplication). The approved HNJ formulary list is attached. Medications requiring prior authorization are denoted by an @.	In regards only to Medicaid outpatient pharmacy benefit provided via retail pharmacies, prior authorization is applied for formulary exceptions and safety edits (e.g., quantity limits, therapeutic duplication). The approved HNJ formulary list is attached. Medications requiring prior authorization are denoted by an @.
List Processes, Strategies and Evidentiary Standards	**Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**	**Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**
	Certain drugs require Prior Authorization/Medical Necessity Determination (PA/MND) review before coverage is approved. The PA/MND process helps ensure that only prescription medicines that are needed and clinically appropriate are approved for coverage. PA/MND also encourages the right use of certain prescription drugs, promotes standard treatment protocols, monitors prescription drug use that may have serious side effects and helps keep the cost of prescription drugs affordable. The Pharmaceutical Utilization Management (UM) Programs help ensure access to medically necessary, appropriate and cost-effective drug therapy. Some prescription medicines can only be used in certain doses based on age, sex and other factors. Dispensing limitations are set based on types of medicines and safety standards. HNJH follows recommendations of the FDA along with our analysis of prescription dispensing trends and clinical guidelines. Dispensing limitations are updated as needed. If a prescriber feels that a drug is medically necessary outside of the dispensing limitations, an exception can be requested by calling our Pharmacy Department at **1-800-682-9094** or completing and faxing an authorization form to the number	Certain drugs require Prior Authorization/Medical Necessity Determination (PA/MND) review before coverage is approved. The PA/MND process helps ensure that only prescription medicines that are needed and clinically appropriate are approved for coverage. PA/MND also encourages the right use of certain prescription drugs, promotes standard treatment protocols, monitors prescription drug use that may have serious side effects and helps keep the cost of prescription drugs affordable. The Pharmaceutical Utilization Management (UM) Programs help ensure access to medically necessary, appropriate and cost-effective drug therapy. Some prescription medicines can only be used in certain doses based on age, sex and other factors. Dispensing limitations are set based on types of medicines and safety standards. HNJH follows recommendations of the FDA along with our analysis of prescription dispensing trends and clinical guidelines. Dispensing limitations are updated as needed. If a prescriber feels that a drug is medically necessary outside of the dispensing limitations, an exception can be requested by calling our Pharmacy Department at **1-800-682-9094** or

	noted. If more information is required, HNJH will contact the prescribing physician. Formulary and Alternatives The formulary provides cost-effective pharmacotherapy based on prospective, concurrent and retrospective review of medication therapies and utilization. The medications included in the formulary are reviewed and approved by the Pharmacy and Therapeutics Committee, which includes practicing physicians and pharmacists from the Horizon NJ Health provider community. The Formulary List is updated annually and as changes are made or new medications are approved as of the date that formulary changes are put in place. Changes to the Formulary List are included in the provider newsletter mailed to all providers. In regard only to Medicaid outpatient pharmacy benefit provided via retail pharmacies, HNJH's Pharmacy prior authorization policy addresses prior authorization standards for formulary exceptions and when medications are prescribed beyond FDA established maximum daily dose guidelines. HNJH's drug utilization review policy addresses prospective/concurrent drug utilization review standards such as drug-drug interactions, early refills, therapeutic duplication, maximum daily dose, minimum daily dose, under-utilization, over- utilization, clinical abuse/misuse.	completing and faxing an authorization form to the number noted. If more information is required, HNJH will contact the prescribing physician. Formulary and Alternatives The formulary provides cost-effective pharmacotherapy based on prospective, concurrent and retrospective review of medication therapies and utilization. The medications included in the formulary are reviewed and approved by the Pharmacy and Therapeutics Committee, which includes practicing physicians and pharmacists from the Horizon NJ Health provider community. The Formulary List is updated annually and as changes are made or new medications are approved as of the date that formulary changes are put in place. Changes to the Formulary List are included in the provider newsletter mailed to all providers. In regard only to Medicaid outpatient pharmacy benefit provided via retail pharmacies, HNJH's Pharmacy prior authorization policy addresses prior authorization standards for formulary exceptions and when medications are prescribed beyond FDA established maximum daily dose guidelines. HNJH's drug utilization review policy addresses prospective/concurrent drug utilization review standards such as drug-drug interactions, early refills, therapeutic duplication, maximum daily dose, minimum daily dose, under-utilization, over- utilization, clinical abuse/misuse.
	Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.	**Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.**
	Prior authorization and drug utilization review are used to avoid drug-drug interactions, inappropriate dosage, contraindications, and patient safety. These policies are re-reviewed annually for	Prior authorization and drug utilization review are used to avoid drug-drug interactions, inappropriate dosage, contraindications, and patient safety. These policies are re-reviewed annually for

	any modifications needed to meet medical necessity. In addition, HNJH leverages the physicians and pharmacists who are part of external oversight committees, to determine what's medically necessary. This helps ensure that our medical necessity criteria and guidelines reflect community-prescribing standards. To help determine what's medically necessary, we have several programs, including Drug Dispensing Limitations, Drug Utilization Review (DUR) and Prior Authorization. Our Pharmacy and Therapeutics (P&T) Committee is made up of physicians, pharmacists and Horizon NJ Health professionals. The committee establishes PA/MND criteria for medicine after evaluating current published, peer-reviewed medical literature, expert opinions, specialty society recommendations and FDA-approved labeling information. Only this review can a prescribed drug be authorized and covered. PA/MND includes other programs to help ensure medical necessity: Generic Substitutions A patient must try a generic drug before an equal brand name drug can be considered medically necessary. When pharmacists enter a prescription, they will see if a PA/MND is required before a brand name drug may be covered and dispensed. You can ask for use of a brand name drug to be reviewed by a clinical reviewer/physician through our PA/MND process. Non-Formulary Medications PA/MND can be requested and will be reviewed by a clinical reviewer/physician if you feel that a non-formulary drug is medically necessary due to ineffectiveness of or intolerance to formulary alternatives. Step Therapy Step therapy requires that one or more drugs be tried before	any modifications needed to meet medical necessity. In addition, HNJH leverages the physicians and pharmacists who are part of external oversight committees, to determine what's medically necessary. This helps ensure that our medical necessity criteria and guidelines reflect community-prescribing standards. To help determine what's medically necessary, we have several programs, including Drug Dispensing Limitations, Drug Utilization Review (DUR) and Prior Authorization. Our Pharmacy and Therapeutics (P&T) Committee is made up of physicians, pharmacists and Horizon NJ Health professionals. The committee establishes PA/MND criteria for medicine after evaluating current published, peer-reviewed medical literature, expert opinions, specialty society recommendations and FDA-approved labeling information. Only this review can a prescribed drug be authorized and covered. PA/MND includes other programs to help ensure medical necessity: Generic Substitutions A patient must try a generic drug before an equal brand name drug can be considered medically necessary. When pharmacists enter a prescription, they will see if a PA/MND is required before a brand name drug may be covered and dispensed. You can ask for use of a brand name drug to be reviewed by a clinical reviewer/physician through our PA/MND process. Non-Formulary Medications PA/MND can be requested and will be reviewed by a clinical reviewer/physician if you feel that a non-formulary drug is medically necessary due to ineffectiveness of or intolerance to formulary alternatives. Step Therapy Step therapy requires that one or more drugs be tried before

	progressing to second-step drugs. These "first" - and corresponding "second"-step medicines are FDA-approved and are used to treat the same conditions. There may be times where a second-step medicine should be tried first. In these cases, PA/MND can be requested and will be reviewed by a clinical reviewer/physician through the PA/MND process. Medicines requiring step therapy are listed in the Formulary Guide. How the process can be modified: Some prescription medicines can only be used in certain doses based on age, sex and other factors. Dispensing limitations are set based on types of medicines and safety standards. We follow recommendations of the FDA along with our analysis of prescription dispensing trends and clinical guidelines. Dispensing limitations are updated as needed. If a prescriber feels that a drug is medically necessary outside of the dispensing limitations, an exception can be requested by calling our Pharmacy Department at 1-800-682-9094 or completing and faxing the appropriate form (sample attached) to 888-567-0681. If more information is required, we will contact the prescribing physician.	progressing to second-step drugs. These "first" - and corresponding "second"-step medicines are FDA-approved and are used to treat the same conditions. There may be times where a second-step medicine should be tried first. In these cases, PA/MND can be requested and will be reviewed by a clinical reviewer/physician through the PA/MND process. Medicines requiring step therapy are listed in the Formulary Guide. How the process can be modified: Some prescription medicines can only be used in certain doses based on age, sex and other factors. Dispensing limitations are set based on types of medicines and safety standards. We follow recommendations of the FDA along with our analysis of prescription dispensing trends and clinical guidelines. Dispensing limitations are updated as needed. If a prescriber feels that a drug is medically necessary outside of the dispensing limitations, an exception can be requested by calling our Pharmacy Department at 1-800-682-9094 or completing and faxing the appropriate form (sample attached) to 888-567-0681. If more information is required, we will contact the prescribing physician.
	Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.	**Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.**
	Prior Authorization The Plan defines prior authorization as the process by which a request for coverage of health care services is assessed prior to a service or course of treatment, for appropriateness of the admission based upon the application of medical necessity.	Prior Authorization The Plan defines prior authorization as the process by which a request for coverage of health care services is assessed prior to a service or course of treatment, for appropriateness of the admission based upon the application of medical necessity.

	The prior authorization program is overseen by the following committees: **Utilization Management/ Case Management Committee** The Utilization Management/ Case Management Committee (UM/CMC) is responsible for the review of Medicare and Medicaid Management to support the Horizon vision statement of improving quality and enhancing patient experience. This committee is responsible for approving and providing direction and recommendations for changes to Utilization Management (UM) policies, Care Management (CM) Policies, the UM and CM program descriptions, evaluations and work plans for the government programs line of business. The committee will promote the effective and efficient use of medical services. The committee will obtain important input from external participating providers on administrative and clinical issues The UM/CMC is charged with the review of the following, including, but not limited to: • Annual review and approval of the UM and CM Work Plans and evaluations • Annual review and approval of clinical criteria applied for medical necessity reviews • Monitoring of utilization/production data, including patterns of appropriate utilization including over and underutilization and overall performance • Annual review of administrative policies pertaining to UM and CM • Monitoring of UM and CM initiatives • Evaluation of medical director/physician advisor and nurse inter-rater reports • Monitoring of UM/CM compliance with external accreditation standards • Monitoring of UM/CM compliance with regulatory requirements • Monitoring of applicable patient safety data and initiatives • Update, review and approve Clinical Practice Guidelines	The prior authorization program is overseen by the following committees: **Utilization Management/ Case Management Committee** The Utilization Management/ Case Management Committee (UM/CMC) is responsible for the review of Medicare and Medicaid Management to support the Horizon vision statement of improving quality and enhancing patient experience. This committee is responsible for approving and providing direction and recommendations for changes to Utilization Management (UM) policies, Care Management (CM) Policies, the UM and CM program descriptions, evaluations and work plans for the government programs line of business. The committee will promote the effective and efficient use of medical services. The committee will obtain important input from external participating providers on administrative and clinical issues The UM/CMC is charged with the review of the following, including, but not limited to: • Annual review and approval of the UM and CM Work Plans and evaluations • Annual review and approval of clinical criteria applied for medical necessity reviews • Monitoring of utilization/production data, including patterns of appropriate utilization including over and underutilization and overall performance • Annual review of administrative policies pertaining to UM and CM • Monitoring of UM and CM initiatives • Evaluation of medical director/physician advisor and nurse inter-rater reports • Monitoring of UM/CM compliance with external accreditation standards • Monitoring of UM/CM compliance with regulatory requirements • Monitoring of applicable patient safety data and initiatives • Update, review and approve Clinical Practice Guidelines

	• Quarterly review of UM Appeals Data The Utilization Management/Case Management Committee reports directly to the Quality Improvement Committee. The Utilization Management/Case Management (UM/CM) Committee meets no less than 5 times per year and quarterly in joint sessions with the Physician Advisory Committee. Internal voting members on the committee to establish quorum include: • Medical Directors (5) • Director, Dental Operations • Director, Medicaid Care Management Programs • Director, Case Management and Clinical Operations, Medicare • Director. Clinical Special Needs Plan • Director, Clinical Operations • Director, Clinical Behavioral Health Services • Director, Utilization Management • Director, Pharmacy • Director, Quality Management Clinical Operations GP External voting members include: Board-certified participating physicians with diverse geographic and specialty representation and designated business leaders have been assigned voting privileges. Other medical and non-medical personnel may attend and participate without voting privileges. **Physician Advisory Committee (PAC)** The purpose of the Physician Advisory Committee (PAC) is to identify issues of concern to the physician community and opportunities for optimizing patient care. The function of PAC is to review and make recommendations to Horizon NJ Health's medical and administrative leadership concerning clinical and administrative issues of importance to the membership and participating practitioners of Horizon NJ Health. The committee will identify issues of concern to the participating medical community and assess clinical policies and programs in the	• Quarterly review of UM Appeals Data The Utilization Management/Case Management Committee reports directly to the Quality Improvement Committee. The Utilization Management/Case Management (UM/CM) Committee meets no less than 5 times per year and quarterly in joint sessions with the Physician Advisory Committee. Internal voting members on the committee to establish quorum include: • Medical Directors (5) • Director, Dental Operations • Director, Medicaid Care Management Programs • Director, Case Management and Clinical Operations, Medicare • Director. Clinical Special Needs Plan • Director, Clinical Operations • Director, Clinical Behavioral Health Services • Director, Utilization Management • Director, Pharmacy • Director, Quality Management Clinical Operations GP External voting members include: Board-certified participating physicians with diverse geographic and specialty representation and designated business leaders have been assigned voting privileges. Other medical and non-medical personnel may attend and participate without voting privileges. **Physician Advisory Committee (PAC)** The purpose of the Physician Advisory Committee (PAC) is to identify issues of concern to the physician community and opportunities for optimizing patient care. The function of PAC is to review and make recommendations to Horizon NJ Health's medical and administrative leadership concerning clinical and administrative issues of importance to the membership and participating practitioners of Horizon NJ Health. The committee will identify issues of concern to the participating medical community and assess clinical policies and programs in the

	context of current standards of care. This committee is defined by regulations of the New Jersey Office of Managed Health Care and is a subcommittee of the Quality Improvement Committee (QIC). This Committee reports its activities and recommendations to the QIC. The committee meets quarterly in joint sessions with the Utilization Management/Case Management (UM/CM) Committee. Additional meetings may be scheduled at the discretion of the chairperson to meet business needs. Membership & Chairperson The committee is chaired by the Plan Executive Medical Director designated by the Chief Medical Officer. At least two providers on the committee shall maintain practices or provide services that predominantly serve Medicaid beneficiaries and other indigent populations, in addition to one or more other practicing providers on the committee who have experience and expertise in serving enrollees with long-term care and special needs. The committee shall meet at least quarterly. Its input and recommendations shall be employed to inform and direct Contractor quality management activities, policy, and operational changes. The physician committee members are all voting members, others may attend and participate without voting privileges. They shall include but are not limited to: • Medical Directors (5) • Director, Dental Operations • Director, Medicaid Care Management Programs • Director, Case Management and Clinical Operations, Medicare • Director. Clinical Special Needs Plan • Director, Clinical Operations • Director, Clinical Behavioral Health Services (2) • Director, Utilization Management • Director, Pharmacy • Director, Quality Management Clinical Operations GP	context of current standards of care. This committee is defined by regulations of the New Jersey Office of Managed Health Care and is a subcommittee of the Quality Improvement Committee (QIC). This Committee reports its activities and recommendations to the QIC. The committee meets quarterly in joint sessions with the Utilization Management/Case Management (UM/CM) Committee. Additional meetings may be scheduled at the discretion of the chairperson to meet business needs. Membership & Chairperson The committee is chaired by the Plan Executive Medical Director designated by the Chief Medical Officer. At least two providers on the committee shall maintain practices or provide services that predominantly serve Medicaid beneficiaries and other indigent populations, in addition to one or more other practicing providers on the committee who have experience and expertise in serving enrollees with long-term care and special needs. The committee shall meet at least quarterly. Its input and recommendations shall be employed to inform and direct Contractor quality management activities, policy, and operational changes. The physician committee members are all voting members, others may attend and participate without voting privileges. They shall include but are not limited to: • Medical Directors (5) • Director, Dental Operations • Director, Medicaid Care Management Programs • Director, Case Management and Clinical Operations, Medicare • Director. Clinical Special Needs Plan • Director, Clinical Operations • Director, Clinical Behavioral Health Services (2) • Director, Utilization Management • Director, Pharmacy

	External voting members include: Board-certified participating physicians with diverse geographic and specialty representation and designated business leaders have been assigned voting privileges. Other medical and non-medical personnel may attend and participate without voting privileges. Why HNJH requires prior authorization: Horizon performs prospective review of select health care services to determine medical necessity and appropriateness. Decisions on medical appropriateness are based on clinical/behavioral health criteria approved by Horizon. How the process may be modified to meet medical necessity: HNJH medical directors may have peer to peer discussions with the servicing provider after an initial adverse determination is made for a HNJH member in an attempt to obtain additional clinical information pertaining to the member's care to substantiate medical necessity and approve services requested.	• Director, Quality Management Clinical Operations GP External voting members include: Board-certified participating physicians with diverse geographic and specialty representation and designated business leaders have been assigned voting privileges. Other medical and non-medical personnel may attend and participate without voting privileges. Why HNJH requires prior authorization: Horizon performs prospective review of select health care services to determine medical necessity and appropriateness. Decisions on medical appropriateness are based on clinical/behavioral health criteria approved by Horizon. How the process may be modified to meet medical necessity: HNJH medical directors may have peer to peer discussions with the servicing provider after an initial adverse determination is made for HNJ H member in an attempt to obtain additional clinical information pertaining to member's care to substantiate medical necessity and approve services requested.
	Evidentiary Standards: Describe evidence that supports the use ofprior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized bythe plan.	**Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.**
	Evidence that supports the use of prior authorization: HNJH UM program uses the following objective, evidenced-based Clinical Criteria/Guidelines for services requiring medical necessity review: MCG®, Centers for Medicare and Medicaid Services ("CMS"), National Coverage Determinations/ Local Coverage Determinations, HNJH Uniform Medical Policies American Society of Addiction Medicine ("ASAM") for SUD withdrawal management. The following factors are considered when applying criteria to services received by anHNJH member,	Evidence that supports the use of prior authorization: HNJH UM program uses the following objective, evidenced-based Clinical Criteria/Guidelines for services requiring medical necessity review: MCG®, Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations/ Local Coverage Determinations, Horizon Uniform Medical Policies. The following factors are considered when applying criteria to services received by a HNJH member, include age, co-morbidities, complications, progress of treatment, psychosocial

	include age, co-morbidities, complications, progress of treatment, psychosocial issues, culture, home environment and other situations as they arise. HNJH also considers the local delivery system available to members to ensure there are not barriers to care. The criteria sets are reviewed annually for appropriateness to the HNJH population's need and updated as applicable when national and/or community-based clinical practice guidelines are updated. The annual review process involves appropriate medical directors and community based practitioners in developing, adopting and reviewing criteria. Members and providers are advised of the availability of criteria sets upon request, in notice of action / UM adverse determination letters, provider manuals, newsletters, the HNJH website, and member handbooks.	issues, culture, home environment and other situations as they arise. HNJH also considers the local delivery system available to members to ensure there are not barriers to care. The criteria sets are reviewed annually for appropriateness to the HNJH population need and updated as applicable when national and/or community- based clinical practice guidelines are updated. The annual review process involves appropriate medical directors and community based practitioners in developing, adopting and reviewing criteria. Members and providers are advised of the availability of criteria sets upon request in the notice of action / UM adverse determination letters, provider manuals, newsletters, the HNJH website and member handbooks.
	Evidentiary Standards: Describe evidence that supports the use ofprior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	**Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.**
	For Medicaid outpatient pharmacy benefit provided via retail pharmacies FDA approved package inserts, American Hospital Formulary Service, Micromedex, Clinical Pharmacology and national guidelines are utilized.	For Medicaid outpatient pharmacy benefit provided via retail pharmacies FDA approved package inserts, American Hospital Formulary Service, Micromedex, Clinical Pharmacology and national guidelines are utilized.

Fail-First Therapy: Inpatient Services	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all inpatient benefits that require fail first therapy	There is no fail first therapy for inpatient M/S or behavioral health. The per diem payment is inclusive of pharmacy services. There is no medical necessity review of drugs for inpatient care	
Processes, Strategies and Evidentiary Standards	**Processes: Explain the process for fail first therapy that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**	**Processes: Explain the process for fail first therapy that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**
	N/A	N/A
	Strategies: Explain why your MCO requires fail first therapy. Describe why fail first therapy is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of fail first therapy.	**Strategies: Explain why your MCO requires fail first therapy.** **Describe why fail first therapy is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of fail first therapy.**
	N/A	N/A
	Evidentiary Standards: Describe evidence that supports the use offail first therapy for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized bythe plan.	**Evidentiary Standards: Describe evidence that supports the use of fail first therapy for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.**
	N/A	N/A

Fail- First Therapy: Outpatient Services	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all inpatient benefits that require fail first therapy	None	None
Processes, Strategies and Evidentiary Standards	Processes: Explain the process for fail first therapy that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for fail first therapy that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	N/A	N/A
	Strategies: Explain why your MCO requires fail first therapy. Describe why fail first therapy is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of fail first therapy.	Strategies: Explain why your MCO requires fail first therapy. Describe why fail first therapy is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of fail first therapy.
	N/A	N/A
	Evidentiary Standards: Describe evidence that supports the use of fail first therapy for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of fail first therapy for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	N/A	N/A

Fail-First Therapy: Emergency Services	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all inpatient benefits that require fail first therapy	None	
Processes, Strategies and Evidentiary Standards	**Processes: Explain the process for fail first therapy that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**	**Processes: Explain the process for fail first therapy that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**
	N/A	N/A
	Strategies: Explain why your MCO requires fail first therapy. Describe why fail first therapy is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of fail first therapy.	**Strategies: Explain why your MCO requires fail first therapy. Describe why fail first therapy is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of failfirsttherapy.**
	N/A	N/A
	Evidentiary Standards: Describe evidence that supports the use of fail first therapy for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	**Evidentiary Standards: Describe evidence that supports the use of fail first therapy for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.**
	N/A	N/A

Fail-First Therapy: Pharmacy Services	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all inpatient benefits that require fail first therapy	None	
Processes, Strategies and Evidentiary Standards	Processes: Explain the process for fail first therapy that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for fail first therapy that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	N/A	N/A
	Strategies: Explain why your MCO requires fail first therapy. Describe why fail first therapy is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of fail first therapy.	Strategies: Explain why your MCO requires fail first therapy. Describe why fail first therapy is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of failfirsttherapy.
	N/A	N/A
	Evidentiary Standards: Describe evidence that supports the use offail first therapy for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of fail first therapy for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	N/A	N/A

Concurrent Review: Inpatient Services	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all inpatient benefits that require concurrent review	Inpatient benefits that require concurrent review: • Inpatient acute • Residential • Rehabilitation	Inpatient benefits that require concurrent review: • Acute inpatient • Post-acute facilities and rehabilitation facilities
Processes, Strategies and Evidentiary Standards	**Processes: Explain the process for concurrent review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**	**Processes: Explain the process for concurrent review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**
	HNJH performs concurrent review to determine medical necessity of continued stay and discharge planning from inpatient to outpatient care. Concurrent review also identifies and facilitates transition to alternate levels of care, when appropriate. Horizon's medical director is responsible for directing and overseeing the inpatient concurrent review function. UM staff and medical directors that are qualified by training, experience and certification/licensure in accordance with state and federal regulations are responsible for carrying out the daily concurrent review operations, including timely, accurate documentation of review activities per contractual and regulatory agreements. Only an appropriately licensed health care professional may make determinations regarding the medical necessity of health care services during the course of concurrent review. Additionally, appropriately licensed health professionals provide day to day supervision of assigned utilization management staff, participate in staff training, monitor for consistent application of UM criteria by UM staff, monitor documentation for adequacy and are available to UM staff either on site or by telephone.	HNJH performs concurrent review to determine medical necessity of continued stay and discharge planning from inpatient to outpatient care. Concurrent review also identifies and facilitates transition to alternate levels of care, when appropriate. Horizon's medical director is responsible for directing and overseeing the inpatient concurrent review function. UM staff and medical directors that are qualified by training, experience and certification/licensure in accordance with state and federal regulations are responsible for carrying out the daily concurrent review operations, including timely, accurate documentation of review activities per contractual and regulatory agreements. Only an appropriately licensed health care professional may make determinations regarding the medical necessity of health care services during the course of concurrent review. Additionally, appropriately licensed health professionals provide day to day supervision of assigned utilization management staff, participate in staff training, monitor for consistent application of UM criteria by UM staff, monitor documentation for adequacy and are available to UM staff either on site or by telephone. Staff are available via telephone seven (7) days a week, twenty-

	Staff are available via telephone seven (7) days a week, twenty-four (24) hours a day to receive inbound communication regarding UM issues. TDD/TYY and the free interpreter services are available for members to discuss UM issues. All utilization management staff are required to identify themselves by name, title, and organization name and if appropriate verbally inform members, facility personnel, attending physician and other ordering providers of specific utilization management requirements, determinations and clinical data for all inpatient admissions and services is documented on an ongoing basis by reviewing information related to the admission or service. Authorization requests that do not meet medical necessity criteria, or for which there are no established criteria will be forwarded to a medical director for review. The medical director will review the service request, clinical information, and the member's need. Using the approved criteria, medical judgment, individual needs of the member, and characteristics of the local delivery system, a determination to approve or deny service will be made. Only a medical director can reduce, deny, partially deny, stop or suspend request for service based on medical necessity review. The UM staff works in conjunction with the facility to identify the services required for the member's discharge planning needs. The UM clinical staff will collaborate with the case manager for those members engaged in Case Management, Dual Special Needs (DSNP), or Managed Long-Term Services and Supports programs in order to transition the discharge planning requirements appropriately. Notification of all Horizon member inpatient acute care admissions is required within one (1) business day of admission. Failure to comply may result in denial or delay of reimbursement. Action is taken within 24 hours of receipt of request; either a determination is made or a request for additional information. If additional information is required to render a medical necessity determination, the determination will be provided within 24 hours from receipt of the clinical but no	four (24) hours a day to receive inbound communication regarding UM issues. TDD/TYY and the free interpreter services are available for members to discuss UM issues. All utilization management staff are required to identify themselves by name, title, and organization name and if appropriate verbally inform members, facility personnel, attending physician and other ordering providers of specific utilization management requirements, determinations and Clinical data for all inpatient admissions and services is documented on an ongoing basis by reviewing information related to the admission or service. Authorization requests that do not meet medical necessity criteria, or for which there are no established criteria will be forwarded to a medical director for review. The medical director will review the service request, clinical information, and the member's need. Using the approved criteria, medical judgment, individual needs of the member, and characteristics of the local delivery system, a determination to approve or deny service will be made. Only a medical director can reduce, deny, partially deny, stop or suspend request for service based on medical necessity review. The UM staff works in conjunction with the facility to identify the services required for the member's discharge planning needs. The UM clinical staff will collaborate with the case manager for those members engaged in Case Management, Dual Special Needs (DSNP), or Managed Long-Term Services and Supports programs in order to transition the discharge planning requirements appropriately. Notification of all Horizon member inpatient acute care admissions is required within one (1) business day of admission. Failure to comply may result in denial or delay of reimbursement. Action is taken within 24 hours of receipt of request; either a determination is made or a request for additional information. If additional information is required to render a medical necessity determination, the determination will be provided within 24 hours from receipt of the clinical but no more than 72 hours from receipt of the request.

	more than 72 hours from receipt of the request. Horizon follows the additional information timeframes for Medicaid providers in compliance with New Jersey Health Claims Authorization, Processing and Payment Act. If additional information is required to approve or deny a request for authorization, the provider shall be notified in writing of the specific information needed to approve or deny the request for authorization. If the provider fails to respond within 72 hours of the request for information, the request shall be deemed withdrawn. If the provider responds within 72 hours a decision shall be made and a notice of determination provided by telephone or in writing to the provider and member within (14) calendar days of receipt of the additional information for standard pre service requests and within 24 hours of receipt of clinical for urgent concurrent inpatient requests. If notification of an emergent inpatient hospital admission is received from a participating hospital later than one (1) business day, but no later than seven (7) business days following the emergent inpatient admission due to the hospital's inability to identify the patient as a Horizon member, the hospital stay will be reviewed for medical necessity for each inpatient day as applicable to facility contract. The review will utilize the usual and customary concurrent review process agreed to by both parties. If additional clinical information is required, the determination will be completed within seven (7) business days from receiving all of the requested information from the participating hospital. Concurrent reviews for acute inpatient hospitalizations and post-acute facilities are conducted on a daily basis as required by contract or on a schedule that is clinically appropriate and according to the medical exigencies of the member. If a member has been discharged, Horizon will allow the provider three (3) business days from the date of discharge to provide clinical information for review. Horizon complies with the CMS two-midnight rule for acute inpatient admissions.	Horizon follows the additional information timeframes for Medicaid providers in compliance with New Jersey Health Claims Authorization, Processing and Payment Act. If additional information is required to approve or deny a request for authorization, the provider shall be notified in writing of the specific information needed to approve or deny the request for authorization. If the provider fails to respond within 72 hours of the request for information, the request shall be deemed withdrawn. If the provider responds within 72 hours a decision shall be made and a notice of determination provided by telephone or in writing to the provider and member within (14) calendar days of receipt of the additional information for standard pre service requests and within 24 hours of receipt of clinical for urgent concurrent inpatient requests. If notification of an emergent inpatient hospital admission is received from a participating hospital later than one (1) business day, but no later than seven (7) business days following the emergent inpatient admission due to the hospital's inability to identify the patient as a Horizon member, the hospital stay will be reviewed for medical necessity for each inpatient day as applicable to facility contract. The review will utilize the usual and customary concurrent review process agreed to by both parties. If additional clinical information is required, the determination will be completed within seven (7) business days from receiving all of the requested information from the participating hospital. Concurrent reviews for acute inpatient hospitalizations and post-acute facilities are conducted on a daily basis as required by contract or on a schedule that is clinically appropriate and according to the medical exigencies of the member. If a member has been discharged, Horizon will allow the provider three (3) business days from the date of discharge to provide clinical information for review. Horizon complies with the CMS two-midnight rule for acute inpatient admissions.

	Concurrent Review decisions and notifications are made in a timely manner in accordance with federal, state regulations and accreditation standards. Where regulatory and accreditation standards differ, the strictest or shortest timeframe is used to assure compliance with all requirements. Notifications shall be in writing and shall meet the language and format requirements of the federal regulations to ensure ease of understanding. As applicable written notification shall be given on a standardized form approved by CMS and the state of New Jersey Department of Human Services. The following shall be included in the written notice: the specific service denied and reason for the action described in layman terms and does not include abbreviations, reference to the criteria used to make the decision, explanation of appeal process (including timeframes), description of appeal rights including expedited appeal process, internal and external review process, notice of the availability of the clinical or other review criteria used to make determination, notification that expedited external review can occur concurrently with the internal appeals process for urgent care, the right for members to request continued benefits pending resolution of appeal as applicable and the right to designate in writing an authorized representative. The member can obtain a free copy of the criteria used to make the determination upon request. Decisions to deny or limit in scope, duration and intensity, service authorizations on the grounds of medical and/or functional appropriateness are solely conducted by medical directors. In order to afford an opportunity for case discussion, the name, contact number, and availability of the medical director who rendered the denial determination is provided on provider notifications. The Horizon medical directors are available for peer-to-peer consultations during normal business hours Monday through Friday 8am – 5pm . If a request for peer-to-peer consultation is received after 7 business days from receipt of notice of determination the caller will be directed to follow the standard appeal process. Once the consultation	Concurrent Review decisions and notifications are made in a timely manner in accordance with federal, state regulations and accreditation standards. Where regulatory and accreditation standards differ, the strictest or shortest timeframe is used to assure compliance with all requirements. Notifications shall be in writing and shall meet the language and format requirements of the federal regulations to ensure ease of understanding. As applicable written notification shall be given on a standardized form approved by CMS and the state of New Jersey Department of Human Services. The following shall be included in the written notice: the specific service denied and reason for the action described in layman terms and does not include abbreviations, reference to the criteria used to make the decision, explanation of appeal process (including timeframes), description of appeal rights including expedited appeal process, internal and external review process, notice of the availability of the clinical or other review criteria used to make determination, notification that expedited external review can occur concurrently with the internal appeals process for urgent care, the right for members to request continued benefits pending resolution of appeal as applicable and the right to designate in writing an authorized representative. The member can obtain a free copy of the criteria used to make the determination upon request. Decisions to deny or limit in scope, duration and intensity, service authorizations on the grounds of medical and/or functional appropriateness are solely conducted by medical directors. In order to afford an opportunity for case discussion, the name, contact number, and availability of the medical director who rendered the denial determination is provided on provider notifications. The Horizon medical directors are available for peer-to-peer consultations during normal business hours Monday through Friday 8am – 5pm . If a request for peer-to-peer consultation is received after 7 business days from receipt of notice of determination the caller will be directed to follow the standard appeal process. Once the consultation

	process is initiated, the Medical Director will outreach the provider twice on two (2) consecutive business days and document all activity in the case notes. In the event that the consultation does not take place within two business days, the standard appeal process will need to be followed. If a member's disenrollment or termination becomes effective during an acute hospitalization and/or acute rehab, member will be covered until the date member is discharged from the facility. For Medicaid & DSNP members, readmission within forty-eight (48) hours of discharge for the same diagnosis will also be covered. Decisions will be reversed only when information provided is materially different from information provided at time of the original determination in accordance with federal and state regulations. NCQA UM1 B NCQA UM4 A1-2 NCQA UM3 A3 NCQA UM4 A2 NCQA UM2 A1-5 NCQA UM5 A2, 3-4, B2, 3-4 NCQA UM7 B1-3	process is initiated, the Medical Director will outreach the provider twice on two (2) consecutive business days and document all activity in the case notes. In the event that the consultation does not take place within two business days, the standard appeal process will need to be followed. If a member's disenrollment or termination becomes effective during an acute hospitalization and/or acute rehab, member will be covered until the date member is discharged from the facility. For Medicaid & DSNP members, readmission within forty-eight (48) hours of discharge for the same diagnosis will also be covered. Decisions will be reversed only when information provided is materially different from information provided at time of the original determination in accordance with federal and state regulations. NCQA UM1 B NCQA UM4 A1-2 NCQA UM3 A3 NCQA UM4 A2 NCQA UM2 A1-5 NCQA UM5 A2, 3-4, B2, 3-4 NCQA UM7 B1-3
	Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.	**Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.**

	HNJH requires concurrent review as a quality of care measure to ensure appropriateness of care, care coordination, proper transitions of care and discharge planning is in place to avoid any gaps in care. The concurrent review function provides an initial and ongoing review of hospitalizations for appropriateness of hospital admission, level of care and need for continued inpatient stay. The review components include the collection of clinical data to determine medical necessity, as well as the opportunity to identify care management needs and assist in timely discharge planning. Clinical information is inclusive of but not limited to: hospital records, history of presenting problem, review of current symptomatology, clinical exams, diagnostic testing results, treatment plan and progress notes, psychosocial history, consultation information, relevant reports from other specialists and information regarding the local delivery system, patient characteristics and information from family members. The coordination and integration of our members back into a safe, cost effective environment is a primary goal.	HNJH requires concurrent review as a quality of care measure to ensure appropriateness of care, care coordination, proper transitions of care and discharge planning is in place to avoid gaps in care. The concurrent review function provides an initial and ongoing review of hospitalizations for appropriateness of hospital / facility admission, level of care and need for continued inpatient stay. The review components include the collection of clinical data to determine medical necessity, as well as the opportunity to identify care management needs and assist in timely discharge. Clinical information is inclusive of but not limited to: hospital records, history of presenting problem, review of current symptomatology, clinical exams, diagnostic testing results, treatment plan and progress notes, psychosocial history, consultation information, operative and pathology reports, rehabilitation, evaluations, and information regarding the local delivery system, patient characteristics and information from family members. The coordination and integration of our members back into a safe, cost effective environment is a primary goal.
	Evidentiary Standards: Describe evidence that supports the use ofconcurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized bythe plan.	**Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.**
	To support inpatient concurrent review decisions, Horizon uses nationally recognized and/or community developed evidence-based criteria. Criteria is applied based on the needs of the individual members and an assessment of the local delivery system. Criteria sets are reviewed annually and updated as applicable. The annual review process involves appropriate practitioners with clinical expertise in the area being reviewed when adopting criteria. The criteria are consistently applied, considering individual needs of the members and allow for consultations with requesting providers when applicable. For inpatient/outpatient medical care reviews, Horizon uses the following medical review criteria:	To support inpatient concurrent review decisions, Horizon uses nationally recognized and/or community developed evidence-based criteria. Criteria is applied based on the needs of the individual members and an assessment of the local delivery system. Criteria sets are reviewed annually and updated as applicable. The annual review process involves appropriate practitioners with clinical expertise in the area being reviewed when adopting criteria. The criteria are consistently applied, considering individual needs of the members and allow for consultations with requesting providers when applicable. For inpatient/outpatient medical care reviews, Horizon uses the following medical review criteria:

	• CMS Guidelines • MCG® • ASAM 4.0-(SUD Services) • Horizon Blue Cross Blue Shield NJ Uniform Medical Policy Principles of review include: • Identification of medically unnecessary and inappropriate hospital days and services. • Appropriateness for alternate levels of care. • Appropriateness of services in relation to the member's diagnosis, problem, or condition. • Identification of case management/discharge planning referrals. • Identification and referral of quality of care issues. • Assessment of the local delivery system and its ability to meet member needs • Consideration of individual needs. • Age • Comorbidities • Complications • Progress of treatment • Psychosocial situation • Home environment, when applicable	• CMS Guidelines • MCG® • ASAM 4.0-(SUD Services) • Horizon Blue Cross Blue Shield NJ Uniform Medical Policy Principles of review include: • Identification of medically unnecessary and inappropriate hospital days and services. • Appropriateness for alternate levels of care. • Appropriateness of services in relation to the member's diagnosis, problem, or condition. • Identification of case management/discharge planning referrals. • Identification and referral of quality of care issues. • Assessment of the local delivery system and its ability to meet member needs • Consideration of individual needs. • Age • Comorbidities • Complications • Progress of treatment • Psychosocial situation • Home environment, when applicable .

Concurrent Review: Outpatient Services	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all outpatient benefits that require concurrent review	• Partial Hospitalization Program ("PHP") • Intensive outpatient ("IOP") • Applied Behavioral Analysis ("ABA") • Electroconvulsive Therapy ("ECT") • rTMS; ASAM 2.5, ASAM 2.1	For DSNP members: • Home Health • Physical Therapy • Speech Therapy • Occupational Therapy • Chiropractic Therapy
List Processes, Strategies and Evidentiary Standards	**Processes: Explain the process for concurrent review that is Utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**	**Processes: Explain the process for concurrent review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**
	Process for concurrent review: HNJH performs concurrent review to access medical necessity, evaluate appropriate utilization of services and promote delivery of quality care on a timely basis. Concurrent review requests are conducted either telephonically or via provider portal. The review components include the collection of clinical data to determine medical necessity, as well as the opportunity to identify care management needs and assist in arranging timely discharge from services. In addition, concurrent review provides information that allows for peer consultation between the servicing provider or requesting physician and a HNJH medical director. Clinical information includes but is not limited to: medical records, history of presenting problem, presenting symptomatology, clinical exam, diagnostic testing results, treatment plan and progress notes, psychosocial history, relevant reports from other specialists and information regarding the local delivery system, patient characteristics, and information from family members. The coordination and integration of our members back into a safe, cost effective environment is a primary goal.	Process for concurrent review: HNJH performs concurrent review to assess medical necessity, evaluate appropriate utilization of services and promote delivery of quality care on a timely basis. Concurrent review requests are conducted either telephonically or via receipt of clinical information via provider portal or email. The review components include the collection of clinical data to determine medical necessity, as well as the opportunity to identify care management needs and assist in arranging timely discharge from services. In addition, concurrent review provides information to allow for peer consultation between the servicing provider or requesting physician and a HNJH medical director. Clinical information includes and is not limited to: medical records, history of presenting problem, clinical exam, diagnostic testing results, treatment plan and progress notes, psychosocial history, consultation information, operative and pathological reports, rehabilitation, evaluations, and information regarding the local delivery system, patient characteristics and information from family members. The coordination and integration of our members back into a safe, cost effective environment is a primary goal.

	Horizon's medical director is responsible for directing and overseeing the inpatient concurrent review function. UM staff and medical directors that are qualified by training, experience and certification/licensure in accordance with state and federal regulations are responsible for carrying out the daily concurrent review operations, including timely, accurate documentation of review activities per contractual and regulatory agreements. Only an appropriately licensed health care professional may make determinations regarding the medical necessity of health care services during the course of concurrent review. Additionally, appropriately licensed health professionals provide day to day supervision of assigned utilization management staff, participate in staff training, monitor for consistent application of UM criteria by UM staff, monitor documentation for adequacy and are available to UM staff either on site or by telephone. Staff are available via telephone seven (7) days a week, twenty-four (24) hours a day to receive inbound communication regarding UM issues. TDD/TYY and the free interpreter services are available for members to discuss UM issues. All utilization management staff are required to identify themselves by name, title, and organization name and if appropriate verbally inform members, facility personnel, attending physician and other ordering providers of specific utilization management requirements, determinations and Clinical data for all outpatient services is documented on an ongoing basis by reviewing information related to the admission/ outpatient service. Authorization requests that do not meet medical necessity criteria, or for which there are no established criteria will be forwarded to a medical director for review. The medical director will review the service request, clinical information, and the member's need. Using the approved criteria, medical judgment, individual needs of the member, and characteristics of the local delivery system, a determination to approve or deny service will be made. Only a medical director can reduce, deny, partially deny, stop or suspend request for service based on medical necessity review. Notifications shall be in writing and shall meet the language and format requirements of the federal regulations to ensure	Horizon's medical director is responsible for directing and overseeing the inpatient concurrent review function. UM staff and medical directors that are qualified by training, experience and certification/licensure in accordance with state and federal regulations are responsible for carrying out the daily concurrent review operations, including timely, accurate documentation of review activities per contractual and regulatory agreements. Only an appropriately licensed health care professional may make determinations regarding the medical necessity of health care services during the course of concurrent review. Additionally, appropriately licensed health professionals provide day to day supervision of assigned utilization management staff, participate in staff training, monitor for consistent application of UM criteria by UM staff, monitor documentation for adequacy and are available to UM staff either on site or by telephone. Staff are available via telephone seven (7) days a week, twenty-four (24) hours a day to receive inbound communication regarding UM issues. TDD/TYY and the free interpreter services are available for members to discuss UM issues. All utilization management staff are required to identify themselves by name, title, and organization name and if appropriate verbally inform members, facility personnel, attending physician and other ordering providers of specific utilization management requirements, determinations and Clinical data for all outpatient services is documented on an ongoing basis by reviewing information related to the admission/ outpatient service. Authorization requests that do not meet medical necessity criteria, or for which there are no established criteria will be forwarded to a medical director for review. The medical director will review the service request, clinical information, and the member's need. Using the approved criteria, medical judgment, individual needs of the member, and characteristics of the local delivery system, a determination to approve or deny service will be made. Only a medical director can reduce, deny, partially deny, stop or suspend request for service based on medical necessity review. Notifications shall be in writing and shall meet the language and format requirements of the federal regulations to ensure ease of

	ease of understanding. As applicable written notification shall be given on a standardized form approved by CMS and the state of New Jersey Department of Human Services. The following shall be included in the written notice: the specific service denied and reason for the action described in layman terms and does not include abbreviations, reference to the criteria used to make the decision, explanation of appeal process (including timeframes), description of appeal rights including expedited appeal process, internal and external review process, notice of the availability of the clinical or other review criteria used to make determination, notification that expedited external review can occur concurrently with the internal appeals process for urgent care, the right for members to request continued benefits pending resolution of appeal as applicable and the right to designate in writing an authorized representative. The member can obtain a free copy of the criteria used to make the determination upon request. Decisions to deny or limit in scope, duration and intensity, service authorizations on the grounds of medical and/or functional appropriateness are solely conducted by medical directors. In order to afford an opportunity for case discussion, the name, contact number, and availability of the medical director who rendered the denial determination is provided on provider notifications. The Horizon medical directors are available for peer-to-peer consultations during normal business hours Monday through Friday 8am – 5pm . If a request for peer-to-peer consultation is received after 7 business days from receipt of notice of determination the caller will be directed to follow the standard appeal process. Once the consultation process is initiated, the Medical Director will outreach the provider twice on two (2) consecutive business days and document all activity in the case notes. In the event that the consultation does not take place within two business days, the standard appeal process will need to be followed.	understanding. As applicable written notification shall be given on a standardized form approved by CMS and the state of New Jersey Department of Human Services. The following shall be included in the written notice: the specific service denied and reason for the action described in layman terms and does not include abbreviations, reference to the criteria used to make the decision, explanation of appeal process (including timeframes), description of appeal rights including expedited appeal process, internal and external review process, notice of the availability of the clinical or other review criteria used to make determination, notification that expedited external review can occur concurrently with the internal appeals process for urgent care, the right for members to request continued benefits pending resolution of appeal as applicable and the right to designate in writing an authorized representative. The member can obtain a free copy of the criteria used to make the determination upon request. Decisions to deny or limit in scope, duration and intensity, service authorizations on the grounds of medical and/or functional appropriateness are solely conducted by medical directors. In order to afford an opportunity for case discussion, the name, contact number, and availability of the medical director who rendered the denial determination is provided on provider notifications. The Horizon medical directors are available for peer-to-peer consultations during normal business hours Monday through Friday 8am – 5pm . If a request for peer-to-peer consultation is received after 7 business days from receipt of notice of determination the caller will be directed to follow the standard appeal process. Once the consultation process is initiated, the Medical Director will outreach the provider twice on two (2) consecutive business days and document all activity in the case notes. In the event that the consultation does not take place within two business days, the standard appeal process will need to be followed.
	Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.	**Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.**

	HNJH requires concurrent review because this is a quality of care review to ensure medical appropriateness of care. Concurrent review ensures care coordination, transitions of care, and discharge planning are in place to avoid gaps in care. The concurrent review function provides an initial and ongoing review of utilization to determine appropriateness of service provision and need for continued stay. The review components include the collection of clinical data to determine medical necessity, as well as the opportunity to identify case management needs and assist in arranging timely discharge. Clinical information includes but is not limited to: treatment records, history ofpresenting problem, current symptomatology, clinical exams, diagnostic testing results, treatment plan and progress notes, psychosocial history, relevant consultative reports from other specialists, rehabilitative history, evaluations and information regarding the local delivery system, patient characteristics and information from family members.	HNJH requires concurrent review because this is a quality of care review to ensure medical appropriateness of care. Concurrent review ensures care coordination, transitions of care, and discharge planning are in place to avoid gaps in care. The concurrent review function provides an initial and ongoing review of care for appropriateness of service provision and need for continued treatment. The review components include the collection of clinical data to determine medical necessity, as well as the opportunity to identify case management needs and assist in arranging timely discharge. Clinical information includes and is not limited to: treatment records, history of presenting problem, clinical exam, diagnostic testing results, treatment plan and progress notes, psychosocial history, consultation information, operative and pathological reports, rehabilitation, evaluations, and information regarding the local delivery system, patient characteristics and information from family members.
	Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized bythe plan.	**Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.**
	To support outpatient concurrent review decisions, Horizon uses nationally recognized and/or community developed evidence-based criteria. Criteria is applied based on the needs of the individual members and an assessment of the local delivery system. Criteria sets are reviewed annually and updated as applicable. The annual review process involves appropriate practitioners with clinical expertise in the area being reviewed when adopting criteria. The criteria are consistently applied, considering individual needs of the members and allow for consultations with requesting providers when applicable. For inpatient/outpatient medical care reviews, Horizon uses the following medical review criteria: • CMS Guidelines • MCG® • ASAM 4.0-(SUD Services) • Horizon Blue Cross Blue Shield NJ Uniform Medical Policy Principles of review include:	To support outpatient concurrent review decisions, Horizon uses nationally recognized and/or community developed evidence-based criteria. Criteria is applied based on the needs of the individual members and an assessment of the local delivery system. Criteria sets are reviewed annually and updated as applicable. The annual review process involves appropriate practitioners with clinical expertise in the area being reviewed when adopting criteria. The criteria are consistently applied, considering individual needs of the members and allow for consultations with requesting providers when applicable. For inpatient/outpatient medical care reviews, Horizon uses the following medical review criteria: • CMS Guidelines • MCG® • Horizon Blue Cross Blue Shield NJ Uniform Medical Policy Principles of review include: • Identification of medically unnecessary and inappropriate

	• Identification of medically unnecessary and inappropriate hospital days and services. • Appropriateness for alternate levels of care. • Appropriateness of services in relation to the member's diagnosis, problem, or condition. • Identification of case management/discharge planning referrals. • Identification and referral of quality of care issues. • Assessment of the local delivery system and its ability to meet member needs • Consideration of individual needs. 1. Age 2. Comorbidities 3. Complications 4. Progress of treatment 5. Psychosocial situation 6. Home environment, when applicable	hospital days and services. • Appropriateness for alternate levels of care. • Appropriateness of services in relation to the member's diagnosis, problem, or condition. • Identification of case management/discharge planning referrals. • Identification and referral of quality of care issues. • Assessment of the local delivery system and its ability to meet member needs • Consideration of individual needs. 1. Age 2. Comorbidities 3. Complications 4. Progress of treatment 5. Psychosocial situation 6. Home environment, when applicable .

Concurrent Review: Emergency Services	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all emergency benefits that require concurrent review	None	
List Processes, Strategies and Evidentiary Standards	**Processes: Explain the process for concurrent review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**	**Processes: Explain the process for concurrent review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**
	N/A	N/A
	Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.	**Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.**
	N/A	N/A
	Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	**Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.**
	N/A	N/A

Concurrent Review: Pharmacy Services	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all Pharmacy benefits that require concurrent review	None	None
List Processes, Strategies and Evidentiary Standards	**Processes: Explain the process for concurrent review that is utilized by your MCO including exceptions and ability to ensure**	**Processes: Explain the process for concurrent review that is utilized by your MCO including exceptions and ability to**
	medically necessary services are provided.	**ensure medically necessary services are provided.**
	N/A	N/A
	Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrentreview.	**Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.**
	N/A	N/A
	Evidentiary Standards: Describe evidence that supports the use ofconcurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	**Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.**
	N/A	N/A

Medical Necessity: Inpatient Services	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical Surgical
Identify the criteria utilized for medical necessity	Criteria utilized for medical necessity: HNJH's Behavioral Health UM program utilizes objective evidenced-based Clinical Criteria/Guidelines for services requiring medical necessity review: MCG®, CMS NCD/LCDs, Horizon Uniform Medical Policies are used for the mental health services and levels of care, while the American Society of Addiction Medicine ("ASAM") criteria are used for the Substance Use Disorder ("SUD") services. HNJH uses the Level of Care criteria guidelines, not absolute standards, and considers them in conjunction with other indications of a member's needs, strengths, including but not limited to age, co-morbidities, complications, and progress of treatment, psychosocial issues, home environment, and other situations as they arise. In addition, the individual member needs and characteristics of the local service delivery system and social supports are taken into consideration. Criteria sets are reviewed annually for appropriateness to HNJH population needs and updated as applicable when national or community-based clinical practice guidelines are updated. The annual review process involves appropriate medical directors and community based practitioners in developing, adopting, or reviewing criteria. Members and providers are advised of the availability of criteria sets upon request, in notice of action / UM adverse determination letters, provider manuals, newsletters, the HNJH website, and member handbooks. When a criteria set may not be appropriate for Horizon Government Program members with complications or for a delivery system with insufficient alternatives to inpatient care the following shall be considered when applying criteria to services: 1. Age, co-morbidities, complications, progress of treatment, psychosocial situation, home environment,	Criteria utilized for medical necessity: HNJH's UM program utilizes objective evidenced based Clinical Criteria/Guidelines for services requiring medical necessity review: MCG®, CMS NCD/LCDs, and HNJH Uniform Medical Policies. HNJH uses these Level of Care criteria as guidelines, not absolute standards, and considers them in conjunction with other indications of a member's needs, strengths, including but not limited to age, co-morbidities, complications, andprogress of treatment, psychosocial issues, home environment, and other situations as they arise. In addition, the individual member needs and characteristics of the local service delivery system and social supports are taken into consideration. Criteria sets are reviewed annually for appropriateness to HNJH population needs and updated as applicable when national or community-based clinical practice guidelines are updated. The annual review process involves appropriate medical directors and community based practitioners in developing, adopting, or reviewing criteria. Members and providers are advised of the availability of criteria sets upon request, in notice of action / UM adverse determination letters, provider manuals, newsletters, the HNJH website, and member handbooks. When a criteria set may not be appropriate for Horizon Government Program members with complications or for a delivery system with insufficient alternatives to inpatient care the following shall be considered when applying criteria to services: 1. Age, co-morbidities, complications, progress of treatment, psychosocial situation, home environment, other situations as they arise. 2. Horizon shall consider the local delivery system available for members, such as: o Availability and or coverage of skilled/sub-acute nursing facilities or home care.

	other situations as they arise. 2. Horizon shall consider the local delivery system available for members, such as: o Availability and or coverage of skilled/sub-acute nursing facilities or home care. o A facility's ability to provide all required services within the estimated length of stay.	o A facility's ability to provide all required services within the estimated length of stay.
	Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	**Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**
	HNJH's process for developing medical necessity criteria is as follows: Initial and annual review process consist of an evaluation of existing criteria, determination of any recommendations or changes, final acknowledgement or acceptance of criteria. The process involves appropriate practitioners in developing, adopting, and reviewing criteria. The Utilization Management/Case Management (UM/CM) Committee and Medical Management Committee (MMC) review criteria sets including American Society of Addiction Medicine (ASAM), and medical policies and the procedures for applying them against current clinical and medical evidence. The UM/CM Committee and MMC are comprised of medical directors and participating community providers representing a broad range of specialties such as, internal medicine, family medicine, pediatrics, ob-gyn and behavioral health and geriatrician who are actively managing members in Commercial, Medicare Advantage and/or Medicaid and DSNP plans. Approved clinical guidelines are submitted to the Horizon Quality Improvement Committee for review and adoption. These guidelines are adopted to promote consistent application of evidence-based treatment methodologies, facilitate improvement of health care, and reduce unnecessary variations in care. Medical policies and applicable Utilization Management	HNJH's process for developing medical necessity criteria is as follows: Initial and annual review process consist of an evaluation of existing criteria, determination of any recommendations or changes, final acknowledgement or acceptance of criteria. The process involves appropriate practitioners in developing, adopting, and reviewing criteria. The Utilization Management/Case Management (UM/CM) Committee and Medical Management Committee (MMC) review criteria sets including American Society of Addiction Medicine (ASAM), and medical policies and the procedures for applying them against current clinical and medical evidence. The UM/CM Committee and MMC are comprised of medical directors and participating community providers representing a broad range of specialties such as, internal medicine, family medicine, pediatrics, ob-gyn and behavioral health and geriatrician who are actively managing members in Commercial, Medicare Advantage and/or Medicaid and DSNP plans. Approved clinical guidelines are submitted to the Horizon Quality Improvement Committee for review and adoption. These guidelines are adopted to promote consistent application of evidence-based treatment methodologies, facilitate improvement of health care, and reduce unnecessary variations in care. Medical policies and applicable Utilization Management (UM)

	(UM) policies are reviewed at least annually based on updates to technology or emerging clinical evidence that support a change in clinical practice resulting in an updated or new medical policy after review of scientific literature and the findings of professional and regulatory bodies. Practitioners of a range of specialties are involved in the development, adoption and annual review of all medical necessity criteria. The process that describes how criteria are applied to individual members with regard to individual patient characteristics and features of the delivery system providing care is reviewed annually with input from practitioners and revised, as appropriate. The approved clinical guidelines are maintained in a written format and are used as the basis for all medical necessity determinations. All criteria are objective and scientifically based. Horizon utilizes the following clinical criteria sets to support UM decision-making include: 1. MCG® 2. American Society of Addition Medicine (ASAM) Criteria 3. CMS Local Coverage Determinations/National Coverage Determinations Guidelines 4. Horizon Uniform Medical Policies 5. Horizon Utilization Management Policies Process for Medical Necessity Review: Horizon's licensed healthcare and behavioral health professionals review prior authorization requests and requests for on-going treatment utilizing the appropriate clinical. Clinical requests for the prior authorization and levels of care are submitted to HNJH either telephonically or through an electronic portal, fax, or email, which HNJH-licensed Behavioral Healthcare clinicians then evaluate against the appropriate clinical criteria set. MCG® clinical guidelines are used for mental health services, while American Society	policies are reviewed at least annually based on updates to technology or emerging clinical evidence that support a change in clinical practice resulting in an updated or new medical policy after review of scientific literature and the findings of professional and regulatory bodies. Practitioners of a range of specialties are involved in the development, adoption and annual review of all medical necessity criteria. The process that describes how criteria are applied to individual members with regard to individual patient characteristics and features of the delivery system providing care is reviewed annually with input from practitioners and revised, as appropriate. The approved clinical guidelines are maintained in a written format and are used as the basis for all medical necessity determinations. All criteria are objective and scientifically based. Horizon utilizes the following clinical criteria sets to support UM decision-making include: 1. MCG® 2. American Society of Addition Medicine (ASAM) Criteria 3. CMS Local Coverage Determinations/National Coverage Determinations Guidelines 4. Horizon Uniform Medical Policies 5. Horizon Utilization Management Policies Process for Medical Necessity Review: Horizon's licensed healthcare and behavioral health professionals review prior authorization requests and requests for on-going treatment utilizing the appropriate clinical. Clinical requests for the prior authorization and levels of care are submitted to HNJH either telephonically or through an electronic portal, fax or email which HNJH-licensed healthcare clinicians evaluate against the appropriate clinical criteria set. MCG® clinical guidelines are used to determine whether the requested care and level of care/service meets medical

	of Addiction Medicine ("ASAM") for Substance Use Disorder ("SUD") services to determine whether the requested care/service meets medical necessity criteria. HNJH maintains compliance with federal and state regulations and guidelines as well as NCQA health plan accreditation standards. Cases that meet medical necessity criteria are approved by licensed Behavioral Health clinicians. Cases that do not meet medical necessity criteria are sent to a medical director for an organizational determination resulting in either an approval or an adverse determination.	necessity criteria. HNJH maintains compliance with federal and state regulations and guidelines as well as NCQA health plan accreditation standards. Cases that meet medical necessity criteria are approved by licensed healthcare clinician and cases that do not meet medical necessity criteria are referred to medical director for an organizational determination resulting in either an approval or an adverse determination.
	HNJH's utilization management department is comprised of licensed and non-licensed healthcare professionals including Psychiatrists, Registered Nurses (RNs), Licensed Clinical Social Workers (LCSWs), Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors (LPCs), Clinical Psychologists and support associates qualified to function within the utilization management program and defined scope of their job descriptions. The process and timeframes for medical necessity review and prior authorization are consistent with the state, federal and accreditation requirements.	HNJH's utilization management department is comprised of licensed and non-licensed healthcare professionals, including Physicians, Registered Nurses, licensed Physical Therapists and Support Associates qualified to function within the utilization management program and the defined scope of their job descriptions. Physician Reviewers known as medical directors are licensed and board certified. The process and timeframes for medical necessity review and prior authorization are consistent with the state, federal and accreditation requirements.
	HNJH's exceptions to the above process for prior authorization of Behavioral Health Services are as follows: Exceptions are granted if there is a need for a service that our network physicians or hospitals cannot accommodate or there are geo access issues and ensure there are no barriers to access of care.	HNJH's exceptions to the above process for prior authorization of Medical/Surgical services are as follows: Exceptions are granted if there is a need for a service that our network physicians or hospitals cannot accommodate or there are geo access issues and ensure there are no barriers to access of care.
	HNJH UM program uses the following objective, evidenced-based Clinical Criteria/Guidelines for services requiring medical necessity review: MCG®, Centers for Medicare and Medicaid Services ("CMS"), National Coverage Determinations/Local Coverage Determinations, Horizon Uniform Medical Policies, American Society of Addiction Medicine ("ASAM") for SUD withdrawal management.	HNJH Utilization Management program uses the following objective, evidenced-based Clinical Criteria/Guidelines for services requiring medical necessity review: MCG®, Centers for Medicare and Medicaid Services (CMS), National Coverage Determinations/ Local Coverage Determinations, HNJH Uniform Medical Policies.

	Providers Members and Non-members can request copies of the clinical criteria by contacting Horizon Utilization Management Department. Providers and members are informed of the availability of clinical criteria and how to request via the Provider Manual and Horizon Web site. All policy changes must be posted on the Web site for 30 days to allow participating providers to comment and/or question changes. Members are afforded the opportunity to request a copy of the clinical criteria that was used to make an adverse determination.	Providers Members and Non-members can request copies of the clinical criteria by contacting Horizon Utilization Management Department. Providers and members are informed of the availability of clinical criteria and how to request via the Provider Manual and Horizon Web site. All policy changes must be posted on the Web site for 30 days to allow participating providers to comment and/or question changes. Members are afforded the opportunity to request a copy of the clinical criteria that was used to make an adverse determination.
	Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.	**Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.**
	HNJH requires medical necessity to ensure we provide access to high quality health care services to our members and support them in making the best decisions about managing their health by helping our members become and stay healthy. To improve the quality of care and life for our members, the HNJH Behavioral Health Utilization Management Program places significant emphasis on maximizing value in provision of healthcare service, increasing the safety and quality of healthcare delivered to our members, reducing healthcare disparities and increasing health literacy (documenting when applicable personal preferences), maintaining quality related reporting requirements of accrediting bodies and other local, state, and federal regulatory and external review organizations. The Utilization Management/Case Management (UM/CM) Committee and Medical Management Committee (MMC) review criteria sets including American Society of Addiction Medicine (ASAM), and medical policies and the procedures for applying them against current clinical	HNJH requires medical necessity to ensure we provide access to high quality health care services to our members and support them in making the best decisions about managing their health by helping our members become and stay healthy. To improve the quality of care and life for our members, the HNJH Utilization Management Program places significant emphasis on maximizing value in provision of healthcare service, increasing the safety and quality of healthcare delivered to our members, reducing healthcare disparities and increasing health literacy (documenting when applicable personal preferences), maintaining quality related reporting requirements of accrediting bodies and other local, state, and federal regulatory and external review organizations. The Utilization Management/Case Management (UM/CM) Committee and Medical Management Committee (MMC) review criteria sets including American Society of Addiction Medicine (ASAM), and medical policies and the procedures for applying them against current clinical and medical

	and medical evidence. The UM/CM Committee and MMC are comprised of medical directors and participating community providers representing a broad range of specialties such as, internal medicine, family medicine, pediatrics, ob-gyn and behavioral health and geriatrician who are actively managing members in Commercial, Medicare Advantage and/or Medicaid and DSNP plans. Approved clinical guidelines are submitted to the Horizon Quality Improvement Committee for review and adoption. These guidelines are adopted to promote consistent application of evidence-based treatment methodologies, facilitate improvement of health care, and reduce unnecessary variations in care. The intent of medical necessity: The program is designed to ensure that established quality standards are in place to make certain the care delivered is appropriate, medically necessary and aligns with clinical best practices and to accommodate modifications where necessary.	evidence. The UM/CM Committee and MMC are comprised of medical directors and participating community providers representing a broad range of specialties such as, internal medicine, family medicine, pediatrics, ob-gyn and behavioral health and geriatrician who are actively managing members in Commercial, Medicare Advantage and/or Medicaid and DSNP plans. Approved clinical guidelines are submitted to the Horizon Quality Improvement Committee for review and adoption. These guidelines are adopted to promote consistent application of evidence-based treatment methodologies, facilitate improvement of health care, and reduce unnecessary variations in care. The intent of medical necessity: The program is designed to ensure that established quality standards are in place to make certain the care delivered is appropriate, medically necessary and aligns with clinical best practices and to accommodate modifications where necessary.
	Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	**Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.**
	Evidence that supports the use of medical necessity: HNJH's Behavioral Health UM program utilizes objective, evidenced- based Clinical Criteria/Guidelines for services requiring medical necessity review; MCG® and Horizon Uniform Medical Policies are used for mental health services and levels of care, while the American Society of Addiction Medicine ("ASAM") is used for the Substance Use Disorder ("SUD") levels of care. The following factors are considered when applying criteria to services received by a HNJH member; age, co- morbidities, complications, progress of treatment, psychosocial issues, home environment, and other situations as they arise. HNJH also considers the local delivery system available for members.	Evidence that supports the use of medical necessity: HNJH's UM program utilizes objective, evidenced-based Clinical Criteria/Guidelines for services requiring medical necessity review: MCG®, and HNJH Uniform Medical Policies. The following factors are considered when applying criteria to services received by a HNJH member; age, co-morbidities, complications, progress of treatment, psychosocial issues, home environment, and other situations as they arise. HNJH also considers the local delivery system available for members.

Medical Necessity: Outpatient Services	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
Identify the criteria utilized for medical necessity	HNJH UM program uses the following objective, evidenced-based Clinical Criteria/Guidelines for services requiring medical necessity review: MCG®, Centers for Medicare and Medicaid Services ("CMS"), National Coverage Determinations/Local Coverage Determinations, Horizon Uniform Medical Policies, and the American Society of Addiction Medicine ("ASAM") is used for the Substance Use Disorder ("SUD") levels of care. HNJH maintains compliance with federal and state regulations andguidelines as well as NCQA health plan accreditation standards.	HNJH UM program uses the following objective, evidenced-based Clinical Criteria/Guidelines for services requiring medical necessity review: MCG®, Centers for Medicare and Medicaid Services ("CMS"), National Coverage Determinations/Local Coverage Determinations, and Horizon Uniform Medical Policies. HNJH maintains compliance with federal and state regulations andguidelines as well as NCQA health plan accreditation standards.
	Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	**Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**
	HNJH's process for developing medical necessity criteria is as follows: Initial and annual review process consist of an evaluation of existing criteria, determination of any recommendations or changes, final acknowledgement or acceptance of criteria. The process involves appropriate practitioners in developing, adopting, and reviewing criteria. The Utilization Management/Case Management (UM/CM) Committee and Medical Management Committee (MMC) review criteria sets including American Society of Addiction Medicine (ASAM), and medical policies and the procedures for applying them against current clinical and medical evidence. The UM/CM Committee and MMC are comprised of medical directors and participating community providers representing a broad range of specialties such as, internal medicine, family medicine, pediatrics, ob-gyn and behavioral health and geriatrician who are actively managing members in Commercial, Medicare Advantage and/or Medicaid and DSNP plans. Approved	HNJH's process for developing medical necessity criteria is as follows: Initial and annual review process consist of an evaluation of existing criteria, determination of any recommendations or changes, final acknowledgement or acceptance of criteria. The process involves appropriate practitioners in developing, adopting, and reviewing criteria. The Utilization Management/Case Management (UM/CM) Committee and Medical Management Committee (MMC) review criteria sets including American Society of Addiction Medicine (ASAM), and medical policies and the procedures for applying them against current clinical and medical evidence. The UM/CM Committee and MMC are comprised of medical directors and participating community providers representing a broad range of specialties such as, internal medicine, family medicine, pediatrics, ob-gyn and behavioral health and geriatrician who are actively managing members in Commercial,

	clinical guidelines are submitted to the Horizon Quality Improvement Committee for review and adoption. These guidelines are adopted to promote consistent application of evidence-based treatment methodologies, facilitate improvement of health care, and reduce unnecessary variations in care. Medical policies and applicable Utilization Management (UM) policies are reviewed at least annually based on updates to technology or emerging clinical evidence that support a change in clinical practice resulting in an updated or new medical policy after review of scientific literature and the findings of professional and regulatory bodies. Practitioners of a range of specialties are involved in the development, adoption and annual review of all medical necessity criteria. The process that describes how criteria are applied to individual members with regard to individual patient characteristics and features of the delivery system providing care is reviewed annually with input from practitioners and revised, as appropriate. The approved clinical guidelines are maintained in a written format and are used as the basis for all medical necessity determinations. All criteria are objective and scientifically based. Horizon utilizes the following clinical criteria sets to support UM decision-making include: • MCG® • American Society of Addition Medicine (ASAM) Criteria • CMS Local Coverage Determinations/National Coverage Determinations Guidelines • Horizon Uniform Medical Policies • Horizon Utilization Management Policies HNJH's process for medical necessity review of Behavioral Health services is as follows: The determination of whether a service is medically necessary is made on a case-by-case basis using the approved evidenced	Medicare Advantage and/or Medicaid and DSNP plans. Approved clinical guidelines are submitted to the Horizon Quality Improvement Committee for review and adoption. These guidelines are adopted to promote consistent application of evidence-based treatment methodologies, facilitate improvement of health care, and reduce unnecessary variations in care. Medical policies and applicable Utilization Management (UM) policies are reviewed at least annually based on updates to technology or emerging clinical evidence that support a change in clinical practice resulting in an updated or new medical policy after review of scientific literature and the findings of professional and regulatory bodies. Practitioners of a range of specialties are involved in the development, adoption and annual review of all medical necessity criteria. The process that describes how criteria are applied to individual members with regard to individual patient characteristics and features of the delivery system providing care is reviewed annually with input from practitioners and revised, as appropriate. The approved clinical guidelines are maintained in a written format and are used as the basis for all medical necessity determinations. All criteria are objective and scientifically based. Horizon utilizes the following clinical criteria sets to support UM decision-making include: • MCG® • American Society of Addition Medicine (ASAM) Criteria • CMS Local Coverage Determinations/National Coverage Determinations Guidelines • Horizon Uniform Medical Policies • Horizon Utilization Management Policies HNJH's process for medical necessity review of Medical/Surgical services is as follows: The determination of whether a service is medically necessary is made on a case-by-case basis using the

	based clinical guidelines and taking into account the individual needs of the member individual member characteristics and features of the delivery system providing care and allows for consultations with requesting providers when appropriate. Clinical requests for the above services and levels of care are submitted to HNJH either telephonically, through an electronic portal, fax, mail, which licensed Behavioral Health clinicians evaluate against the appropriate evidenced-based clinical criteria guidelines: MCG®; American Society of Addiction Medicine ("ASAM") for Substance Use Disorder ("SUD") and Horizon Uniform Medical Policy to determine whether the requested level of care/service meets medical necessity criteria. HNJH maintains compliance with federal and state regulations and guidelines as well as NCQA health plan accreditation standards. Cases that meet medical necessity criteria are approved by Behavioral Health care clinicians. The cases that do not meet medical necessity criteria are referred to a medical director for organizational determination resulting in either an approval or adverse determination HNJH's Behavioral Health utilization management department is comprised of licensed and non-licensed healthcare professionals including Psychiatrists, Registered Nurses, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, licensed Professional Counselors, Clinical Psychologists, BCBAs (Autism ABA Service), and Support Associates qualified to function within the utilization management program and the defined scope of their job descriptions. Physician Reviewers, known as medical Directors are licensed and board certified. HNJH follows NCQA requirements for obtaining all medically necessary clinical information in order to render a clinical determination. The process and timeframes for medical necessity review and prior authorization are consistent with state, federal, and NCQA accreditation requirements. HNJH's exceptions to the above process for prior authorization of Behavioral Health services are as follows: Exceptions are granted if there is a need for a service that our network providers/ hospitals cannot accommodate or there are	approved evidenced based clinical guidelines and taking into account the individual needs of the member individual member characteristics and features of the delivery system providing care and allows for consultations with requesting providers when appropriate. Clinical requests for the above services and levels of care are submitted to HNJH either telephonically, through an electronic portal, fax, mail. Licensed healthcare clinicians then evaluate against the appropriate clinical criteria set: MCG®; Horizon Uniform Medical Policies, Centers for Medicare and Medicaid Services ("CMS"), to determine whether the requested care and level of care/service meets medical necessity criteria. HNJH maintains compliance with federal and state regulations and guidelines as well as NCQA health plan accreditation standards. The cases that meet medical necessity criteria are approved by licensed healthcare clinicians and cases that do not meet medical necessity criteria are referred to a medical director for an organizational determination resulting in either an approval or adverse determination. HNJH's utilization management department is comprised of licensed and non-licensed healthcare professionals, including Physicians, Registered Nurses, Licensed Physical Therapists and support associates qualified to function within the utilization management program and the defined scope of their job descriptions. HNJH follows NCQA requirements for obtaining all medically necessary clinical information in order to render a clinical determination The process and timeframes for medical necessity review and prior authorization are consistent with the state, federal and accreditation requirements. HNJH's exceptions to the above process for prior authorization of Medical/Surgical services are as follows: Exceptions are granted if there is a need for a service that

	geo access issues. Exceptions are granted when medically necessary to ensure there are not barriers to access to care.	our network providers/ hospitals cannot accommodate or there are geo access issues. Exceptions are granted when medically necessity to ensure there are not barriers to access of care.
	Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.	**Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.**
	HNJH requires medical necessity to ensure we provide access to high quality health care services to our members and support them in making the best decisions about managing their health by helping our members become and stay healthy. To improve the quality of care and life for our members, the HNJH Behavioral Health Utilization Management Program places significant emphasis on maximizing value in provision of healthcare service, increasing the safety and quality of healthcare delivered to our members, reducing healthcare disparities and increasing health literacy (documenting when applicable personal preferences), maintaining quality related reporting requirements of accrediting bodies and other local, state, and federal regulatory and external review organizations. The Utilization Management/Case Management (UM/CM) Committee and Medical Management Committee (MMC) review criteria sets including American Society of Addiction Medicine (ASAM), and medical policies and the procedures for applying them against current clinical and medical evidence. The UM/CM Committee and MMC are comprised of medical directors and participating community providers representing a broad range of specialties such as, internal medicine, family medicine, pediatrics, ob-gyn and behavioral health and geriatrician who are actively managing members in Commercial, Medicare Advantage and/or Medicaid and DSNP plans. Approved clinical guidelines are submitted to the Horizon Quality Improvement Committee for review and adoption. These guidelines are adopted to promote consistent application of evidence-based treatment methodologies,	HNJH requires medical necessity to ensure we provide access to high quality health care services to our members and support them in making the best decisions about managing their health by helping our members become and stay healthy. To improve the quality of care and life for our members, the HNJH Utilization Management Program places significant emphasis on maximizing value in provision of healthcare service, increasing the safety and quality of healthcare delivered to our members, reducing healthcare disparities and increasing health literacy (documenting when applicable personal preferences), maintaining quality related reporting requirements of accrediting bodies and other local, state, and federal regulatory and external review organizations. The Utilization Management/Case Management (UM/CM) Committee and Medical Management Committee (MMC) review criteria sets including American Society of Addiction Medicine (ASAM), and medical policies and the procedures for applying them against current clinical and medical evidence. The UM/CM Committee and MMC are comprised of medical directors and participating community providers representing a broad range of specialties such as, internal medicine, family medicine, pediatrics, ob-gyn and behavioral health and geriatrician who are actively managing members in Commercial, Medicare Advantage and/or Medicaid and DSNP plans. Approved clinical guidelines are submitted to the Horizon Quality Improvement Committee for review and adoption. These guidelines are adopted to promote consistent

	facilitate improvement of health care, and reduce unnecessary variations in care. The intent of medical necessity: The program is designed to ensure that established quality standards are in place to make certain the care delivered is appropriate, medically necessary and aligns with clinical best practices and to accommodate modifications where necessary.	application of evidence-based treatment methodologies, facilitate improvement of health care, and reduce unnecessary variations in care. The intent of medical necessity: The program is designed to ensure that established quality standards are in place to make certain the care delivered is appropriate, medically necessary and aligns with clinical best practices and to accommodate modifications where necessary.
	Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	**Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.**
	Evidence that supports the use of medical necessity: HNJH's BH UM program utilizes objective evidenced-based Clinical Criteria/Guidelines for services requiring medical necessity review: MCG®, Centers for Medicare and Medicaid Services (CMS) and Horizon Uniform Medical Policies are used for mental health services, while ASAM is used the Substance Use Disorder Services and all levels of care. The following factors are considered when applying criteria to services received by a HNJH member; age, co-morbidities, complications, progress of treatment, psychosocial issues, culture, health care disparities, home environment, and other situations as they arise. HNJH also considers the local delivery system available for members.	Evidence that supports the use of medical necessity: HNJH's UM program utilizes objective evidenced based Clinical Criteria/Guidelines for services requiring medical necessity review: MCG®, Centers for Medicare and Medicaid Services (“CMS”), Horizon Uniform Medical Policies. The following are considered when applying criteria to services received by a HNJH member; age, co-morbidities, complications, progress of treatment, psychosocial issues, culture, health care disparities, home environment, and other situations as they arise HNJH also considers the local delivery system available for members.

Medical Necessity: Emergency Services	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
Identify the criteria utilized for medical necessity	N/A	N/A
	Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	**Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**
	N/A	N/A
	Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.	**Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.**
	N/A	N/A
	Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	**Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.**
	N/A	N/A
Medical Necessity: Emergency Services	**Behavioral Health (Mental Health and Substance Use Disorder Services)**	**Medical/Surgical Services**

Medical Necessity: Pharmacy Services	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
Identify the criteria utilized for medical necessity	The criteria utilized is the Pharmacy prior authorization and Drug utilization review policies.	The criteria utilized is the Pharmacy prior authorization and Drug utilization review policies.
	Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	**Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**
	In regards only to Medicaid outpatient pharmacy benefit provided via retail pharmacies, refer to Pharmacy prior authorization policy (which addresses prior authorization standards for formulary exceptions and when medications are prescribed beyond FDA established maximum daily dose guidelines) and Drug utilization review policy (which addresses prospective/concurrent drug utilization review standards such as drug-drug interactions, early refills, therapeutic duplication, maximum daily dose, minimum daily dose, under-utilization, over-utilization, clinical abuse/misuse).	In regards only to Medicaid outpatient pharmacy benefit provided via retail pharmacies, refer to Pharmacy prior authorization policy (which addresses prior authorization standards for formulary exceptions and when medications are prescribed beyond FDA established maximum daily dose guidelines) and Drug utilization review policy (which addresses prospective/concurrent drug utilization review standards such as drug-drug interactions, early refills, therapeutic duplication, maximum daily dose, minimum daily dose, under-utilization, over-utilization, clinical abuse/misuse).
	Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.	**Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.**
	In regards only to Medicaid outpatient pharmacy benefit provided via retail pharmacies, prior authorization and drug utilization review are used to avoid drug-drug interactions, inappropriate dosage, contraindications, and patient safety. Policies are re-reviewed annually for any modifications needed to meet medical necessity.	In regards only to Medicaid outpatient pharmacy benefit provided via retail pharmacies, prior authorization and drug utilization review are used to avoid drug-drug interactions, inappropriate dosage, contraindications, and patient safety. Policies are re-reviewed annually for any modifications needed to meet medical necessity.

	Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	**Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.**
	In regards only to Medicaid outpatient pharmacy benefit provided via retail pharmacies, FDA-approved package insert, American Hospital Formulary Service, Micromedex, Clinical Pharmacology and national guidelines are utilized.	In regards only to Medicaid outpatient pharmacy benefit provided via retail pharmacies, FDA-approved package insert, American Hospital Formulary Service, Micromedex, Clinical Pharmacology and national guidelines are utilized.

Retrospective Review: Inpatient Services	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all inpatient benefits that require retrospective review	The Horizon Utilization Management Departments may conduct retrospective medical necessity reviews of inpatient clinical services, prior to the claim submission.	The Horizon Utilization Management Departments may conduct retrospective medical necessity reviews of inpatient clinical services, prior to the claim submission.
Processes, Strategies and Evidentiary Standards	**Processes: Explain the process for retrospective review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**	**Processes: Explain the process for retrospective review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**
	HNJH's process for retrospective review of Behavioral Health services is as follows: Retrospective review: A retrospective review request is defined as an authorization request that is initiated after the requested service has been performed and prior to claim submission. Timeline for Submission and Retrospective Review: 1. If a member has been discharged from an inpatient admission, Horizon will allow the provider three (3) business days from the date of discharge to provide a Notice of Admission. 3. If the above is met, Horizon will process the authorization request as an urgent concurrent and/or prior authorization. 4. If above is not met, Horizon will process as a retrospective review and process within thirty (30) calendar days of receipt. 5. In cases of extenuating circumstances related to eligibility verification/exhaustion of primary benefits will be reviewed and require supporting documentation. 7. All hospital stays will be reviewed for medical necessity 8. For retrospective decisions, Horizon does give electronic and written notification of the decision to the practitioners within thirty (30) calendar days of the request.	HNJH's process for retrospective review of Medical/Surgical services is as follows: Retrospective review: A retrospective review request is defined as an authorization request that is initiated after the requested service has been performed and prior to claim submission. Timeline for Submission and Retrospective Review: 1. If a member has been discharged from an inpatient admission, Horizon will allow the provider three (3) business days from the date of discharge to provide a Notice of Admission. 3. If the above is met, Horizon will process the authorization request as an urgent concurrent and/or prior authorization. 4. If above is not met, Horizon will process as a retrospective review and process within thirty (30) calendar days of receipt. 5. In cases of extenuating circumstances related to eligibility verification/exhaustion of primary benefits will be reviewed and require supporting documentation. 7. All hospital stays will be reviewed for medical necessity 8. For retrospective decisions, Horizon does give electronic and written notification of the decision to the practitioners within thirty (30) calendar days of the request

	Process for Determining and Applying Services Subject to Retrospective Review: All services subject to prior authorization are subject to retrospective review. Horizon's Medical Management Committee ("MMC") is responsible for the implementation and administration of prior authorization for MH/SUD and M/S benefits in the outpatient and inpatient classification. The MMC's primary responsibilities include annual evaluation and approval of administrative policies and clinical criteria; as well as monitoring the prior authorization process, including the factors and evidentiary standards relied on in the NQTL's program design and application. This includes clinical rationale, internal methods or metrics reviewed or used to design the NQTL, and processes or procedures applied to prior authorization. Horizon's utilization management program and the medical necessity criteria that it utilizes are reviewed and approved by the MMC annually to assure that appropriate updates and changes align with Horizon's evidenced based approach to clinical management for services subject to prior authorization. Medical Management Committee Composition The Medical Management Committee ("MMC") is comprised of behavioral health and physical health senior leadership. The MMC generally meets bimonthly, but in no event less than four times per calendar year. MMC meetings are scheduled by the Chairperson. Voting privileges may not be assigned to alternates attending in place of Committee members. Majority (50% + 1) of the voting membership must be present to meet the quorum. Action is taken by a simple majority vote of the members present.	Process for Determining and Applying Services Subject to Retrospective Review: All services subject to prior authorization are subject to retrospective review. Horizon's Medical Management Committee ("MMC") is responsible for the implementation and administration of prior authorization for MH/SUD and M/S benefits in the outpatient and inpatient classification. The MMC's primary responsibilities include annual evaluation and approval of administrative policies and clinical criteria; as well as monitoring the prior authorization process, including the factors and evidentiary standards relied on in the NQTL's program design and application. This includes clinical rationale, internal methods or metrics reviewed or used to design the NQTL, and processes or procedures applied to prior authorization. Horizon's utilization management program and the medical necessity criteria that it utilizes are reviewed and approved by the MMC annually to assure that appropriate updates and changes align with Horizon's evidenced based approach to clinical management for services subject to prior authorization. Medical Management Committee Composition The Medical Management Committee ("MMC") is comprised of behavioral health and physical health senior leadership. The MMC generally meets bimonthly, but in no event less than four times per calendar year. MMC meetings are scheduled by the Chairperson. Voting privileges may not be assigned to alternates attending in place of Committee members. Majority (50% + 1) of the voting membership must be present to meet the quorum. Action is taken by a simple majority vote of the members present.

	The representation of behavioral health voting members includes the Director of Clinical Behavioral Health and the Medical Director for Behavioral Health services. The MMC Charter and the current voting committee member composition (including names) are attached. (See Medical Management Committee Charter, effective August 18, 2024, Member Composition for the Medical Management Committee, effective August 18, 2024.) As set forth in the MMC Charter, the MMC consists of the following members, which includes both M/S and MH/SUD members: Medical Director III, Health Network Solutions and Network Management (Chairperson and tiebreaker voting member). • Medical Director - HCM&T (2 voting members). • Senior Director, Chief Quality Officer/Director - Quality Management (1 voting member). • Executive/Senior Medical Director, Medical Policy (1 voting member). • Director/Manager, Utilization Management Appeals and Quality of Care (1 voting member). • Vice President/Directors/Managers, Clinical Operations and other Clinical Directors/Managers (3 voting members). • Medical Director (Behavioral Health) (1 voting member). • Director/Manager, Delegate & Vendor Oversight (1 voting member). • External Participating Physicians (1-2 voting members). • Senior Director/Director Clinical Behavioral Health (2 voting members). • Director/Manager, Clinical Pharmacy Operations (1 voting member). • Other representatives as requested by Chairperson or person officially in “acting position” for any of the above positions - (non-voting).	The representation of behavioral health voting members includes the Director of Clinical Behavioral Health and the Medical Director for Behavioral Health services. The MMC Charter and the current voting committee member composition (including names) are attached. (See Medical Management Committee Charter, effective August 18, 2024, Member Composition for the Medical Management Committee, effective August 18, 2024.) As set forth in the MMC Charter, the MMC consists of the following members, which includes both M/S and MH/SUD members: Medical Director III, Health Network Solutions and Network Management (Chairperson and tiebreaker voting member). • Medical Director - HCM&T (2 voting members). • Senior Director, Chief Quality Officer/Director - Quality Management (1 voting member). • Executive/Senior Medical Director, Medical Policy (1 voting member). • Director/Manager, Utilization Management Appeals and Quality of Care (1 voting member). • Vice President/Directors/Managers, Clinical Operations and other Clinical Directors/Managers (3 voting members). • Medical Director (Behavioral Health) (1 voting member). • Director/Manager, Delegate & Vendor Oversight (1 voting member). • External Participating Physicians (1-2 voting members). • Senior Director/Director Clinical Behavioral Health (2 voting members). • Director/Manager, Clinical Pharmacy Operations (1 voting member). • Other representatives as requested by Chairperson or person officially in “acting position” for any of the above positions - (non-voting).

	Medical Criteria Development Strategies Horizon is responsible to confirm that medical necessity criteria are established in accordance with generally accepted standards of medical practice and are objective, based on medical evidence, and clinically appropriate for the member's condition. Initial and annual review process consist of an evaluation of existing criteria, determination of any recommendations or changes, final acknowledgement or acceptance of criteria. The process involves appropriate practitioners in developing, adopting, and reviewing criteria. The Medical Management Committee (MMC) reviews criteria sets including MCG, American Society of Addiction Medicine (ASAM), and medical policies and the procedures for applying them against current clinical and medical evidence. Medical policies and applicable Utilization Management (UM) policies are reviewed at least annually based on updates to technology or emerging clinical evidence that support a change in clinical practice resulting in an updated or new medical policy after review of scientific literature and the findings of professional and regulatory bodies. Practitioners of a range of specialties are involved in the development, adoption and annual review of all medical necessity criteria. The process that describes how criteria are applied to individual members with regard to individual patient characteristics and features of the delivery system providing care is reviewed annually with input from practitioners and revised, as appropriate.	Medical Criteria Development Strategies Horizon is responsible to confirm that medical necessity criteria are established in accordance with generally accepted standards of medical practice and are objective, based on medical evidence, and clinically appropriate for the member's condition. Initial and annual review process consist of an evaluation of existing criteria, determination of any recommendations or changes, final acknowledgement or acceptance of criteria. The process involves appropriate practitioners in developing, adopting, and reviewing criteria. The Medical Management Committee (MMC) reviews criteria sets including MCG, American Society of Addiction Medicine (ASAM), and medical policies and the procedures for applying them against current clinical and medical evidence. Medical policies and applicable Utilization Management (UM) policies are reviewed at least annually based on updates to technology or emerging clinical evidence that support a change in clinical practice resulting in an updated or new medical policy after review of scientific literature and the findings of professional and regulatory bodies. Practitioners of a range of specialties are involved in the development, adoption and annual review of all medical necessity criteria. The process that describes how criteria are applied to individual members with regard to individual patient characteristics and features of the delivery system providing care is reviewed annually with input from practitioners and revised, as appropriate.
	Strategies: Explain why your MCO requires retrospective review. Describe why retrospective review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity.	**Strategies: Explain why your MCO requires retrospective review. Describe why prior authorization is provided inthe manner described under "Processes" and how the process may be modified to meet medical**

	Describe the intent of retrospective review.	**necessity. Describe the intent of retrospective review.**
	Retrospective review is triggered when there is a failure to obtain prior authorization or when information is not available to make a concurrent determination. Retro-review is limited to situations in which a facility notifies HNJH of a patient admission outside of the expected timeframe. Retrospective review may also be conducted when information is not available to make a prior authorization or concurrent determination. Why HNJH requires retrospective review: HNJH conducts retrospective review when an authorization request is initiated after the requested service has been performed and prior to claim submission. In this instance, the Utilization Management Department will elect to perform a medical necessity review after the requested services were rendered. How the process may be modified to meet medical necessity: If notification for an inpatient admission is received within the required time period from the date of discharge Horizon will process the authorization request as an urgent concurrent or prior authorization. If the required time frame is not met, Horizon will process the request as a retrospective review.	Retrospective review is triggered when there is a failure to obtain prior authorization or when information is not available to make a concurrent determination. Retro-review is limited to situations in which a facility notifies HNJH of a patient admission outside of the expected timeframe. Retrospective review may also be conducted when information is not available to make a prior authorization or concurrent determination. Why HNJH requires retrospective review: HNJH conducts retrospective review when an authorization request is initiated after the requested service has been performed and prior to claim submission. In this instance, the Utilization Management Department will elect to perform a medical necessity review after the requested services were rendered. How the process may be modified to meet medical necessity: If notification for an inpatient admission is received within the required time period from the date of discharge Horizon will process the authorization request as an urgent concurrent or prior authorization. If the required time frame is not met, Horizon will process the request as a retrospective review.
	Evidentiary Standards: Describe evidence that supports the use ofretrospective review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized bythe plan.	**Evidentiary Standards: Describe evidence that supports the use of retrospective review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.**
	Evidence that supports the use of retrospective review: Horizon has written, objective, evidenced-based Clinical Criteria Guidelines for determining the medical necessity	Evidence that supports the use of retrospective review: Horizon has written, objective, evidenced-based Clinical Criteria Guidelines for determining the medical necessity

	and clinical appropriateness of medical, behavioral healthcare and pharmaceutical a request for service. Criteria sets are reviewed annually for appropriateness to Horizon's population needs and updated as applicable when national and/or community-based clinical practice guidelines are revised. The annual review of clinical criteria involves medical directors and practitioners with appropriate clinical expertise in the areas being reviewed for adoption. Members and providers are advised that the clinical criteria used to make a medical necessity determination are available upon request in the notice of action letter or integrated denial notice (CMS). Clinical criteria are available upon request and are also accessible via the provider manual, member and provider newsletters. Horizon website, and member handbook. NCQA UM 2 A1-5 Clinical staff who make medical necessity determinations are trained on the clinical criteria guidelines. A detailed policy outlining the use of established decision criteria promotes consistency of reviews. Clinical staff will consider the member's medical history, age, comorbidities, complications, progress of treatment, psycho-social situation, home environment, requesting provider's recommendations, and clinical notes when making a determination and authorize as long as medically necessary to avoid disruptions in care. For prior authorization of elective inpatient and outpatient services, the following clinical review criteria are consulted as applicable to the member's plan: • Centers for Medicare and Medicaid Services o National Coverage Determinations (NCD) o Local Coverage Determinations (LCD) • State of New Jersey Medicaid Benefits • MCG • American Society of Addiction Medicine (ASAM) • Horizon BCBSNJ Medical Policies NCQA UM 1 A6	and clinical appropriateness of medical, behavioral healthcare and pharmaceutical a request for service. Criteria sets are reviewed annually for appropriateness to Horizon's population needs and updated as applicable when national and/or community-based clinical practice guidelines are revised. The annual review of clinical criteria involves medical directors and practitioners with appropriate clinical expertise in the areas being reviewed for adoption. Members and providers are advised that the clinical criteria used to make a medical necessity determination are available upon request in the notice of action letter or integrated denial notice (CMS). Clinical criteria are available upon request and are also accessible via the provider manual, member and provider newsletters. Horizon website, and member handbook. NCQA UM 2 A1-5 Clinical staff who make medical necessity determinations are trained on the clinical criteria guidelines. A detailed policy outlining the use of established decision criteria promotes consistency of reviews. Clinical staff will consider the member's medical history, age, comorbidities, complications, progress of treatment, psycho-social situation, home environment, requesting provider's recommendations, and clinical notes when making a determination and authorize as long as medically necessary to avoid disruptions in care. For prior authorization of elective inpatient and outpatient services, the following clinical review criteria are consulted as applicable to the member's plan: • Centers for Medicare and Medicaid Services o National Coverage Determinations (NCD) o Local Coverage Determinations (LCD) • State of New Jersey Medicaid Benefits • MCG • American Society of Addiction Medicine (ASAM) • Horizon BCBSNJ Medical Policies NCQA UM 1 A6

	Horizon considers the services available in the local delivery system when applying clinical criteria. Assessment of services and their ability to meet the needs of members may include: • Availability of inpatient outpatient and transitional facilities. • Availability of outpatient services in lieu of inpatient services such as surgicenters vs. inpatient surgery. • Availability of highly specialized services, such as transplant facilities or cancer centers. • Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge. • Local hospitals' ability to provide all recommended services within the estimated length of stay. If a health care service has been pre-authorized or approved, the specific standards, criteria or procedures used in the determination shall not be modified pursuant to retrospective review. Determinations for services that have been delivered shall be made within thirty (30) calendar days of receipt the necessary information. NCQA UM5	Horizon considers the services available in the local delivery system when applying clinical criteria. Assessment of services and their ability to meet the needs of members may include: • Availability of inpatient outpatient and transitional facilities. • Availability of outpatient services in lieu of inpatient services such as surgicenters vs. inpatient surgery. • Availability of highly specialized services, such as transplant facilities or cancer centers. • Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge. • Local hospitals' ability to provide all recommended services within the estimated length of stay. If a health care service has been pre-authorized or approved, the specific standards, criteria or procedures used in the determination shall not be modified pursuant to retrospective review. Determinations for services that have been delivered shall be made within thirty (30) calendar days of receipt the necessary information. NCQA UM5

Retrospective Review: Outpatient Services	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all outpatient benefits that require retrospective review	Outpatient services: Partial Hospitalization (PHP) Partial Care Partial SUD (ASAM 2.5) Intensive Outpatient (IOP) IOP SUD (ASAM 2.1) Adult Mental Health Rehabilitation (AMHR) Group Homes and Apartments Applied Behavior Analysis (ABA) Repetitive Transcranial Magnetic Stimulation (rTMS) Electroconvulsive Therapy (ECT) Psych Testing/Neuropsychological Testing Medically Managed Detox (ASAM 4.0) Medically Monitored Detox (SUD ASAM 3.7D) Services by non-participating providers OP Specialty Services	Outpatient Services: Outpatient elective surgery Durable medical equipment Home health services/Personal Care Assistant/Private Duty Nursing/Hospice Home IV therapy Chiropractic services after initial evaluation Chemotherapy Radiation therapy Dialysis (excluding Medicare Advantage) Outpatient therapies such as Cardiac rehab, Speech/Cognitive/Physical/Occupational Therapy OB U/S not listed as part of GEMS program Services requested by non-participating providers Medical Day services (Pediatric and Adult) MLTSS Services (as determined by the members Plan of Care)
	Processes: Explain the process for retrospective review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	**Processes: Explain the process for retrospective review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**
	HNJH's process for retrospective review of Behavioral Health services is as follows: The Horizon Utilization Management Departments may conduct retrospective medical necessity reviews of outpatient clinical services, prior to the claim submission. Timeline for Submission and Retrospective Review:	HNJH's process for retrospective review of outpatient Medical/Surgical services is as follows: The Horizon Utilization Management Departments may conduct retrospective medical necessity reviews of outpatient clinical services, prior to the claim submission. Timeline for Submission and Retrospective Review:

	The provider must notify Horizon of outpatient services rendered within six (6) business days of the request for prior authorization. If the above is met, Horizon will process the authorization request as an urgent concurrent and/or prior authorization. If above is not met, Horizon will process as a retrospective review and process within thirty (30) calendar days of receipt. For retrospective decisions, Horizon does give electronic and written notification of the decision to the practitioners within thirty (30) calendar days of the request. Process for Determining and Applying Services Subject to Retrospective Review**:** All services subject to prior authorization are subject to retrospective review. Horizon's Medical Management Committee ("MMC") is responsible for the implementation and administration of prior authorization for MH/SUD and M/S benefits in the outpatient and inpatient classification. The MMC's primary responsibilities include annual evaluation and approval of administrative policies and clinical criteria; as well as monitoring the prior authorization process, including the factors and evidentiary standards relied on in the NQTL's program design and application. This includes clinical rationale, internal methods or metrics reviewed or used to design the NQTL, and processes or procedures applied to prior authorization. Horizon's utilization management program and the medical necessity criteria that it utilizes are reviewed and approved by the MMC annually to assure that appropriate updates and changes align with Horizon's evidenced based approach to clinical management for services subject to prior authorization.	The provider must notify Horizon of outpatient services rendered within six (6) business days of the request for prior authorization. If the above is met, Horizon will process the authorization request as an urgent concurrent and/or prior authorization. If above is not met, Horizon will process as a retrospective review and process within thirty (30) calendar days of receipt. Dialysis services have a twenty (20) business day allowance for the submission of request for authorization after the service has been rendered. For retrospective decisions, Horizon does give electronic and written notification of the decision to the practitioners within thirty (30) calendar days of the request. Process for Determining and Applying Services Subject to Retrospective Review: All services subject to prior authorization are subject to retrospective review. Horizon's Medical Management Committee ("MMC") is responsible for the implementation and administration of prior authorization for MH/SUD and M/S benefits in the outpatient and inpatient classification. The MMC's primary responsibilities include annual evaluation and approval of administrative policies and clinical criteria; as well as monitoring the prior authorization process, including the factors and evidentiary standards relied on in the NQTL's program design and application. This includes clinical rationale, internal methods or metrics reviewed or used to design the NQTL, and processes or procedures applied to prior authorization. Horizon's utilization management program and the medical necessity criteria that it utilizes are reviewed and approved by the MMC annually to assure that appropriate updates and

	Medical Management Committee Composition: The Medical Management Committee ("MMC") is comprised of behavioral health and physical health senior leadership. The MMC generally meets bimonthly, but in no event less than four times per calendar year. MMC meetings are scheduled by the Chairperson. Voting privileges may not be assigned to alternates attending in place of Committee members. Majority (50% + 1) of the voting membership must be present to meet the quorum. Action is taken by a simple majority vote of the members present. The representation of behavioral health voting members includes the Director of Clinical Behavioral Health and the Medical Director for Behavioral Health services. The MMC Charter and the current voting committee member composition (including names) are attached. (See Medical Management Committee Charter, effective August 18, 2024, Member Composition for the Medical Management Committee, effective August 18, 2024.) As set forth in the MMC Charter, the MMC consists of the following members, which includes both M/S and MH/SUD members: • Medical Director III, Health Network Solutions and Network Management (Chairperson and tiebreaker voting member). • Medical Director - HCM&T (2 voting members). • Senior Director, Chief Quality Officer/Director - Quality Management (1 voting member). • Executive/Senior Medical Director, Medical Policy (1 voting member). • Director/Manager, Utilization Management Appeals and Quality of Care (1 voting member). • Vice President/Directors/Managers, Clinical Operations and other Clinical Directors/Managers (3 voting members). • Medical Director (Behavioral Health) (1 voting member).	changes align with Horizon's evidenced based approach to clinical management for services subject to prior authorization. Medical Management Committee Composition: The Medical Management Committee ("MMC") is comprised of behavioral health and physical health senior leadership. The MMC generally meets bimonthly, but in no event less than four times per calendar year. MMC meetings are scheduled by the Chairperson. Voting privileges may not be assigned to alternates attending in place of Committee members. Majority (50% + 1) of the voting membership must be present to meet the quorum. Action is taken by a simple majority vote of the members present. The representation of behavioral health voting members includes the Director of Clinical Behavioral Health and the Medical Director for Behavioral Health services. The MMC Charter and the current voting committee member composition (including names) are attached. (See Medical Management Committee Charter, effective August 18, 2024, Member Composition for the Medical Management Committee, effective August 18, 2024.) As set forth in the MMC Charter, the MMC consists of the following members, which includes both M/S and MH/SUD members: • Medical Director III, Health Network Solutions and Network Management (Chairperson and tiebreaker voting member). • Medical Director - HCM&T (2 voting members). • Senior Director, Chief Quality Officer/Director - Quality Management (1 voting member). • Executive/Senior Medical Director, Medical Policy (1 voting member). • Director/Manager, Utilization Management Appeals and Quality of Care (1 voting member). • Vice President/Directors/Managers, Clinical

	• Director/Manager, Delegate & Vendor Oversight (1 voting member). • External Participating Physicians (1-2 voting members). • Senior Director/Director Clinical Behavioral Health (2 voting members). • Director/Manager, Clinical Pharmacy Operations (1 voting member). • Other representatives as requested by Chairperson or person officially in "acting position" for any of the above positions - (non-voting). **Medical Criteria Development Strategies** Horizon is responsible to confirm that medical necessity criteria are established in accordance with generally accepted standards of medical practice and are objective, based on medical evidence, and clinically appropriate for the member's condition. Initial and annual review process consist of an evaluation of existing criteria, determination of any recommendations or changes, final acknowledgement or acceptance of criteria. The process involves appropriate practitioners in developing, adopting, and reviewing criteria. The Medical Management Committee (MMC) reviews criteria sets including MCG, American Society of Addiction Medicine (ASAM), and medical policies and the procedures for applying them against current clinical and medical evidence. Medical policies and applicable Utilization Management (UM) policies are reviewed at least annually based on updates to technology or emerging clinical evidence that support a change in clinical practice resulting in an updated or new medical policy after review of scientific literature and the findings of professional and regulatory bodies. Practitioners of a range of specialties are involved in the development,	Operations and other Clinical Directors/Managers (3 voting members). • Medical Director (Behavioral Health) (1 voting member). • Director/Manager, Delegate & Vendor Oversight (1 voting member). • External Participating Physicians (1-2 voting members). • Senior Director/Director Clinical Behavioral Health (2 voting members). • Director/Manager, Clinical Pharmacy Operations (1 voting member). • Other representatives as requested by Chairperson or person officially in "acting position" for any of the above positions - (non-voting). **Medical Criteria Development Strategies** Horizon is responsible to confirm that medical necessity criteria are established in accordance with generally accepted standards of medical practice and are objective, based on medical evidence, and clinically appropriate for the member's condition. Initial and annual review process consist of an evaluation of existing criteria, determination of any recommendations or changes, final acknowledgement or acceptance of criteria. The process involves appropriate practitioners in developing, adopting, and reviewing criteria. The Medical Management Committee (MMC) reviews criteria sets including MCG, American Society of Addiction Medicine (ASAM), and medical policies and the procedures for applying them against current clinical and medical evidence. Medical policies and applicable Utilization Management (UM) policies are reviewed at least annually based on updates to technology or emerging clinical evidence that support a change in clinical practice resulting in an updated or new medical policy after review of scientific literature and the findings of professional and regulatory bodies. Practitioners of a range of specialties are involved in the

	adoption and annual review of all medical necessity criteria. The process that describes how criteria are applied to individual members with regard to individual patient characteristics and features of the delivery system providing care is reviewed annually with input from practitioners and revised, as appropriate.	development, adoption and annual review of all medical necessity criteria. The process that describes how criteria are applied to individual members with regard to individual patient characteristics and features of the delivery system providing care is reviewed annually with input from practitioners and revised, as appropriate.
	Strategies: Explain why your MCO requires retrospective review. Describe why retrospective review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.	**Strategies: Explain why your MCO requires retrospective review. Describe why retrospective review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.**
	Retrospective review is triggered when there is a failure to obtain prior authorization or when information is not available to make a concurrent determination. Retro-review is limited to situations in which a facility notifies HNJH of a patient admission outside of the expected timeframe. Retrospective review may also be conducted when information is not available to make a prior authorization or concurrent determination. Why HNJH requires retrospective review: HNJH conducts retrospective review when an authorization request is initiated after the requested service has been performed and prior to claim submission. In this instance, the Utilization Management Department will elect to perform a medical necessity review after the requested services were rendered. How the process may be modified to meet medical necessity: If notification for an inpatient admission is received within the required time period from the date of discharge Horizon will process the authorization request as an urgent concurrent or prior authorization. If the required time frame is not met, Horizon will process	Retrospective review is triggered when there is a failure to obtain prior authorization or when information is not available to make a concurrent determination. Retro-review is limited to situations in which a facility notifies HNJH of a patient admission outside of the expected timeframe. Retrospective review may also be conducted when information is not available to make a prior authorization or concurrent determination. Why HNJH requires retrospective review: HNJH conducts retrospective review when an authorization request is initiated after the requested service has been performed and prior to claim submission. In this instance, the Utilization Management Department will elect to perform a medical necessity review after the requested services were rendered. How the process may be modified to meet medical necessity: If notification for an inpatient admission is received within the required time period from the date of discharge Horizon will process the authorization request as an urgent concurrent or prior authorization. If the required time frame is not met, Horizon will process

	the request as a retrospective review.	the request as a retrospective review.
	Evidentiary Standards: Describe evidence that supports the use of retrospective review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by **the plan.**	Evidentiary Standards: Describe evidence that supports the use of retrospective review for the benefits identified. Include any evidentiary practice guidelines or internal data that **is utilized by the plan.**
	Evidence that supports the use of retrospective review: Horizon has written, objective, evidenced-based Clinical Criteria Guidelines for determining the medical necessity and clinical appropriateness of medical, behavioral healthcare and pharmaceutical a request for service. Criteria sets are reviewed annually for appropriateness to Horizon's population needs and updated as applicable when national and/or community-based clinical practice guidelines are revised. The annual review of clinical criteria involves medical directors and practitioners with appropriate clinical expertise in the areas being reviewed for adoption. Members and providers are advised that the clinical criteria used to make a medical necessity determination are available upon request in the notice of action letter or integrated denial notice (CMS). Clinical criteria are available upon request and are also accessible via the provider manual, member and provider newsletters. Horizon website, and member handbook. NCQA UM 2 A1-5 Clinical staff who make medical necessity determinations are trained on the clinical criteria guidelines. A detailed policy outlining the use of established decision criteria promotes consistency of reviews. Clinical staff will consider the member's medical history, age, comorbidities, complications, progress of treatment, psycho-social situation, home environment, requesting provider's recommendations, and clinical notes when making a determination and authorize as long as medically necessary to avoid disruptions in care. For prior authorization of elective inpatient and outpatient services, the following clinical review criteria are consulted as applicable to the member's plan:	Evidence that supports the use of retrospective review: Horizon has written, objective, evidenced-based Clinical Criteria Guidelines for determining the medical necessity and clinical appropriateness of medical, behavioral healthcare and pharmaceutical a request for service. Criteria sets are reviewed annually for appropriateness to Horizon's population needs and updated as applicable when national and/or community-based clinical practice guidelines are revised. The annual review of clinical criteria involves medical directors and practitioners with appropriate clinical expertise in the areas being reviewed for adoption. Members and providers are advised that the clinical criteria used to make a medical necessity determination are available upon request in the notice of action letter or integrated denial notice (CMS). Clinical criteria are available upon request and are also accessible via the provider manual, member and provider newsletters. Horizon website, and member handbook. NCQA UM 2 A1-5 Clinical staff who make medical necessity determinations are trained on the clinical criteria guidelines. A detailed policy outlining the use of established decision criteria promotes consistency of reviews. Clinical staff will consider the member's medical history, age, comorbidities, complications, progress of treatment, psycho-social situation, home environment, requesting provider's recommendations, and clinical notes when making a determination and authorize as long as medically necessary to avoid disruptions in care. For prior authorization of elective inpatient and outpatient services, the following clinical review criteria are consulted as applicable to the

	• Centers for Medicare and Medicaid Services
	  ○ National Coverage Determinations (NCD)
	  ○ Local Coverage Determinations (LCD)
	• State of New Jersey Medicaid Benefits
	• MCG
	• American Society of Addiction Medicine (ASAM)
	• Horizon BCBSNJ Medical Policies
	
	NCQA UM 1 A6
	
	Horizon considers the services available in the local delivery system when applying clinical criteria. Assessment of services and their ability to meet the needs of members may include:
	• Availability of inpatient outpatient and transitional facilities.
	• Availability of outpatient services in lieu of inpatient services such as surgicenters vs. inpatient surgery.
	• Availability of highly specialized services, such as transplant facilities or cancer centers.
	• Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge.
	• Local hospitals' ability to provide all recommended services within the estimated length of stay.
	
	If a health care service has been pre-authorized or approved, the specific standards, criteria or procedures used in the determination shall not be modified pursuant to retrospective review.
	
	Determinations for services that have been delivered shall be made within thirty (30) calendar days of receipt the necessary information.
	
	NCQA UM5
		member's plan:
		
		• Centers for Medicare and Medicaid Services
		  ○ National Coverage Determinations (NCD)
		  ○ Local Coverage Determinations (LCD)
		• State of New Jersey Medicaid Benefits
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		NCQA UM 1 A6
		
		Horizon considers the services available in the local delivery system when applying clinical criteria. Assessment of services and their ability to meet the needs of members may include:
		• Availability of inpatient outpatient and transitional facilities.
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		• Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge.
		• Local hospitals' ability to provide all recommended services within the estimated length of stay.
		
		If a health care service has been pre-authorized or approved, the specific standards, criteria or procedures used in the determination shall not be modified pursuant to retrospective review.
		
		Determinations for services that have been delivered shall be made within thirty (30) calendar days of receipt the necessary information.
		
		NCQA UM5

Retrospective Review: Emergency Services	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all emergency benefits that require retrospective review and/or fail first therapy	Emergency services are not subject to retrospective review	Emergency services are not subject to retrospective review
List Processes, Strategies and Evidentiary Standards	**Processes: Explain the process for retrospective review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**	**Processes: Explain the process for retrospective review that isutilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**
	N/A	N/A
	Strategies: Explain why your MCO requires retrospective review. Describe why retrospective review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.	**Strategies: Explain why your MCO requires retrospective review. Describe why retrospective review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.**
	N/A	N/A
	Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized bythe plan.	**Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.**
	N/A	N/A

Retrospective Review: Pharmacy Services	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all Pharmacy benefits that require retrospective review	There are no pharmacy benefits subject to retrospective review as all medications subject to prior authorization must receive prior authorization prior to a prescription being dispensed.	There are no pharmacy benefits subject to retrospective review as all medications subject to prior authorization must receive prior authorization prior to a prescription being dispensed
List Processes, Strategies and Evidentiary Standards	**Processes: Explain the process for retrospective review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**	**Processes: Explain the process for retrospective review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.**
	N/A	N/A
	Strategies: Explain why your MCO requires retrospective review. Describe why retrospective review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of retrospective review.	**Strategies: Explain why your MCO requires retrospective review. Describe why retrospective review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of retrospective review.**
	N/A	N/A
	Evidentiary Standards: Describe evidence that supports the use of retrospective review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of retrospective review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	N/A	N/A

Finding and Conclusions	Behavioral Health (Mental Health and Substance Use Disorder Services) and Medical/Surgical Services
Comparability and Stringency: Explain how the processes, strategies and evidentiary standards listed above as applied to MH/SUD benefits are comparable and are not applied more stringently than the processes, strategies and evidentiary standards applied to M/S benefits	The processes, strategies, and evidentiary standards described above with respect to Mental Health and Substance Use Disorder services (MH/SUD) are comparable to, and applied no more stringently than, the processes, strategies, and evidentiary standards with respect to Medical/Surgical (M/S) services. The MCO has compared the benefits subject to, the processes to ensure, the strategies applied, and the evidentiary standards that support the use of prior authorization, concurrent review, retrospective review, pharmacy services, and medical necessity for both MH/SUD and M/S services. In all the areas examined above, the processes, strategies, and evidentiary standards applied to MH/SUD and M/S are comparable and applied no more stringently to MH/SUD than to M/S to ensure medically necessary services are provided comparably.
Evaluation of Processes, Strategies and Evidentiary Standards : Are medical necessity requirements applied comparably between MH/SUD and M/S benefits	The medical necessity requirements described above with respect to Mental Health and Substance Use Disorder services are comparable to and applied no more stringently than the medical necessity requirements with respect to Medical/Surgical services.
If medical necessity is not applied consistently between MH/SUD, describe how the plan will modify existing processes, strategies and use of evidentiary standards to meet parity	N/A

NQTL Analysis for MCOs		MCO name: WELLPOINT New Jersey, Inc.
Inpatient Services - Prior Authorization	**Behavioral Health (Mental Health and Substance Use Disorder Services**	**Medical/Surgical Services**
List all inpatient benefits that require prior authorization	All elective inpatient admissions require prior authorization. All emergent inpatient admissions require notification within 24 hours followed by medical necessity review	All elective inpatient admissions require prior authorization. All emergent inpatient admissions require notification followed by concurrent medical necessity review
Processes, Strategies and Evidentiary Standards	Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	Nationally recognized standards are used for medical necessity reviews. We currently utilize: 1)Interqual for Inpatient NICU and Post Acute services and MCG - Milliman Care Guidelines beginning 10/5/18 for all other inpatient services, including Acute Inpatient Psychiatric Admissions. ASAM Criteria is used for all Substance Use Admissions. 2) WellPoint Medical Policy and Anthem Clinical UM Guidelines for Outpatient and DME. Inpatient reviews that require concurrent review are: 1) Submitted by the provider to WellPoint through an online portal, fax or verbally. 2) WellPoint licensed clinician reviews submitted clinical to determine medical necessity using Milliman Care Guidelines (MCG), American Society of Addiction Medicine (ASAM), WellPoint Medical Policy, and WellPoint Clinical UM guidelines. - The authorization is completed in accordance with NCQA timeframes. 3) If the reviewing clinician determines medical necessity is met, requestor is notified and provided a reference number 4) If the reviewing clinician determines medical necessity criteria is NOT met, outreach is made to the requestor for additional supporting clinical information. 5) If the reviewing clinician determines medical necessity criteria is still NOT met, the request is sent to Medical Director review to determine if medical necessity is met. 6) The reviewing clinician notifies the requestor of the 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. **Authorization is not required for Emergency Services**.	Nationally recognized standards are used for medical necessity reviews. We currently utilize: 1) Interqual for Post Acute services and MCG - Milliman Care Guidelines beginning 10/5/18 for all other inpatient services 2) Wellpoint Medical Policy and Wellpoint Clinical UM Guidelines for Outpatient. Carelon MBM (Medical Benefits Management) guidelines are used for Musculoskeletal, Radiology, Genetic Testing, and Sleep Studies. Inpatient reviews that require concurrent review are: 1) Submitted by the provider to Wellpoint through an online portal, fax or verbally. 2) Wellpoint licensed clinician reviews submitted clinical to determine medical necessity using InterQual® Level of Care for post-acute admissions and MCG for all other admissions. 3) The authorization is completed in accordance with New Jersey state timeframes. 4) If the reviewing clinician determines medical necessity is met, requestor is notified and provided a reference number. 5) If the reviewing clinician determines medical necessity criteria is NOT met, outreach is made to the requestor for additional supporting clinical information. 6) 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. 7) The reviewing clinician notifies the requestor of the determination following Medical Director Review. 8) Upon final determination of the request, member and/or provider notification is provided based on State and Federal Requirements as well as NCQA requirements.
	Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.	Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.
	The purpose of the Prior Authorization 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. Right Care , Right Time, Right Place. We utilize this process to enhance consistency in reviewing cases by providing a framework for clinical decision making. This process ensures compliance with local, state, and federal requirements, as well as accreditation bodies, i.e., NCQA. The goals of the process are to ensure adequacy of service availability and accessibility to eligible members; to maximize appropriate medical and behavioral health care; and to minimize/eliminate over-and/or under-utilization of medical and behavioral health care. Providers have the opportunity to request peer to peer discussion with the medical director on any adverse determination. They can provide additional clinical information which might modify the determination based on medical necessity.	The purpose of the Prior Authorization (PA) 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. Right Care, Right Time, Right Place. Wellpoint utilizes this process to enhance consistency in reviewing cases by providing a framework for clinical decision making. This process ensures compliance with local, state, and federal requirements, as well as accreditation bodies, i.e., NCQA. The goals of the process are to ensure adequacy of service availability and accessibility to eligible members; to maximize appropriate medical and behavioral health care; and to minimize/eliminate over-and/or under-utilization of medical and behavioral health care. Providers have the opportunity to request peer to peer discussion with the medical director on any adverse determination. They can provide additional clinical information which might modify the determination based on medical necessity.
	Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	See attached Evidentiary Standards.	See attached Evidentiary Standards.
Outpatient Services - Prior Authorization	Behavioral Health (Mental Health and Substance Use Disorder Services	Medical/Surgical Services

List all outpatient benefits that require prior authorization	• Applied Behavioral Analysis (ABA) • Developmental, Individual Difference, Relationship Based Model (DIR) • Acute Partial Hospitalization for Mental Health • Psychiatric Partial Hospitalization for Mental Health • Adult Mental Health Rehab (AMHR) • Partial Care for Mental Health • Transcranial Magnetic Stimulation (TMS) • Ambulatory Withdrawal Management/Ambulatory Detox – ASAM 2.0 WM • Non-Medical Detoxification/Non-Hospital Based Withdrawal Management – ASAM 3.7 WM • Substance Use Disorder Intensive Outpatient (IOP) – ASAM 2.1 • Substance Use Disorder Partial Care – ASAM 2.5 • Substance Use Disorder Long-Term Residential - ASAM 3.5 • Substance Use Disorder Short-Term Residential – ASAM 3.7 Providers have the ability to locate on the WellPoint provider portal all codes that require prior authorization.	Prior Authorization (PA) is required at this time for some, but not all of these services. Also Specialist services do not require PA if provider is in network. Below is a list of outpatient benefits that require a PA: • Cardiac Rehab - outpatient • Genetic Testing • Gynecology Surgery (if subsequent inpatient stay is requested) • Home Health Aide • Home Health Skilled Nursing • Home Health Therapy • Home Infusion • Interventional Cardiology • LTSS services (must be an MLTSS member to have these reviewed as part of your benefit package) • Medical Injectables • OON services • Oral Maxillofacial • Organ/Tissue Transplant and Donor Organ • Orthopedic Procedures • Plastic/Cosmetic/Reconstructive Surgery • Private Duty Nursing • Prosthetics/Orthotics • Radiation Therapy • Radiology/Imaging • Rehab Therapy (PT/ST/OT) • Sleep Study Providers have the ability to locate on the Wellpoint provider portal all codes that require prior authorization.
List Processes, Strategies and Evidentiary Standards	Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	All outpatient benefits that require prior authorizations are: 1) Submitted by the provider to WellPoint through an online portal, fax or verbally. 2) WellPoint licensed clinician reviews submitted clinical to determine medical necessity using NJ State Regulations, Milliman Care Guidelines (MCG), American Society of Addiction Medicine (ASAM), WellPoint Medical Policy, and WellPoint Clinical UM guidelines. The authorization is completed in accordance with NCQA timeframes. 3) If the reviewing clinician determines medical necessity is met, requestor is notified and provided a reference number. 4) If the reviewing clinician determines medical necessity criteria is NOT met, outreach is made to the requestor for additional supporting clinical information. 5) If the reviewing clinician determines medical necessity criteria is still NOT met, the request is sent to Medical Director review to determine if medical necessity is met. 6) The reviewing clinician notifies the requestor of the 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. MLTSS services are delivered in accordance with the NJ MLTSS service dictionary.	All outpatient benefits that require prior authorizations are: 1) Submitted by the provider to Wellpoint through an online portal, fax or verbally. 2) Wellpoint licensed clinician reviews submitted clinical to determine medical necessity using NJ State Regulations, InterQual® Level of Care, Wellpoint Medical Policy, Wellpoint Clinical UM guidelines and Carelon MBM Guidelines. 3) The authorization is completed in accordance with NCQA timeframes. 4) If the reviewing clinician determines medical necessity is met, requestor is notified and provided a reference number. 5) If the reviewing clinician determines medical necessity criteria is NOT met, outreach is made to the requestor for additional supporting clinical information. 6) 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. 7) The reviewing clinician notifies the requestor of the determination following Medical Director Review. 8) Upon final determination of the request, member and/or provider notification is provided based on State and Federal Requirements as well as NCQA requirements. 9) MLTSS services are delivered in accordance with the NJ MLTSS service dictionary.
	Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.	Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.
	We utilize this process to enhance consistency in reviewing cases by providing a framework for clinical decision making. This process ensures compliance with local, state, and federal requirements, as well as accreditation bodies, i.e., NCQA. The goals of the prior authorization review process are to ensure adequacy of service availability and accessibility to eligible members; to maximize appropriate medical and behavioral health care; and to minimize/eliminate over-and/or under-utilization of medical and behavioral health care. The purpose of the prior authorization 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. Providers have the opportunity to request peer to peer discussion with the medical director on any adverse determination. They can provide additional clinical information which might modify the determination based on medical necessity.	We utilize this process to enhance consistency in reviewing cases by providing a framework for clinical decision making. This process ensures compliance with local, state, and federal requirements, as well as accreditation bodies, i.e., NCQA. The goals of the prior authorization review process are to ensure adequacy of service availability and accessibility to eligible members; to maximize appropriate medical and behavioral health care; and to minimize/eliminate over-and/or under-utilization of medical and behavioral health care. The purpose of the prior authorization 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. Providers have the opportunity to request peer to peer discussion with the medical director on any initial adverse determination. They can provide additional clinical information which might modify the determination based on medical necessity.
	Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.

	See attached Evidentiary Standards.	See attached Evidentiary Standards.
Emergency Services - Prior Authorization	Behavioral Health (Mental Health and Substance Use Disorder Services	Medical/Surgical Services
List all emergency benefits that require prior authorization and/or fail first therapy	Emergency Services do not require Prior Authorization Fail First Therapy- None for Behavioral Health	Emergency Services do not require Prior Authorization Fail First Therapy- None for Medical
List Processes, Strategies and Evidentiary Standards	Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	No prior authorization is required for emergency services.	No prior authorization is required for emergency services.
	Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.	Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.
	No prior authorization is required for emergency services.	No prior authorization is required for emergency services.
	Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	N/A	N/A
Pharmacy Services - Prior Authorization	Behavioral Health (Mental Health and Substance Use Disorder Services	Medical/Surgical Services
List all Pharmacy benefits that require prior authorization	See NJ Parity excel file- MH PA Tab	See NJ Parity Excel file - MH PA Tab
List Processes, Strategies and Evidentiary Standards	Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	All Prior Authorizations are developed using label and evidence based medicine and approved by a Pharmacy & Therapeutics committee (P&T) of independent practicing physicians and pharmacists. A Pharmacist Reviewer will use their clinical judgement in reviewing a request that does not exactly meet clinical criteria in order to best serve the member. Each situation is reviewed on a case-by-case basis in considering all the clinical information a provider may have submitted.	All Prior Authorizations are developed using label and evidence-based medicine and approved by a Pharmacy & Therapeutics committee (P&T) of independent practicing physicians and pharmacists. A Pharmacist Reviewer will use their clinical judgement in reviewing a request that does not exactly meet clinical criteria in order to best serve the member. Each situation is reviewed on a case-by-case basis in considering all the clinical information a provider may have submitted.
	Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.	Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.
	Prior authorization is used to ensure appropriate use of a medication based on labeled indications or significant evidenciary standards to support use for an off-label indication.	Prior authorization is used to ensure appropriate use of a medication based on labeled indications or significant evidenciary standards to support use for an off-label indication.
	Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	Review of medications done using labeled indications, compendia (DrugDex, AHFS, NCCN), clinical practice guidelines, and grading studies with the Delfini method and evidence based medicine.	Review of medications done using labeled indications, compendia (DrugDex, AHFS, NCCN), clinical practice guidelines, and grading studies with the Delfini method and evidence based medicine.
Inpatient Services - fail first therapy	Behavioral Health (Mental Health and Substance Use Disorder Services	Medical/Surgical Services
List all inpatient benefits that require fail first therapy	N/A	N/A
Processes, Strategies and Evidentiary Standards	Processes: Explain the process for fail first therapy that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for fail first therapy that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	N/A	N/A
	Strategies: Explain why your MCO requires fail first therapy. Describe why fail first therapy is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of fail first therapy.	Strategies: Explain why your MCO requires fail first therapy. Describe why fail first therapy is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of fail first therapy.
	N/A	N/A
	Evidentiary Standards: Describe evidence that supports the use of fail first therapy for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of fail first therapy for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	N/A	N/A

Outpatient Services - fail first therapy	Behavioral Health (Mental Health and Substance Use Disorder Services	Medical/Surgical Services
List all inpatient benefits that require fail first therapy	N/A	N/A
Processes, Strategies and Evidentiary Standards	Processes: Explain the process for fail first therapy that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for fail first therapy that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	N/A	N/A
	Strategies: Explain why your MCO requires fail first therapy. Describe why fail first therapy is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of fail first therapy.	Strategies: Explain why your MCO requires fail first therapy. Describe why fail first therapy is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of fail first therapy.
	N/A	N/A
	Evidentiary Standards: Describe evidence that supports the use of fail first therapy for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of fail first therapy for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	N/A	N/A
Emergency Services - fail first therapy	Behavioral Health (Mental Health and Substance Use Disorder Services	Medical/Surgical Services
List all inpatient benefits that require fail first therapy	N/A	N/A
Processes, Strategies and Evidentiary Standards	Processes: Explain the process for fail first therapy that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for fail first therapy that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	N/A	N/A
	Strategies: Explain why your MCO requires fail first therapy. Describe why fail first therapy is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of fail first therapy.	Strategies: Explain why your MCO requires fail first therapy. Describe why fail first therapy is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of fail first therapy.
	N/A	N/A
	Evidentiary Standards: Describe evidence that supports the use of fail first therapy for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of fail first therapy for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	N/A	N/A
Pharmacy Services - fail first therapy	Behavioral Health (Mental Health and Substance Use Disorder Services	Medical/Surgical Services
List all inpatient benefits that require fail first therapy	See NJ Parity excel file- MH ST Tab	See NJ Parity Excel file - MH ST Tab
Processes, Strategies and Evidentiary Standards	Processes: Explain the process for fail first therapy that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for fail first therapy that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	The drugs are reviewed for clinical efficacy. If efficacy appears equivalent, step therapy may be employed. A non-preferred agent presented for fill will require prior authorization. At that time, it will be determined whether the step therapy criteria has been met. If so, the non-preferred agent will be approved. If not, the non-preferred agent will not be approved and it will be communicated that a trial of a preferred agent is required.	The drugs are reviewed for clinical efficacy. If efficacy appears equivalent, step therapy may be employed. A non-preferred agent presented for fill will require prior authorization. At that time, it will be determined whether the step therapy criteria has been met. If so, the non-preferred agent will be approved. If not, the non-preferred agent will not be approved and it will be communicated that a trial of a preferred agent is required.
	Strategies: Explain why your MCO requires fail first therapy. Describe why fail first therapy is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of fail first therapy.	Strategies: Explain why your MCO requires fail first therapy. Describe why fail first therapy is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of fail first therapy.
	Intent of step therapy is to utilize medications for a particular condition that are cost effective and deemed to be as medically effective as the higher priced medication. A Pharmacist Reviewer will use their clinical judgement in reviewing a request that does not exactly meet clinical criteria in order to best serve the member. Each situation is reviewed on a case-by-case basis in considering all the clinical information a provider may have submitted.	Intent of step therapy is to utilize medications for a particular condition that are cost effective and deemed to be as medically effective as the higher priced medication. A Pharmacist Reviewer will use their clinical judgement in reviewing a request that does not exactly meet clinical criteria in order to best serve the member. Each situation is reviewed on a case-by-case basis in considering all the clinical information a provider may have submitted.
	Evidentiary Standards: Describe evidence that supports the use of fail first therapy for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of fail first therapy for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	Review of medications done using labeled indications, compendia (DrugDex, AHFS, NCCN), clinical practice guidelines and grading studies with the Delfini method and evidence based medicine.	Review of medications done using labeled indications, compendia (DrugDex, AHFS, NCCN), clinical practice guidelines and grading studies with the Delfini method and evidence based medicine.
Inpatient Services - Concurrent Review	Behavioral Health (Mental Health and Substance Use Disorder Services	Medical/Surgical Services
List all inpatient benefits that require concurrent review	See above Inpatient Prior Authorization	See above Inpatient Prior Authorization
Processes, Strategies and Evidentiary Standards	Processes: Explain the process for concurrent review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for concurrent review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	See above Inpatient Prior Authorization	See above Inpatient Prior Authorization

	Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.	Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.
	See above Inpatient Prior Authorization	See above Inpatient Prior Authorization
	Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	See above Inpatient Prior Authorization	See above Inpatient Prior Authorization
Outpatient Services - Concurrent Review	Behavioral Health (Mental Health and Substance Use Disorder Services	Medical/Surgical Services
List all outpatient benefits that require concurrent review	See above Outpatient Prior Authorization	See above Outpatient Prior Authorization
List Processes, Strategies and Evidentiary Standards	Processes: Explain the process for prior concurrent review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for prior concurrent review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	See above Outpatient Prior Authorization	See above Outpatient Prior Authorization
	Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.	Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.
	See above Outpatient Prior Authorization	See above Outpatient Prior Authorization
	Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	See above Outpatient Prior Authorization	See above Outpatient Prior Authorization
Emergency Services - Concurrent Review	Behavioral Health (Mental Health and Substance Use Disorder Services	Medical/Surgical Services
List all emergency benefits that require concurrent review	No prior authorization is required for emergency services.	No prior authorization is required for emergency services.
List Processes, Strategies and Evidentiary Standards	Processes: Explain the process for concurrent review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for concurrent review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	No prior authorization is required for emergency services.	No prior authorization is required for emergency services.
	Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.	Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.
	No prior authorization is required for emergency services.	No prior authorization is required for emergency services.
	Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	No prior authorization is required for emergency services.	No prior authorization is required for emergency services.
Pharmacy Services - Concurrent Review	Behavioral Health (Mental Health and Substance Use Disorder Services	Medical/Surgical Services
List all Pharmacy benefits that require concurrent review	Applies to general pharmacy benefits.	Applies to general pharmacy benefits.
List Processes, Strategies and Evidentiary Standards	Processes: Explain the process for concurrent review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for concurrent review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	Concurrent review is done via use of Medispan databank set of various clinical situations including drug-drug interaction, drug-age interaction, high dose and therapy duplication. The alert is provided to the dispensing pharmacist to assist in proper processing and dispensing of the medicaiton. High Dose and Therapy Duplication will require the dispensing pharmacist to enter an override code in order to continue processing the medication as presented. The override code will track the actions taken by the dispensing pharmacist for evaluation of the interaction.	Concurrent review is done via use of Medispan databank set of various clinical situations including drug-drug interaction, drug-age interaction, high dose and therapy duplication. The alert is provided to the dispensing pharmacist to assist in proper processing and dispensing of the medicaiton. High Dose and Therapy Duplication will require the dispensing pharmacist to enter an override code in order to continue processing the medication as presented. The override code will track the actions taken by the dispensing pharmacist for evaluation of the interaction.
	Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.	Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.
	Concurrent review will not result in a prior authorization requirement. It is a message to the dispensing pharmacist to assist in proper dispensing of the medication.	Concurrent review will not result in a prior authorization requirement. It is a message to the dispensing pharmacist to assist in proper dispensing of the medication.
	Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	Data is provided by Medispan Data Bank	Data is provided by Medispan Data Bank

Medical Necessity - Inpatient	Behavioral Health (Mental Health and Substance Use Disorder Services	Medical/Surgical Services
Identify the criteria utilized for medical necessity	WellPoint licensed clinician reviews submitted clinical to determine medical necessity using Milliman Care Guidelines (MCG), American Society of Addiction Medicine (ASAM), WellPoint Medical Policy, and WellPoint Clinical UM guidelines.	Interqual, Milliman Care Guidelines (MCG), Wellpoint Medical Policies, Wellpoint Clinical UM Policies, and Carelon MBM policies
	Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	See above for Inpatient Prior Authorization	See above for Inpatient Prior Authorization
	Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.	Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.
	See above for Inpatient Prior Authorization	See above for Inpatient Prior Authorization
	Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	See above for Inpatient Prior Authorization	See above for Inpatient Prior Authorization
Comparability and Stringency- explain how the processes, strategies and evidentiary standards applied to MH/SUD benefits are comparable and are not applied more stringently than the standards applied to M/S benefits	Medical Necessity requirements for both MH/SUD and M/S benefits require medical necessity review using Evidenced Based Criteria utilized by licensed clinicians. Applications of benefits and review criteria are comparable.	Medical Necessity requirements for both MH/SUD and M/S benefits require medical necessity review using evidenced-based criteria utilized by licensed clinicians. Applications of benefits and review criteria are comparable.
Evaluation of Processes, Strategies and Evidentiary Standards-Are medical necessity requirements applied comparably between MH/SUD and M/S benefits	Medical Necessity requirements for both MH/SUD and M/S benefits require medical necessity review using Evidenced Based Criteria utilized by licensed clinicians. Applications of benefits and review criteria are comparable.	Medical Necessity requirements for both MH/SUD and M/S benefits require medical necessity review using evidenced-based criteria utilized by licensed clinicians. Applications of benefits and review criteria are comparable.
If medical necessity is not applied consistently between MH/SUD, describe how the plan will modify existing processes, strategies and use of evidentiary standards to meet parity	N/A	N/A
Medical Necessity - Outpatient	Behavioral Health (Mental Health and Substance Use Disorder Services	Medical/Surgical Services
Identify the criteria utilized for medical necessity	See above for outpatient Prior Authorization	See above for outpatient Prior Authorization
	Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	See above for outpatient Prior Authorization	See above for outpatient Prior Authorization
	Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.	Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.
	See above for outpatient Prior Authorization	See above for outpatient Prior Authorization
	Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	See above for outpatient Prior Authorization	See above for outpatient Prior Authorization

Comparability and Stringency-explain how the processes, strategies and evidentiary standards applied to MH/SUD benefits are comparable and are not applied more stringently than the standards applied to M/S benefits	See above for inpatient	See above for inpatient authorization.
Evaluation of Processes, Strategies and Evidentiary Standards-Are medical necessity requirements applied comparably between MH/SUD and M/S benefits	See above for inpatient	See above for inpatient authorization.
If medical necessity is not applied consistently between MH/SUD, describe how the plan will modify existing processes, strategies and use of evidentiary standards to meet parity	N/A	N/A
Medical Necessity - Emergency	Behavioral Health (Mental Health and Substance Use Disorder Services	Medical/Surgical Services
Identify the criteria utilized for medical necessity	No prior authorization is required for emergency services.	No prior authorization is required for emergency services.
	Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	No prior authorization is required for emergency services.	No prior authorization is required for emergency services.
	Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.	Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.
	No prior authorization is required for emergency services.	No prior authorization is required for emergency services.
	Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	No prior authorization is required for emergency services.	No prior authorization is required for emergency services.
Comparability and Stringency-explain how the processes, strategies and evidentiary standards applied to MH/SUD benefits are comparable and are not applied more stringently than the standards applied to M/S benefits	No prior authorization is required for emergency services.	No prior authorization is required for emergency services.
Evaluation of Processes, Strategies and Evidentiary Standards-Are medical necessity requirements applied comparably between MH/SUD and M/S benefits	No prior authorization is required for emergency services.	No prior authorization is required for emergency services.
If medical necessity is not applied consistently between MH/SUD, describe how the plan will modify existing processes, strategies and use of evidentiary standards to meet parity	N/A	N/A

Medical Necessity - Pharmacy	Behavioral Health (Mental Health and Substance Use Disorder Services	Medical/Surgical Services
Identify the criteria utilized for medical necessity	See NJ Parity excel file- MH PA Tab	See NJ Parity Excel file - MH PA Tab
	Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	Prior Authorization and Medical necessity are considered the same with regard to pharmacy benefits. All Prior Authorization criteria are developed using label and evidence based medicine and approved by a Pharmacy & Therapeutics committiee (P&T) of independent practiccing physicians and pharmacists. A Pharmacist Reviewer will use their clinical judgement in reviewing a request that does not exactly meet clinical criteria in order to best serve the member. Each situation is reviewed on a case-by-case basis in considering all the clinical information a provider may have submitted.	Prior Authorization and Medical necessity are considered the same with regard to pharmacy benefits. All Prior Authorization criteria are developed using label and evidence based medicine and approved by a Pharmacy & Therapeutics committiee (P&T) of independent practiccing physicians and pharmacists. A Pharmacist Reviewer will use their clinical judgement in reviewing a request that does not exactly meet clinical criteria in order to best serve the member. Each situation is reviewed on a case-by-case basis in considering all the clinical information a provider may have submitted.
	Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.	Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.
	Prior Authorization and Medical necessity are considered the same with regard to pharmacy benefits. Prior authorization is used to ensure appropriate use of a medication based on labeled indications or significant evidenciary standards to support use for an off-label indication.	Prior Authorization and Medical necessity are considered the same with regard to pharmacy benefits. Prior authorization is used to ensure appropriate use of a medication based on labeled indications or significant evidenciary standards to support use for an off-label indication.
	Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	Review of medical necessity performed using labeled indications, compendia (DrugDex, AHFS, NCCN), clinical practice guidelines and grading studies with the Delfini method and evidence based medicine..	Review of medical necessity performed using labeled indications, compendia (DrugDex, AHFS, NCCN), clinical practice guidelines and grading studies with the Delfini method and evidence based medicine.
Comparability and Stringency- explain how the processes, strategies and evidentiary standards applied to MH/SUD benefits are comparable and are not applied more stringently than the standards applied to M/S benefits	All processes are applied consistently across all medications; no differentiation between Mental Health and Medical/Surgical medications.	All processes are applied consistently across all medications; no differentiation between Mental Health and Medical/Surgical medications.
Evaluation of Processes, Strategies and Evidentiary Standards-Are medical necessity requirements applied comparably between MH/SUD and M/S benefits	All processes are applied consistently across all medications; no differentiation between Mental Health and Medical/Surgical medications.	All processes are applied consistently across all medications; no differentiation between Mental Health and Medical/Surgical medications.
If medical necessity is not applied consistently between MH/SUD, describe how the plan will modify existing processes, strategies and use of evidentiary standards to meet parity	All processes are applied consistently across all medications; no differentiation between Mental Health and Medical/Surgical medications.	All processes are applied consistently across all medications; no differentiation between Mental Health and Medical/Surgical medications.

Parity NQTL Analysis for NJ Plans (pursuant to 42 CFR Subpart K)		
Inpatient Services-Prior Authorization	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all inpatient benefits that require prior authorization	**All Plans** • **MH Non-Emergent Acute Inpatient** • **SUD Acute Inpatient Detoxification** **DDD, LTSS, FIDE Specific** • **MH Subacute Residential Treatment** • **SUD Acute Inpatient Rehab** • **SUD Subacute Residential Treatment**	• **Bariatric surgery** • **Breast reconstruction (non-mastectomy)** • **Cardiology** • **Cerebral seizure monitoring – Inpatient video Electroencephalogram (EEG)** • **Chemotherapy** • **Cosmetic and reconstructive** • **Gender dysphoria treatment** • **Hospice** • **Hospital Inpatient Admission** • **Hysterectomy** • **Joint replacement** • **Orthognathic surgery** • **Post Acute Care (SNF, AIR, LTAC)** • **Shoulder Surgery** • **Sleep apnea procedures and surgeries** • **Spinal surgery** • **Transplants** • **Ventricular assist devices (VAD)**
Processes, Strategies and Evidentiary Standards	Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	The Clinical Quality & Operations Committee (CQOC) oversees the MH/SUD UM program and is responsible for the development and maintenance of the MH/SUD prior authorization processes. The CQOC ensures that the UM program considers the factors and evidentiary standards for applying UM and is comprised of representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. **Prior Authorization is a required clinical assessment that takes place before non-emergent inpatient services are delivered, ensuring that care is medically necessary and appropriate according to the member's health plan. In-network providers must submit a prior authorization request before providing services, using the provider portal, phone, fax, or electronic medical record systems, while members may also submit requests by phone, fax, or mail. Once a request is received, non-clinical staff confirm eligibility and benefit coverage, referring cases to clinical reviewers when needed. Clinical reviewers use objective, evidence-based criteria and nationally recognized guidelines to assess medical necessity; if criteria are met, the service is approved, otherwise the case is escalated to a peer clinical reviewer. Peer reviewers may request additional information and conduct discussions with providers, and only they can issue adverse determinations. Providers and members are notified of approvals or denials, with appeal rights available for adverse decisions. The process is supported by annual assessments and audits to ensure consistency and quality, and reviewers must pass reliability assessments.**	**The Utilization Management Program Committee (UMPC) oversees the M/S UM program and is responsible for the development and maintenance of the M/S prior authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. and is comprised of Medical Officers, Senior Vice Presidents, Vice Presidents, and Senior Directors from various departments including clinical advancement, policy, medical management, medical policy affordability, UM, appeals, and product teams.** **Prior Authorization is a required clinical assessment that takes place before non-emergent inpatient services are delivered, ensuring that care is medically necessary and appropriate according to the member's health plan. In-network providers must submit a prior authorization request before providing services, using the provider portal, phone, fax, or electronic medical record systems, while members may also submit requests by phone, fax, or mail. Once a request is received, non-clinical staff confirm eligibility and benefit coverage, referring cases to clinical reviewers when needed. Clinical reviewers use objective, evidence-based criteria and nationally recognized guidelines to assess medical necessity; if criteria are met, the service is approved, otherwise the case is escalated to a peer clinical reviewer. Peer reviewers may request additional information and conduct discussions with providers, and only they can issue adverse determinations. Providers and members are notified of approvals or denials, with appeal rights available for adverse decisions. The process is supported by annual assessments and audits to ensure consistency and quality, and reviewers must pass reliability assessments.**

	Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.	Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.
	Prior Authorization is an essential part of the Plan's Utilization Management (UM) program, ensuring members receive coverage that matches their clinical status and health care needs. The process begins before inpatient services are delivered and uses objective, evidence-based criteria and nationally recognized guidelines to determine the most appropriate clinical coverage in accordance with the benefit plan language.	**Prior Authorization is an essential part of the Plan's Utilization Management (UM) program, ensuring members receive coverage that matches their clinical status and health care needs. The process begins before inpatient services are delivered and uses objective, evidence-based criteria and nationally recognized guidelines to determine the most appropriate clinical coverage in accordance with the benefit plan language.**
	Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	The Plan determines whether prior authorization will be applied to a specific MH/SUD benefit or service by evaluating regulatory or state contractual requirements, which refer to health plan or state regulations governing prior authorization. Clinical appropriateness is assessed by internal medical experts using objective, evidence-based criteria, including ASAM Criteria, LOCUS, CALOCUS-CASII, ECSII guidelines, and nationally recognized guidelines such as those from the American Psychiatric Association. The decision to add prior authorization requirements also considers value, defined as the cost of the inpatient service exceeding the administrative costs of prior authorization, which is determined through analysis of internal claims data, utilization management program operating costs, and authorization data.	**The Plan determines whether prior authorization will be applied to a specific M/S benefit or service by evaluating regulatory or state contractual requirements, which refer to health plan or state regulations governing prior authorization. Clinical appropriateness is assessed by internal medical experts using objective, evidence-based criteria, InterQual, and nationally recognized guidelines such as those from the American Medical Association. The decision to add prior authorization requirements also considers value, defined as the cost of the inpatient service exceeding the administrative costs of prior authorization, which is determined through analysis of internal claims data, utilization management program operating costs, and authorization data.**
Outpatient Services-Prior Authorization	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all outpatient benefits that require prior authorization	**All Plans** • **Applied Behavioral Analysis (ABA)** **DDD, LTSS, FIDE Specific** • **Ambulatory Withdrawal Management/ Detoxification** • **Electroconvulsive Therapy (ECT)** • **Intensive Outpatient** • **Partial Hospitalization/ Adult Day Treatment** • **Psychological Testing** • **Transcranial Magnetic Stimulation (TMS)**	• **Acupuncture** • **Bariatric surgery** • **Bone growth stimulator** • **Breast reconstruction (non-mastectomy)** • **Cancer supportive care** • **Cardiology** • **Cardiovascular** • **Chemotherapy** • **Cochlear implants and other auditory implants** • **Cosmetic and reconstructive** • **Durable medical equipment (DME) - Prior authorization required only for DME codes listed with a retail purchase or cumulative rental cost of more than $500"** • **Enteral services** • **Experimental and investigational (and/or linked services)** • **Functional endoscopic sinus surgery (FESS)** • **Genetic and molecular testing to include BRCA** • **Gender dysphoria treatment** • **Home and community-based services - All Home and Community Based Services (HCBS) and Long-Term Care Services** **(LTSS) require authorization for those members on the Managed Long-Term Services and Supports (MLTSS) benefit** **program** • **Home health care** • **Hospice** • **Hysterectomy** • **Injectable medications** • **Joint replacement** • **Non-emergent air ambulance transport**

List Processes, Strategies and Evidentiary Standards	Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	The Clinical Quality & Operations Committee (CQOC) oversees the MH/SUD UM program and is responsible for the development and maintenance of the MH/SUD prior authorization processes. The CQOC ensures that the UM program considers the factors and evidentiary standards for applying UM and is comprised of representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. **Prior Authorization is a required clinical assessment that takes place before outpatient services are delivered, ensuring that care is medically necessary and appropriate according to the member's health plan. In-network providers must submit a Prior Authorization request before providing services, using the provider portal, phone, fax, or electronic medical record systems, while members may also submit requests by phone, fax, or mail. Once a request is received, non-clinical staff confirm eligibility and benefit coverage, referring cases to clinical reviewers when needed. Clinical reviewers use objective, evidence-based criteria and nationally recognized guidelines to assess medical necessity; if criteria are met, the service is approved, otherwise the case is escalated to a peer clinical reviewer. Peer reviewers may request additional information and conduct discussions with providers, and only they can issue adverse determinations. Providers and members are notified of approvals or denials, with appeal rights available for adverse decisions. The process is supported by annual assessments and audits to ensure consistency and quality, and reviewers must pass reliability assessments.**	**The Utilization Management Program Committee (UMPC) oversees the M/S UM program and is responsible for the development and maintenance of the M/S prior authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM and is comprised of Medical Officers, Senior Vice Presidents, Vice Presidents, and Senior Directors from various departments including clinical advancement, policy, medical management, medical policy affordability, UM, appeals, and product teams.** **Prior Authorization is a required clinical assessment that takes place before outpatient services are delivered, ensuring that care is medically necessary and appropriate according to the member's health plan. In-network providers must submit a Prior Authorization request before providing services, using the provider portal, phone, fax, or electronic medical record systems, while members may also submit requests by phone, fax, or mail. Once a request is received, non-clinical staff confirm eligibility and benefit coverage, referring cases to clinical reviewers when needed. Clinical reviewers use objective, evidence-based criteria and nationally recognized guidelines to assess medical necessity; if criteria are met, the service is approved, otherwise the case is escalated to a peer clinical reviewer. Peer reviewers may request additional information and conduct discussions with providers, and only they can issue adverse determinations. Providers and members are notified of approvals or denials, with appeal rights available for adverse decisions. The process is supported by annual assessments and audits to ensure consistency and quality, and reviewers must pass reliability assessments.**
	Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.	Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.
	Prior Authorization is an essential part of the Plan's Utilization Management (UM) program, ensuring members receive coverage that matches their clinical status and health care needs. The process begins before inpatient services are delivered and uses objective, evidence-based criteria and nationally recognized guidelines to determine the most appropriate clinical coverage in accordance with the benefit plan language.	**Prior Authorization is an essential part of the Plan's Utilization Management (UM) program, ensuring members receive coverage that matches their clinical status and health care needs. The process begins before inpatient services are delivered and uses objective, evidence-based criteria and nationally recognized guidelines to determine the most appropriate clinical coverage in accordance with the benefit plan language.**
	Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.

	The Plan determines whether prior authorization will be applied to a specific MH/SUD benefit or service by evaluating regulatory or state contractual requirements, which refer to health plan or state regulations governing prior authorization. Clinical appropriateness is assessed by internal medical experts using objective, evidence-based criteria, including ASAM Criteria, LOCUS, CALOCUS-CASII, ECSII guidelines, and nationally recognized guidelines such as those from the American Psychiatric Association. The decision to add prior authorization requirements also considers value, defined as the cost of the inpatient service exceeding the administrative costs of prior authorization, which is determined through analysis of internal claims data, utilization management program operating costs, and authorization data. **To remove a service from the prior authorization list, the Plan considers low value, defined as services that do not result in a minimum savings of at least $50 per review, consistency, which is demonstrated by adherence to evidence-based guidelines with an adverse determination rate of less than 5%, and low volume, defined as services with fewer than 100 authorizations per year, all determined through internal data.** **To retain a service on the prior authorization list, the Plan considers whether the service is experimental, investigational, or unproven based on clinical policy, patient safety as defined by the World Health Organization and supported by professional judgment and clinical criteria, level of care based on site of service and volume greater than 100 requests per year, high-cost drugs and services with allowed amounts greater than $100,000 per treated patient per year, and rehabilitation or habilitative therapy at risk for overutilization or as required by contract, determined through medical policy and internal claims data.**	**The Plan determines whether prior authorization will be applied to a specific M/S benefit or service by evaluating regulatory or state contractual requirements, which refer to health plan or state regulations governing prior authorization. Clinical appropriateness is assessed by internal medical experts using objective, evidence-based criteria, InterQual, and nationally recognized guidelines such as those from the American Psychiatric Association. The decision to add prior authorization requirements also considers value, defined as the cost of the inpatient service exceeding the administrative costs of prior authorization, which is determined through analysis of internal claims data, utilization management program operating costs, and authorization data.** **To remove a service from the prior authorization list, the Plan considers low value, defined as services that do not result in a minimum savings of at least $50 per review, consistency, which is demonstrated by adherence to evidence-based guidelines with an adverse determination rate of less than 5%, and low volume, defined as services with fewer than 100 authorizations per year, all determined through internal data.** **To retain a service on the prior authorization list, the Plan considers whether the service is experimental, investigational, or unproven based on clinical policy, patient safety as defined by the World Health Organization and supported by professional judgment and clinical criteria, level of care based on site of service and volume greater than 100 requests per year, high-cost drugs and services with allowed amounts greater than $100,000 per treated patient per year, and rehabilitation or habilitative therapy at risk for overutilization or as required by contract, determined through medical policy and internal claims data.**
Emergency Services-Prior Authorization	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all emergency benefits that require prior authorization and/or fail first therapy	**N/A**	**N/A**
List Processes, Strategies and Evidentiary Standards	Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	N/A **All emergency department and post-stabilization services are covered without authorization.**	**N/A** **All emergency department and post-stabilization services are covered without authorization.**
	Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.	Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.
	N/A **All emergency department and post-stabilization services are covered without authorization.**	**N/A** **All emergency department and post-stabilization services are covered without authorization.**
	Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.

Pharmacy Services-Prior Authorization	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all Pharmacy benefits that require prior authorization	**Please see the New Jersey Family Care Preferred Drug List (PDL) at https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/nj/pharmacy/NJ-Preferred-Drug-List-Family-Care.pdf**	**Please see the New Jersey Family Care Preferred Drug List (PDL) at https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/nj/pharmacy/NJ-Preferred-Drug-List-Family-Care.pdf**
List Processes, Strategies and Evidentiary Standards	Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for prior authorization that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	Clinical criteria for prescription drug prior authorization are developed and maintained by the Pharmacy & Therapeutics (P&T) Committee, which includes physicians from various specialties and pharmacists. The committee evaluates FDA-approved product labeling, peer-reviewed medical literature, published clinical practice guidelines, randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, and claims data analysis. These criteria are designed to ensure that drugs are used optimally, safely, and cost-effectively. **The prior authorization process begins when a provider or member requests coverage for a prescription drug. Non-clinical staff first confirm eligibility and coverage. Clinical reviewers then assess whether the drug meets the established criteria by considering the drug's place in therapy, its safety and efficacy compared to alternatives, the availability of clinically similar lower-cost medications, and the potential for off-label or unproven uses. The review process also considers whether the requested quantity exceeds established limits, which are set to align with FDA labeling, prevent abuse, and optimize dosing. If the criteria are met, the drug is approved; otherwise, only qualified clinical reviewers can issue denials, and members and providers are notified with information about appeal rights.**	**Clinical criteria for prescription drug prior authorization are developed and maintained by the Pharmacy & Therapeutics (P&T) Committee, which includes physicians from various specialties and pharmacists. The committee evaluates FDA-approved product labeling, peer-reviewed medical literature, published clinical practice guidelines, randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, and claims data analysis. These criteria are designed to ensure that drugs are used optimally, safely, and cost-effectively.** **The prior authorization process begins when a provider or member requests coverage for a prescription drug. Non-clinical staff first confirm eligibility and coverage. Clinical reviewers then assess whether the drug meets the established criteria by considering the drug's place in therapy, its safety and efficacy compared to alternatives, the availability of clinically similar lower-cost medications, and the potential for off-label or unproven uses. The review process also considers whether the requested quantity exceeds established limits, which are set to align with FDA labeling, prevent abuse, and optimize dosing. If the criteria are met, the drug is approved; otherwise, only qualified clinical reviewers can issue denials, and members and providers are notified with information about appeal rights.**
	Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.	Strategies: Explain why your MCO requires prior authorization. Describe why prior authorization is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of prior authorization.
	The purpose of prior authorization for prescription drugs is to ensure that medications are covered only when they meet established clinical criteria, supporting both cost-effectiveness and optimal clinical outcomes for members. This process is part of the Plan's utilization management program and is designed to apply objective, evidence-based standards and nationally recognized guidelines before a prescription drug is approved for coverage. Prior authorization helps confirm that the requested medication is appropriate for the member's specific clinical situation and aligns with benefit plan requirements	**The purpose of prior authorization for prescription drugs is to ensure that medications are covered only when they meet established clinical criteria, supporting both cost-effectiveness and optimal clinical outcomes for members. This process is part of the Plan's utilization management program and is designed to apply objective, evidence-based standards and nationally recognized guidelines before a prescription drug is approved for coverage. Prior authorization helps confirm that the requested medication is appropriate for the member's specific clinical situation and aligns with benefit plan requirements**
	Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of prior authorization for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.

	The Plan determines whether prior authorization will be applied to a specific MH/SUD benefit or service by considering several factors. First, it assesses the prescription drug's place in therapy, aiming to promote optimal drug use based on FDA-approved product labeling, peer-reviewed medical literature, clinical trials, drug comparison studies, pharmacoeconomic and outcomes research, published clinical practice guidelines, efficacy and side effect comparisons, potential for off-label use, and claims data analysis. The availability of clinically similar, lower-cost medications to treat the condition is also considered, with the goal of encouraging the use of appropriate alternatives before approving more expensive options. This assessment is supported by regulatory requirements, review of external clinical evidence, and evaluation of nationally recognized evidence-based guidelines and benchmarks. The Plan evaluates the value of implementing prior authorization or step therapy, determining whether automated approval processes or coverage reviews are appropriate, using previous claim or medication history, diagnosis codes, and claim logic. Decisions are guided by regulations, clinical evidence, and program-specific criteria. Relative safety and efficacy are reviewed through comprehensive comparisons of efficacy, side effects, and drug interactions among alternatives, ensuring decisions are based on reliable evidence. Finally, the Plan considers the prevention of off-label or unproven uses by evaluating the potential for drugs to be used for indications not included in FDA-approved labeling, relying on regulatory guidance and comprehensive clinical evidence to support coverage decisions.	**The Plan determines whether prior authorization will be applied to a specific M/S benefit or service by considering several factors. First, it assesses the prescription drug's place in therapy, aiming to promote optimal drug use based on FDA-approved product labeling, peer-reviewed medical literature, clinical trials, drug comparison studies, pharmacoeconomic and outcomes research, published clinical practice guidelines, efficacy and side effect comparisons, potential for off-label use, and claims data analysis. The availability of clinically similar, lower-cost medications to treat the condition is also considered, with the goal of encouraging the use of appropriate alternatives before approving more expensive options. This assessment is supported by regulatory requirements, review of external clinical evidence, and evaluation of nationally recognized evidence-based guidelines and benchmarks. The Plan evaluates the value of implementing prior authorization or step therapy, determining whether automated approval processes or coverage reviews are appropriate, using previous claim or medication history, diagnosis codes, and claim logic. Decisions are guided by regulations, clinical evidence, and program-specific criteria. Relative safety and efficacy are reviewed through comprehensive comparisons of efficacy, side effects, and drug interactions among alternatives, ensuring decisions are based on reliable evidence. Finally, the Plan considers the prevention of off-label or unproven uses by evaluating the potential for drugs to be used for indications not included in FDA-approved labeling, relying on regulatory guidance and comprehensive clinical evidence to support coverage decisions.**
Inpatient Services-fail first therapy	**N/A**	**N/A**
List all inpatient benefits that require fail first therapy	**N/A** • **Fail first therapy requirements are not applied to MH/SUD inpatient services.**	**N/A** • **Fail first therapy requirements are not applied to MH/SUD inpatient services.**
Outpatient Services-fail first therapy	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all inpatient benefits that require fail first therapy	**N/A** • **Fail first therapy requirements are not applied to MH/SUD outpatient services.**	**N/A** • **Fail first therapy requirements are not applied to MH/SUD outpatient services.**
Emergency Services-fail first therapy	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all inpatient benefits that require fail first therapy	**N/A** • **Fail first therapy requirements are not applied to MH/SUD emergency services.**	**N/A** • **Fail first therapy requirements are not applied to MH/SUD emergency services.**
Pharmacy Services-fail first therapy	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services

List all inpatient benefits that require fail first therapy	**The following PDL drugs are routinely covered only after a sufficient trial of an indicated first-line agent has been adequately tried and failed. These medications may also be requested through the Prior authorization process.** • **Amerge** • **Aricept 23mg** • **calcipotriene cream & oint 0.005%** • **calcitriol 3mcg/gm** • **DPP4 Inhibitors (Nesina, Kazano, Oseni)** • **Elidel** • **Eucrisa** • **fenofibrate** • **GLP-1 Agonists (Adlyxin, Trulicity, Victoza 2 pen pack)** • **GLP-1/Insulin Combinations classes: (Soliqua)** • **lubiprostone** • **Motegrity** • **Movantik** • **Optivar** • **Ranexa** • **Renvela** • **SGLT-2 Inhibitors (Steglatro, Segluromet)** • **tacrolimus 0.03%** • **tacrolimus 0.1%** • **olterodine** • **trospium 3** • **Trulance** • **Uloric** • **Xopenex Respules**	**The following PDL drugs are routinely covered only after a sufficient trial of an indicated first-line agent has been adequately tried and failed. These medications may also be requested through the Prior authorization process.** • **Amerge** • **Aricept 23mg** • **calcipotriene cream & oint 0.005%** • **calcitriol 3mcg/gm** • **DPP4 Inhibitors (Nesina, Kazano, Oseni)** • **Elidel** • **Eucrisa** • **fenofibrate** • **GLP-1 Agonists (Adlyxin, Trulicity, Victoza 2 pen pack)** • **GLP-1/Insulin Combinations classes: (Soliqua)** • **lubiprostone** • **Motegrity** • **Movantik** • **Optivar** • **Ranexa** • **Renvela** • **SGLT-2 Inhibitors (Steglatro, Segluromet)** • **tacrolimus 0.03%** • **tacrolimus 0.1%** • **olterodine** • **trospium 3** • **Trulance** • **Uloric** • **Xopenex Respules**
Inpatient Services-Concurrent Review	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services

List all inpatient benefits that require concurrent review	• **All Plans**
	  o **MH Non-Emergent Acute Inpatient**
	  o **SUD Acute Inpatient Detoxification**
	• **DDD, LTSS, FIDE Specific**
	  o **MH Subacute Residential Treatment**
	  o **SUD Acute Inpatient Rehab**
	  o **SUD Subacute Residential Treatment**
		• **Cerebral seizure monitoring – Inpatient video Electroencephalogram (EEG)**
		• **Chemotherapy**
		• **Hospice**
		• **Hospital Inpatient Admission**
		• **Post Acute Care (SNF, AIR, LTAC)**
		• **Transplants**
		• **Ventricular assist devices (VAD)**
		• **All unplanned M/S inpatient admissions are subject to initial Concurrent Review**
		• **All M/S inpatient admissions are subject to ongoing Concurrent Review if coverage of additional days is requested after initial Concurrent Review approved days expire**

Processes, Strategies and Evidentiary Standards	Processes: Explain the process for concurrent review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for concurrent review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.

	The Clinical Quality & Operations Committee (CQOC) oversees the MH/SUD UM program and is responsible for the development and maintenance of the MH/SUD concurrent review processes. The CQOC ensures that the UM program considers the factors and evidentiary standards for applying UM and is comprised of representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. **The concurrent review process begins when a provider notifies the plan of an inpatient admission. Non-clinical staff first check eligibility and may approve straightforward cases. More complex requests go to clinical reviewers, who use objective, evidence-based criteria and nationally recognized guidelines to assess medical necessity. If approval isn't possible, a peer clinical reviewer (e.g., Medical Director) makes the final decision and may request additional information. Providers can discuss adverse decisions with reviewers, and appeals are available. Ongoing reviews are conducted if additional days are requested, following the same process. All decisions are based on objective criteria, and staff must pass annual reliability assessments. The process is supported by annual assessments and audits to ensure consistency and quality, and reviewers must pass reliability assessments.**	**The Utilization Management Program Committee (UMPC) oversees the M/S UM program and is responsible for the development and maintenance of the M/S concurrent review processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. and is comprised of Medical Officers, Senior Vice Presidents, Vice Presidents, and Senior Directors from various departments including clinical advancement, policy, medical management, medical policy affordability, UM, appeals, and product teams.** **The concurrent review process begins when a provider notifies the plan of an inpatient admission. Non-clinical staff first check eligibility and may approve straightforward cases. More complex requests go to clinical reviewers, who use objective, evidence-based criteria and nationally recognized guidelines to assess medical necessity. If approval isn't possible, a peer clinical reviewer (e.g., physician, mid-level practitioner) makes the final decision and may request additional information. Providers can discuss adverse decisions with reviewers, and appeals are available. Ongoing reviews are conducted if additional days are requested, following the same process. All decisions are based on objective criteria, and staff must pass annual reliability assessments. The process is supported by annual assessments and audits to ensure consistency and quality, and reviewers must pass reliability assessments.**
	Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.	Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.
	Concurrent review is a component of the Plan's utilization management activities and includes medical necessity reviews. The Medical Director and other independently licensed clinical staff review hospitalizations to detect and better manage over- and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. **This process helps the health plan monitor ongoing treatment, confirm that services continue to meet clinical criteria, and support optimal outcomes for members. By regularly reviewing the need for continued hospitalization, the Plan can promote efficient use of resources, prevent unnecessary or prolonged stays, and maintain compliance with federal and state regulations.** **Concurrent reviews determinations are made using clinical policies and external criteria that describe Generally Accepted Standards of Medical practice.** **Policies and procedures are reviewed annually or as new technology emerges.**	**Concurrent review is a component of the Plan's utilization management activities and includes medical necessity reviews. The Medical Director and other independently licensed clinical staff review hospitalizations to detect and better manage over- and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines.** **This process helps the health plan monitor ongoing treatment, confirm that services continue to meet clinical criteria, and support optimal outcomes for members. By regularly reviewing the need for continued hospitalization, the Plan can promote efficient use of resources, prevent unnecessary or prolonged stays, and maintain compliance with federal and state regulations.** **Concurrent reviews determinations are made using clinical policies and external criteria that describe Generally Accepted Standards of Medical practice. .** **Policies and procedures are reviewed annually or as new technology emerges.**
	Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.

	The Plan's use of concurrent review is supported by a range of evidence and data sources that ensure the process is clinically appropriate, effective, and compliant with regulatory standards. The Plan relies on objective, evidence-based clinical criteria from nationally recognized guidelines, such as ASAM Criteria®, LOCUS, CALOCUS-CASII, and ECSII, as well as guidelines from organizations like the American Psychiatric Association. Internal claims data, utilization management program operating costs, and authorization data are analyzed to assess the value and impact of concurrent review. **Additionally, the Plan uses outcomes research, peer-reviewed medical literature, clinical trials, and published clinical practice guidelines to inform decision-making. Quality oversight is maintained through annual inter-rater reliability assessments, national case audits, and ongoing monitoring of performance metrics, including approval and denial rates, timeliness, and adherence to evidence-based standards. Regulatory requirements at the federal and state levels, as well as accreditation standards, further guide the application and evaluation of concurrent review.**	**The Plan's use of concurrent review is supported by a range of evidence and data sources that ensure the process is clinically appropriate, effective, and compliant with regulatory standards. The Plan relies on objective, evidence-based clinical criteria from nationally recognized guidelines, such as InterQual® as well as guidelines from organizations like the American Medical Association. Internal claims data, utilization management program operating costs, and authorization data are analyzed to assess the value and impact of concurrent review.** **Additionally, the Plan uses outcomes research, peer-reviewed medical literature, clinical trials, and published clinical practice guidelines to inform decision-making. Quality oversight is maintained through annual inter-rater reliability assessments, national case audits, and ongoing monitoring of performance metrics, including approval and denial rates, timeliness, and adherence to evidence-based standards. Regulatory requirements at the federal and state levels, as well as accreditation standards, further guide the application and evaluation of concurrent review.**
Outpatient Services-Concurrent Review	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all outpatient benefits that require concurrent review	**The Plan reclassifies M/S and MH/SUD outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests consistent with NCQA UM standards. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services.**	**The Plan reclassifies M/S and MH/SUD outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests consistent with NCQA UM standards. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services.**
List Processes, Strategies and Evidentiary Standards	Processes: Explain the process for prior concurrent review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for prior concurrent review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	The Plan reclassifies M/S and MH/SUD outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests consistent with NCQA UM standards. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services.	**The Plan reclassifies M/S and MH/SUD outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests consistent with NCQA UM standards. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services.**
	Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.	Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.
	The Plan reclassifies M/S and MH/SUD outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests consistent with NCQA UM standards. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services.	**The Plan reclassifies M/S and MH/SUD outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests consistent with NCQA UM standards. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services.**
	Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	The Plan reclassifies M/S and MH/SUD outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests consistent with NCQA UM standards. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services.	**The Plan reclassifies M/S and MH/SUD outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests consistent with NCQA UM standards. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services.**

Emergency Services-Concurrent Review	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all emergency benefits that require concurrent review	**Emergency services are not reviewed.** **All inpatient admissions require concurrent review following the initial authorization. The concurrent review process for urgent/emergent services follows the same process as inpatient once the member is admitted.**	**Emergency services are not reviewed.** **All inpatient admissions require concurrent review following the initial authorization. The concurrent review process for urgent/emergent services follows the same process as inpatient once the member is admitted.**
List Processes, Strategies and Evidentiary Standards	Processes: Explain the process for concurrent review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for concurrent review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	Emergency services are not reviewed. **All inpatient admissions require concurrent review following the initial authorization. The concurrent review process for urgent/emergent services follows the same process as inpatient once the member is admitted.**	**Emergency services are not reviewed.** **All inpatient admissions require concurrent review following the initial authorization. The concurrent review process for urgent/emergent services follows the same process as inpatient once the member is admitted.**
	Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.	Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.
	N/A **All emergency department and post-stabilization services are covered without authorization.**	**N/A** **All emergency department and post-stabilization services are covered without authorization.**
	Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	The concurrent review process for urgent/emergent services follows the same process as IP once the member is admitted. Emergency services are not reviewed.	**The concurrent review process for urgent/emergent services follows the same process as IP once the member is admitted. Emergency services are not reviewed.**
Pharmacy Services-Concurrent Review	Behavioral Health (Mental Health and Substance Use Disorder Services	Medical/Surgical Services
List all Pharmacy benefits that require concurrent review	**Medicaid (all products)**	**Medicaid (all products)**
List Processes, Strategies and Evidentiary Standards	Processes: Explain the process for concurrent review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for concurrent review that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	Concurrent Review is not applicable to the pharmacy benefit. All pharmacy requests are classified as prior authorization requests.	**Concurrent Review is not applicable to the pharmacy benefit. All pharmacy requests are classified as prior authorization requests.**
	Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.	Strategies: Explain why your MCO requires concurrent review. Describe why concurrent review is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of concurrent review.
	Concurrent Review is not applicable to the pharmacy benefit. All pharmacy requests are classified as prior authorization requests.	**Concurrent Review is not applicable to the pharmacy benefit. All pharmacy requests are classified as prior authorization requests.**
	Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of concurrent review for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	Concurrent Review is not applicable to the pharmacy benefit. All pharmacy requests are classified as prior authorization requests.	**Concurrent Review is not applicable to the pharmacy benefit. All pharmacy requests are classified as prior authorization requests.**
Medical Necessity-Inpatient	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services

Identify the criteria utilized for medical necessity	**Medical necessity determinations are based on evidence-based nationally recognized external clinical criteria and internally-developed medical policies. These criteria are policies are reviewed and updated annually by CQOC.** **Generally Accepted Standards of Medical Practice are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.** **If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered.**	**Medical necessity determinations are based on evidence-based nationally recognized external clinical criteria and internally-developed medical policies. These criteria are policies are reviewed and updated annually by MTAC.** **Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.** **If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered.**
	Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	The medical necessity process is designed to ensure that healthcare services, technologies, and treatments provided to members are in accordance with generally accepted standards of medical practice, clinically appropriate for the member's condition, cost-effective, and essential for diagnosing, preventing, or treating a medical issue. This process is rooted in both internal and externally developed, evidence-based clinical criteria, such as ASAM Criteria, LOCUS, CALOCUS-CASII, and ECSII guidelines, as well as policies required by contract or state-specific requirements. **Committees comprised of licensed clinicians and executive medical directors oversee the development, approval, and application of medical necessity criteria. These committees review scientific evidence, peer-reviewed literature, and consensus statements to determine the safety, efficacy, and appropriateness of services and technologies. The process involves a hierarchy of authority, beginning with state and federal laws and regulations, followed by plan documents and clinical policies. Clinical reviewers use their independent judgment to evaluate whether a member's condition meets the established criteria, and all staff involved in coverage determinations participate in annual assessments to ensure consistency and accuracy.**	**The medical necessity process is designed to ensure that healthcare services, technologies, and treatments provided to members are in accordance with generally accepted standards of medical practice, clinically appropriate for the member's condition, cost-effective, and essential for diagnosing, preventing, or treating a medical issue. This process is rooted in both internal and externally developed, evidence-based clinical criteria, such as InterQual, as well as policies required by contract or state-specific requirements.** **Committees comprised of licensed clinicians and executive medical directors oversee the development, approval, and application of medical necessity criteria. These committees review scientific evidence, peer-reviewed literature, and consensus statements to determine the safety, efficacy, and appropriateness of services and technologies. The process involves a hierarchy of authority, beginning with state and federal laws and regulations, followed by plan documents and clinical policies. Clinical reviewers use their independent judgment to evaluate whether a member's condition meets the established criteria, and all staff involved in coverage determinations participate in annual assessments to ensure consistency and accuracy.**
	Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.	Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.
	The Plan requires medical necessity to ensure that healthcare services, technologies, and treatments provided to members are in accordance with generally accepted standards of medical practice, are appropriate for the member's disorder, disease, or symptoms, and are essential for diagnosing, preventing, or treating a medical condition. The principle of medical necessity is designed to safeguard the best interests of the patient by relying on evidence-based standards of medical practice. This approach helps ensure that healthcare resources are allocated efficiently and that patients receive care that is truly needed based on their medical situation.	**The Plan requires medical necessity to ensure that healthcare services, technologies, and treatments provided to members are in accordance with generally accepted standards of medical practice, are appropriate for the member's disorder, disease, or symptoms, and are essential for diagnosing, preventing, or treating a medical condition. The principle of medical necessity is designed to safeguard the best interests of the patient by relying on evidence-based standards of medical practice. This approach helps ensure that healthcare resources are allocated efficiently and that patients receive care that is truly needed based on their medical situation.**
	Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.

	The Plan assesses evidence from the following when developing internal clinical criteria and approving external criteria: **• Well-designed systematic reviews with or without meta-analyses of multiple well-designed randomized controlled trials** **• Individual well-designed randomized controlled trials** **• Large non-randomized controlled trials** **• Large prospective trials** **• Comparative and cohort studies** **• Cross sectional studies** **• Retrospective studies with one or more historical (not concurrent) comparison group(s)** **• Surveillance studies** **• Case reviews/case series without comparison group** **In the absence of strong and compelling scientific evidence, behavioral clinical policies may include evidence from:** **• National consensus statements** **• Publications by recognized authorities such as government sources and/or professional societies** **• Anecdotal/editorial statements and professional opinions (only used to support adoption of behavioral clinical policies when no other source is available)**	**The Plan assesses evidence from the following when developing internal clinical criteria and approving external criteria:** **• Well-designed systematic reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials** **• Individual well-designed randomized controlled trials** **• Well-designed observational studies with one or more concurrent comparison group(s), including, cohort studies, case control studies, cross-sectional studies, and systematic reviews (with or without meta-analyses) of such studies** **• Observational studies with one or more historical (not concurrent) comparison group(s)** **• Case series without comparison group** **In the absence of strong and compelling scientific evidence, medical policies may be based upon national consensus statements or clinical guidelines by recognized authorities. The following stratification describes the hierarchy of use of medical policies and clinical guidelines within UHC:** **• National guidelines and consensus statements** **• Centers for Medicare and Medicaid Services (CMS) National Coverage Decisions (NCDs)** **• Clinical position papers based upon rigorous review of scientific evidence or clinical registry data from professional specialty societies when their statements are based upon referenced clinical evidence** **• Guidelines using Grading of Recommendations, Assessment, Development and Evaluation (GRADE) methodology as outlined in the Cochrane Handbook for Systematic Reviews of Interventions**
Comparability and Stringency-explain how the processes, strategies and evidentiary standards applied to MH/SUD benefits are comparable and are not applied more stringently than the standards applied to M/S benefits	**The Plan's analysis confirmed the strategies, processes, evidentiary standards, and sources used to develop and apply medical necessity criteria for MH/SUD were comparable to those for M/S and not applied more stringently, both "as written" and "in operation." MH/SUD policies and procedures were found to be equivalent to M/S processes.** **Both benefit types use consistent methodologies to develop internal clinical policies and review external criteria. Clinical reviewers for M/S and MH/SUD follow the same process: review state and federal laws, then Plan documents, and apply evidence-based policies. All reviewers must pass an annual Inter-Rater Reliability (IRR) assessment validating comparability in the application of criteria.**	
Evaluation of Processes, Strategies and Evidentiary Standards-Are medical necessity requirements applied comparably between MH/SUD and M/S benefits	**YES**	
If medical necessity is not applied consistently between MH/SUD, describe how the plan will modify existing processes, strategies and use of evidentiary standards to meet parity	**N/A**	
Medical Necessity-Outpatient	Behavioral Health (Mental Health and Substance Use Disorder Services	Medical/Surgical Services

Identify the criteria utilized for medical necessity	**Benefits are administered using evidence-based nationally recognized medical policies, clinical guidelines and criteria. Such policies are reviewed and updated annually by CQOC.** **The aforementioned standards are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.** **If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Plan reserves the right to consult expert opinions in determining whether mental health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.**	**Benefits are administered using evidence-based nationally recognized medical policies, clinical guidelines and criteria. Such policies are reviewed and updated annually by MTAC.** **The aforementioned standards are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.** **If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Plan reserves the right to consult expert opinions in determining whether mental health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.**
	Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	The medical necessity process is designed to ensure that healthcare services, technologies, and treatments provided to members are in accordance with generally accepted standards of medical practice, clinically appropriate for the member's condition, cost-effective, and essential for diagnosing, preventing, or treating a medical issue. This process is rooted in both internal and externally developed, evidence-based clinical criteria, such as InterQual, ASAM Criteria, LOCUS, CALOCUS-CASII, and ECSII guidelines, as well as policies required by contract or state-specific requirements. **Committees comprised of licensed clinicians and executive medical directors oversee the development, approval, and application of medical necessity criteria. These committees review scientific evidence, peer-reviewed literature, and consensus statements to determine the safety, efficacy, and appropriateness of services and technologies. The process involves a hierarchy of authority, beginning with state and federal laws and regulations, followed by plan documents and clinical policies. Clinical reviewers use their independent judgment to evaluate whether a member's condition meets the established criteria, and all staff involved in coverage determinations participate in annual assessments to ensure consistency and accuracy.**	**The medical necessity process is designed to ensure that healthcare services, technologies, and treatments provided to members are in accordance with generally accepted standards of medical practice, clinically appropriate for the member's condition, cost-effective, and essential for diagnosing, preventing, or treating a medical issue. This process is rooted in both internal and externally developed, evidence-based clinical criteria, such as InterQual, ASAM Criteria, LOCUS, CALOCUS-CASII, and ECSII guidelines, as well as policies required by contract or state-specific requirements.** **Committees comprised of licensed clinicians and executive medical directors oversee the development, approval, and application of medical necessity criteria. These committees review scientific evidence, peer-reviewed literature, and consensus statements to determine the safety, efficacy, and appropriateness of services and technologies. The process involves a hierarchy of authority, beginning with state and federal laws and regulations, followed by plan documents and clinical policies. Clinical reviewers use their independent judgment to evaluate whether a member's condition meets the established criteria, and all staff involved in coverage determinations participate in annual assessments to ensure consistency and accuracy.**
	Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.	Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.
	The Plan requires medical necessity to ensure that healthcare services, technologies, and treatments provided to members are in accordance with generally accepted standards of medical practice, are appropriate for the member's disorder, disease, or symptoms, and are essential for diagnosing, preventing, or treating a medical condition. The principle of medical necessity is designed to safeguard the best interests of the patient by relying on evidence-based standards of medical practice. This approach helps ensure that healthcare resources are allocated efficiently and that patients receive care that is truly needed based on their medical situation.	**The Plan requires medical necessity to ensure that healthcare services, technologies, and treatments provided to members are in accordance with generally accepted standards of medical practice, are appropriate for the member's disorder, disease, or symptoms, and are essential for diagnosing, preventing, or treating a medical condition. The principle of medical necessity is designed to safeguard the best interests of the patient by relying on evidence-based standards of medical practice. This approach helps ensure that healthcare resources are allocated efficiently and that patients receive care that is truly needed based on their medical situation.**

	Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	The Plan assesses evidence from the following when developing internal clinical criteria and approving external criteria: **• Well-designed systematic reviews with or without meta-analyses of multiple well-designed randomized controlled trials** **• Individual well-designed randomized controlled trials** **• Large non-randomized controlled trials** **• Large prospective trials** **• Comparative and cohort studies** **• Cross sectional studies** **• Retrospective studies with one or more historical (not concurrent) comparison group(s)** **• Surveillance studies** **• Case reviews/case series without comparison group** **In the absence of strong and compelling scientific evidence, behavioral clinical policies may include evidence from:** **• National consensus statements** **• Publications by recognized authorities such as government sources and/or professional societies** **• Anecdotal/editorial statements and professional opinions (only used to support adoption of behavioral clinical policies when no other source is available)**	**The Plan assesses evidence from the following when developing internal clinical criteria and approving external criteria:** **• Well-designed systematic reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials** **• Individual well-designed randomized controlled trials** **• Well-designed observational studies with one or more concurrent comparison group(s), including, cohort studies, case control studies, cross-sectional studies, and systematic reviews (with or without meta-analyses) of such studies** **• Observational studies with one or more historical (not concurrent) comparison group(s)** **• Case series without comparison group** **In the absence of strong and compelling scientific evidence, medical policies may be based upon national consensus statements or clinical guidelines by recognized authorities. The following stratification describes the hierarchy of use of medical policies and clinical guidelines within UHC:** **• National guidelines and consensus statements** **• Centers for Medicare and Medicaid Services (CMS) National Coverage Decisions (NCDs)** **• Clinical position papers based upon rigorous review of scientific evidence or clinical registry data from professional specialty societies when their statements are based upon referenced clinical evidence** **• Guidelines using Grading of Recommendations, Assessment, Development and Evaluation (GRADE) methodology as outlined in the Cochrane Handbook for Systematic Reviews of Interventions**
Comparability and Stringency-explain how the processes, strategies and evidentiary standards applied to MH/SUD benefits are comparable and are not applied more stringently than the standards applied to M/S benefits	**The Plan's analysis confirmed the strategies, processes, evidentiary standards, and sources used to develop and apply medical necessity criteria for MH/SUD were comparable to those for M/S and not applied more stringently, both "as written" and "in operation." MH/SUD policies and procedures were found to be equivalent to M/S processes.** **Both benefit types use consistent methodologies to develop internal clinical policies and review external criteria. Clinical reviewers for M/S and MH/SUD follow the same process: review state and federal laws, then Plan documents, and apply evidence-based policies. All reviewers must pass an annual Inter-Rater Reliability (IRR) assessment validating comparability in the application of criteria.**	
Evaluation of Processes, Strategies and Evidentiary Standards-Are medical necessity requirements applied comparably between MH/SUD and M/S benefits	**YES**	

If medical necessity is not applied consistently between MH/SUD, describe how the plan will modify existing processes, strategies and use of evidentiary standards to meet parity	**N/A**	
Medical Necessity-Emergency	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
Identify the criteria utilized for medical necessity	**Medical Necessity does not apply to Emergency services.**	**Medical Necessity does not apply to Emergency services.**
	Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	Medical Necessity does not apply to Emergency services.	**Medical Necessity does not apply to Emergency services.**
	Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.	Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.
	Medical Necessity does not apply to Emergency services.	**Medical Necessity does not apply to Emergency services.**
	Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	Medical Necessity does not apply to Emergency services.	**Medical Necessity does not apply to Emergency services.**
Comparability and Stringency- explain how the processes, strategies and evidentiary standards applied to MH/SUD benefits are comparable and are not applied more stringently than the standards applied to M/S benefits	**Medical Necessity does not apply to Emergency services.**	

Evaluation of Processes, Strategies and Evidentiary Standards-Are medical necessity requirements applied comparably between MH/SUD and M/S benefits	**YES**	
If medical necessity is not applied consistently between MH/SUD, describe how the plan will modify existing processes, strategies and use of evidentiary standards to meet parity	**N/A**	
Medical Necessity-Pharmacy	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
Identify the criteria utilized for medical necessity	**Medical Necessity does not apply to pharmacy services.**	**Medical Necessity does not apply to pharmacy services.**
	Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.	Processes: Explain the process for medical necessity that is utilized by your MCO including exceptions and ability to ensure medically necessary services are provided.
	Medical Necessity does not apply to pharmacy services.	**Medical Necessity does not apply to pharmacy services.**
	Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.	Strategies: Explain why your MCO requires medical necessity. Describe why medical necessity is provided in the manner described under "Processes" and how the process may be modified to meet medical necessity. Describe the intent of medical necessity.
	Medical Necessity does not apply to pharmacy services.	**Medical Necessity does not apply to pharmacy services.**
	Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.	Evidentiary Standards: Describe evidence that supports the use of medical necessity for the benefits identified. Include any evidentiary practice guidelines or internal data that is utilized by the plan.
	Medical Necessity does not apply to pharmacy services.	**Medical Necessity does not apply to pharmacy services.**
Comparability and Stringency-explain how the processes, strategies and evidentiary standards applied to MH/SUD benefits are comparable and are not applied more stringently than the standards applied to M/S benefits	**Medical Necessity does not apply to pharmacy services.**	
Evaluation of Processes, Strategies and Evidentiary Standards-Are medical necessity requirements applied comparably between MH/SUD and M/S benefits	**YES**	**YES**

If medical necessity is not applied consistently between MH/SUD, describe how the plan will modify existing processes, strategies and use of evidentiary standards to meet parity	**N/A**	**N/A**
Inpatient Services-failure to complete treatment	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all inpatient benefit exclusions based on failure to complete a treatment	**N/A** • **No such exclusions are applicable to MH/SUD and therefore not a parity concern for MH/SUD and M/S benefits.**	**N/A** • **No such exclusions are applicable to MH/SUD and therefore not a parity concern for MH/SUD and M/S benefits.**
Outpatient Services-failure to complete treatment	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
List all outpatient benefit exclusions based on failure to complete a treatment	**N/A** • **No such exclusions are applicable to MH/SUD and therefore not a parity concern for MH/SUD and M/S benefits.**	**N/A** • **No such exclusions are applicable to MH/SUD and therefore not a parity concern for MH/SUD and M/S benefits.**
Emergency Services-failure to complete treatment	Behavioral Health (Mental Health and Substance Use Disorder Services	Medical/Surgical Services
List all emergency benefit exclusions based on failure to complete a treatment	**N/A** • **No such exclusions are applicable to MH/SUD and therefore not a parity concern for MH/SUD and M/S benefits.**	**N/A** • **No such exclusions are applicable to MH/SUD and therefore not a parity concern for MH/SUD and M/S benefits.**
Pharmacy Services-failure to complete treatment	N/A	N/A
List all pharmacy benefit exclusions based on failure to complete a treatment	**N/A** • **No such exclusions are applicable to MH/SUD and therefore not a parity concern for MH/SUD and M/S benefits.**	**N/A** • **No such exclusions are applicable to MH/SUD and therefore not a parity concern for MH/SUD and M/S benefits.**
Restrictions based on geographic location or provider/facility type (including Network Admission standards)	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services

	• No geographic restrictions are applicable to MH/SUD and therefore geographic location restriction is not a parity concern. Further, the plan does not restrict the provider or facility type, as long as the following credentialing requirements are satisfied: Participation criteria for providers include: 1. Education • Psychiatrists must be board certified by the American Board of Psychiatry and Neurology (ABPN) or the American Osteopathic Association (AOA). If not board certified by ABPN or AOA, a physician who has completed an American College of Graduate Medical Education approved residency in psychiatry or an ABPN or AOA approved program for combined pediatrics/child and adolescent residency may be acceptable. • Physicians without a residency in psychiatry may be accepted if they are board certified by the America Society of Addictions Medicine (ASAM) • Physician addictionologists must be board certified by ASAM or have added qualifications in Addiction Psychiatry through the ABPN. • Developmental Behavioral Pediatricians (DBP) must provide evidence of passing the National Certification Exam. 2. Licensing Applicants must maintain current, valid licensure or certification, without material restrictions, conditions or other disciplinary actions in all states where the applicant practices. 3. Admitting privileges If the applicant's practice requires hospital staff privileges, those privileges must be in good standing at a network hospital. Privileges at any hospital must not have been suspended during the past 12 months due to inappropriate, inadequate or tardy completion of medical records or for quality of care issues.	• No geographic restrictions are applicable to MH/SUD and therefore geographic location restriction is not a parity concern. Further, the plan does not restrict the provider or facility type, as long as the following credentialing requirements are satisfied: Participation criteria for providers include: 1. Education • M.D.s and O.D.s: graduation from allopathic or osteopathic medical school and successful completion of either a residency program or other clinical training and experience for their specialty and scope of practice. • Chiropractors: graduation from chiropractic college • Dentists: graduation from dental school • Podiatrists: graduation from podiatry school and successful completion of a hospital residency program • Mid-level practitioners: graduation from an accredited professional school and successful completion of a training program. Any board certification claimed by an applicant shall be verified by the credentialing committee. 2. Licensing Applicants must maintain current, valid licensure or certification, without material restrictions, conditions or other disciplinary actions in all states where the applicant practices. 3. Admitting privileges Must have full hospital admitting privileges without material restrictions, conditions or other disciplinary actions with at least one network hospital or arrangements with a network physician to admit and provide hospital coverage to members at a network hospital.