

2026 Nonquantitative Treatment Limitation (NQTL) Submission Template

Instructions: This NQTL reporting submission form includes the required six information elements or Required Steps as specified by the Mental Health Parity and Addiction Equity Act (MHPAEA) and its regulations, including 42 USC Section 300gg-26(a)(8)(A) and 45 CFR 146.137. The comparative analyses to be performed must be reported using this submission form and should comply with MHPAEA, its regulations, federal guidance, and the instructions, both separately provided and set forth herein.

A separate reporting form should be prepared and completed for each NQTL requested by the BOI in each benefits classification/sub-classification. For example, the comparative analysis for prior authorization for the Inpatient, In-Network benefits classification should be provided on its own reporting submission form, and the comparative analysis for prior authorization for the Inpatient, Out-of-Network classification should be provided in a separate reporting submission form. Similarly, the comparative analyses for prior authorization for Outpatient benefits should be reported separately, with a form used for In-Network and a form to be used for Out-of-Network. If there are questions about how to properly report using this form, please contact the BOI.

In-Network Inpatient Retrospective Review

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See [45 CFR 146.137\(c\)\(1\)](#). Step 1 must include the following:

- (i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;
- (ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and
- (iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also [FAQ 45](#) (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response:

This document represents an NQTL comparative analysis for In-Network Inpatient Retrospective Review parameters applied to mental health/substance use disorder (“MH/SUD”) and/or medical/surgical (“M/S”) services for the inpatient benefit classification and is incorporated in plans insured Cigna Health and Life Insurance Company (“CHLIC”). In the review and analysis of the In-Network Inpatient Retrospective Review NQTL, Cigna reviewed policies applicable to Cigna and Evernorth Behavioral Health (EBH), Delegated Vendor(s), and Connect Bronze 6500 Indiv Med Deductible plan certificate.

Retrospective review is a review performed when care or service has already been completed or a discharge has occurred prior to an authorization of a coverage request. Retrospective review is considered a non- quantitative treatment limitation (“NQTL”) under the Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”) and its implementing regulations and sub-regulatory guidance.

Evernorth Behavioral Health (“Evernorth,” “EBH” or “Behavioral Health”) an affiliate of CHLIC, performs utilization reviews for MH/SUD benefits. Cigna Health Management, Inc., also an affiliate of CHLIC performs utilization reviews for M/S benefits not otherwise delegated to a separate entity. All entities collectively referred to as “Cigna” and references to “Cigna” contained herein include Evernorth Behavioral Health.

Cigna delegates utilization management to EviCore for the medical necessity review of M/S services including high tech imaging and cardiology, radiation and medical oncology, musculoskeletal management, spinal procedures, vascular intervention, sleep, molecular labs and gastrointestinal endoscopic procedures.

EviCore utilizes co-branded clinical coverage policies (which Cigna reviews and approves) when performing utilization reviews. The data provided in this NQTL analysis is inclusive of utilization reviews conducted by the above referenced entities.

Delegation arrangements vary according to the contract and the capability of the entity. The contract or standards of delegation documents outline the functions delegated and the responsibilities of both parties. Cigna retains the responsibility for ensuring that the delegated functions are carried out properly.

Cigna and Evernorth do not delegate utilization management for any MH/SUD services to any other entities.

No third parties or separate related entities played a role in developing the NQTL, its comparative

analysis, or the policies and procedures contained in this response. Cigna maintains corporate-wide policies applicable to multiple business segments including Cigna Healthcare (M/S) and Behavioral Health (MH/SUD), and policies applicable to specific business segments only.

The plan language or coverage terms governing Utilization Management is excerpted from the Connect Bronze 6500 Indiv Med Deductible plan certificate and states as follows:

Connect Bronze 6500 Indiv Med Deductible Plan Language

Claim Determination Procedures

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the Policy. The procedures for determining medical necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical necessity determinations are made on either a pre-service, concurrent, or post-service basis, as described below.

Certain services require Prior Authorization in order to be covered. This Prior Authorization is called a "pre-service medical necessity determination." The Policy describes who is responsible for obtaining this review. The Insured Person or their authorized representative (typically, their health care Provider) must request medical necessity determinations according to the procedures described below, in the Policy, and in the Insured Person's Provider's network participation documents as applicable.

When services or benefits are determined to be not Medically Necessary, the Insured Person or their representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Policy, in the Insured Person's Provider's network participation documents, and in the determination notices.

Post-service Medical Necessity Determinations

When an Insured Person or their representative requests a medical necessity determination after services have been rendered, Cigna Healthcare will notify them of the determination within two business days after receiving the request. However, if more time is needed to make a determination due to matters beyond Our control, We will notify the Insured Person or their representative within two business days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Insured Person or their representative must provide the specified information to Us within 45 days after receiving the notice. The determination period will be suspended on the date Cigna Healthcare sends such a notice of missing information, and the determination period will resume on the date the Insured Person or their representative responds to the notice.¹

Glossary:

1. The ASAM Criteria®: Objective guidelines developed and published by American Society of Addiction Medicine that help clinicians standardize treatment planning and determine where patients are placed in treatment, and how to provide continuing, integrated care and ongoing service planning. See [About the ASAM Criteria](#).
2. Concurrent Review: A request for service that occurs after an admission or treatment has begun even if it is an initial request.
3. Customer: anyone covered by a plan, including the person who signed up for the plan and any dependents. Customer may also be referred to as: member, patient, or enrollee.
4. Independent Review Organization (IRO)/Review Organization: acts as a third-party medical review resource which provides objective, unbiased medical determinations that support

effective decision making, based only on medical evidence. IROs deliver conflict-free decisions that help clinical and claims management professionals better allocate healthcare resources.

5. Internally Developed Clinical Coverage Policies: These tools are evidence-based decision support tools which are intended to provide an objective review of available published literature and/or other published information regarding a particular clinical indication or topic. Coverage Policies are not product or plan language specific.
6. MCG™ Guidelines: unbiased, evidence-based clinical decision support to identify safe and effective treatments and guide the appropriate level of care. See [MCG Care Guidelines](#)
7. Medical Necessity: Typically, Cigna considers medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, or devices to be medically necessary if the following criteria are met:
 - Required to diagnose or treat an illness, injury, disease or its symptoms;
 - In accordance with generally accepted standards of medical practice;
 - Clinically appropriate in terms of type, frequency, extent, site and duration;
 - Not primarily for the convenience of the patient, physician or other health professional.
 - Not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of the member's sickness, injury, condition, disease or its symptoms; and
 - Rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications, or settings when determining least intensive setting.
8. Mental Health/Substance Use Disorder (MH/SUD): Means benefits with respect to items or services for mental health conditions or substance use disorders that are included in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), as defined under the term of the plan and in accordance with applicable federal and state law. Any condition defined by the plan as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the International Classification of Diseases (ICD), or state guidelines).
9. Medical/Surgical (M/S): Means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan and in accordance with applicable federal and state law, but does not include mental health or substance use disorder benefits. Any condition defined by the plan being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the ICD or state guidelines).
10. Non-Clinical Staff: Any staff that does not hold a license or certification to include advocates and care coordinators.
11. Non-Urgent: A situation that is considered routine in nature.
12. Peer Reviewer (for behavioral health): an independently licensed behavioral health practitioner from appropriate specialty areas. Peer-reviewers may be a doctorate level psychologists, addictionologists, or board-certified psychiatrists depending on the credentials of the practitioner requesting the service. Peer-reviewers may review with clinical peers regardless of sub-specialty (Child & Adolescent). Behavioral Health's psychologists shall not make denial determinations regarding reimbursement for inpatient care or reimbursement for prescription drugs.
13. Peer Reviewer (for medical): an independently licensed medical director.

A medical director must:

- Hold an active unrestricted license or certification to practice medicine in a state or territory of the United States
- Unless expressly allowed by state or federal regulations, are located in a state or territory of the United States when conducting a peer clinical review.
- Are qualified as determined by the Senior Medical Director to render a clinical opinion about the medical condition, procedure and treatment under review.
- Hold a current and valid license in the same category as the ordering provider or as a Doctor of Medicine, or as a Doctor of Osteopathic Medicine.

14. Prior Authorization: The requirement that a provider (physician, hospital, etc.) obtain approval from Cigna before performing a particular procedure. Prior authorization may also be referred to as precertification, predetermination, and pre-approval.
15. Provider/Practitioner: A licensed physician, non-physician health care practitioner, hospital or other facility, supplier, or other individual or entity involved in the delivery of health care services or benefits.
16. Retrospective Review: A review performed when care or service has already been completed or a discharge has occurred prior to an authorization of a coverage request.

Supporting Documents:

Document/Policy Name	Description
Connect Bronze 6500 Indiv Med Deductible Plan Booklet	Plan specific document that outlines the details of a health insurance plan, including plan and benefit information, claim review procedures, and participation rights. The plan booklet provides comprehensive information about what the plan covers, how it is administered, and the procedures for reviewing claims. It is intended to help members understand their rights and responsibilities under the plan.
HM CLN 035: Timeliness of UM Decisions and Notification Policy	The purpose of this policy and procedure is to set forth standards for timeliness of Utilization Management Decisions. Behavioral Health's care management staff shall make and communicate UM decisions in a consistent and timely manner. This policy is written to the more stringent of DOL, NCQA or URAC standards regarding utilization management decisions and notification. In cases where state law is more stringent than this policy, state law will take precedence.
HM CLN 039: Utilization Management Decisions Appropriate Professional Assessment	The purpose of this policy is to ensure that qualified licensed health professionals assess the clinical information used to make appropriate utilization management decisions. Behavioral Health's policy requires that appropriately licensed behavioral health professionals assess and supervise utilization management decisions. Only psychologists, addictionologists or board-certified psychiatrists are allowed to assess and make medical necessity denial decisions.

OPS 48: Healthcare Medical Assessment and Coverage Process for Determination of Medical Necessity Coverage Criteria Recommendations Policy	The purpose of this policy is: • To establish and apply a consistent process in the development of evidence-based Coverage Policies for a wide variety of medical and behavioral technologies. • To ensure national delegated vendor guidelines used to support utilization management decisions are developed with the application of evidence-based principles consistent with Cigna standards, and that the Healthcare Medical Assessment Committee (HMAC) supports and approves applicable vendor guidelines. • To offer a timely and consistent review methodology for medical and behavioral technologies; and • To assist in facilitation of benefit coverage decisions in keeping with evidence-based standards through: • Timely review of relevant peer-reviewed literature and evidence. • Prompt revision of Coverage Policies and other collateral materials with changing technology status, including regularly scheduled reviews of existing Coverage Policies. • A focus on safety, effectiveness, and meaningful clinical outcomes. • Use of a hierarchy of evidence, amongst other variables, to help evaluate the relative strength of the scientific evidence. • Assessing and providing referenced information from published literature and medical expert opinion summaries.
UM 12: Qualified Health Professionals Render UM Decisions Policy	The purpose of this policy is to validate licensed professionals supervise and render all levels of utilization management (UM) decisions.
UM 39: Timeliness of Health Services Decisions Policy	The purpose of this policy is to clearly define required timelines for making utilization management (UM) decisions and providing decision notifications. Cigna and its delegates will adhere to internal quality, accreditation and applicable regulatory timeliness requirements when reviewing and responding to Prospective, Concurrent and Retrospective requests for medical services.
OPS 18: Policy and Procedure Maintenance, Review and Approval Process	The purpose of this policy is to ensure review and dissemination of policies and process within the scope of oversight by the Policy Committee in a timely manner.
QA 02: Delegation Policy	The purpose of this policy is to establish an effective oversight process that assures delegated entities performing services meet accreditation, key regulatory and contractual requirements.
HM CLN 001: Administrative Denial Policy	The purpose of this policy is to outline the conditions under which denials may be issues based on administrative issues.
HM CLN 009: Clinical and Administrative Information for Making a Determination	The purpose of this policy is to describe the information Behavioral Health collects and considers in making medical necessity determinations of coverage.
HM OPS 023: Emergency Services Policy	Emergency Services are generally covered under the medical plan. Behavioral Health shall cover psychiatric services (including post stabilization) provided in an emergency room by an appropriately licensed clinician without prior authorization.
UM 32: Emergency Services Policy	The purpose of this policy is to provide a definition and the process to ensure coverage of emergency services. This policy is provided to demonstrate that emergency services do not require prior authorization

Inpatient Benefit Classification

Cigna maps benefit classifications for Mental Health/Substance Use Disorder (MH/SUD) and Medical/Surgical (M/S) benefits consistent with generally recognized independent standards of medical practice. Benefits are mapped to Inpatient, Outpatient, Prescription Drugs and Emergency Care. Cigna further sub-classifies the Outpatient benefit classification to Office Visit and Outpatient All Other. New codes are assigned benefit classification through Cigna's code attribute process. Cigna's Proprietary Code Attribute Lead (PCAL) receives the code updates from Cigna's Enterprise Reference Data Management (ERDM) team who obtains the information from CMS - Centers for Medicare & Medicaid Services and American Medical Association (AMA). Code descriptions are reviewed and for classification alignment within Cigna's claims processing systems. Based on sorting and review of code description, most codes will naturally align to the appropriate benefit classification. The PCAL coordinates with the appropriate clinical SMEs, including medical, pharmacy, and behavioral health for codes that do not naturally align for further determination.

Services covered under a Cigna-administered benefit plan, including M/S and MH/SUD benefits, may be subject to retrospective review if a prior authorization or concurrent review request was required but not obtained.

Services Subject to the NQTL

	<i>Medical/Surgical</i>	<i>Mental Health & Substance Use</i>
Is NQTL applied to In-Network Inpatient classification?	Yes Inpatient (Medical) Hospice - IP Other HC Facility Non-Emergent Inpatient Hospital (except for 48/96-hour maternity stays) Non-Emergent Inpatient Surgery Non-Emergent Inpatient Services at Other Health Care Facilities	Yes Inpatient (MH/SUD) Non-Emergent Inpatient (Mental Health and Substance Use) Residential Treatment (Mental Health and Substance Use) Non-Emergent Inpatient Detoxification

Retrospective Review Process:

For both MH/SUD and M/S, a provider may submit a request for retrospective review via fax, email, or phone.

The case is referred to a nurse reviewer (M/S)/care manager (MH/SUD) who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the service requested, he/she authorizes those services. If the nurse reviewer/care manager determines that the enrollee does not appear to meet medical necessity criteria for the service requested, he/she refers the case to a peer reviewer.

No non-clinical reviews are performed for retrospective requests.

Cigna does not utilize notification as a form of prior authorization, concurrent or retrospective review. The term is used to reference that a provider is expected to communicate to Cigna when a customer requires authorization.

The review process is discussed further in step 4.

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See [45 CFR 146.137\(c\)\(2\)](#). Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

- (i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and
- (ii) A definition of each factor, including:
 - (A) A detailed description of the factor;
 - (B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and
 - (C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also [FAQ 45](#) guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Benefit Classification/Sub-classification: In-Network Inpatient Retrospective Review (M/S and MH/SUD)

The same factors used to determine whether a code or code set is placed on the Master Precertification List (prior authorization) are used to determine if retrospective review applies. That said, Cigna utilizes the **factors** outlined below to determine services that are subject to

retrospective review. In making and determination of the In-network, Inpatient Retrospective Review NQTL there were no additional factors considered and rejected. These factors are applied uniformly and without weighting and do not operate in a systematically discriminatory manner, as they are not based on data, sources, or evidence that disfavor MH/SUD, including outdated, non-objective, or biased medical guidelines.

Factors	Sources for Each Factor
1. Experimental/Investigational/Unproven service (Non-quantitative)	1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies
2. Potential benefit exclusion (Non-quantitative)	2. Plan documents
3. Serious safety risk (Non-quantitative)	3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies
4. Significant variation in Evidence-based practice (Non-quantitative)	4. Greater frequency of deviation from evidence-based practice compared to Cigna's book of business.
5. Potential for Fraud, Waste or Abuse (Non-quantitative)	5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Member, Pharmacy and Prescriber Analytics; Cigna claims data
6. Estimated average cost (Quantitative)	6. Cigna claims data

In establishing the factors used to determine what services are subject to retrospective review, Cigna considers the following **sources and evidentiary standards**:

Factor	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
1. Experimental / Investigational / Unproven Service (Non-quantitative)	1. Inadequate volume of existing peer-reviewed, evidence-based, scientific literature to establish whether or not a technology, supplies, treatments, procedures, or devices is safe and effective for treating or diagnosing the condition or sickness for which its use is proposed; When subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use; The subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials.	1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies
2. Potential benefit exclusion (Non-quantitative)	2. CMS.gov: <i>"CMS PUB. 100-02 Medicare Benefit Policy Manual, Chapter 16 – General</i>	2. Plan Documents

	<i>Exclusions from Coverage</i>	
3. Serious safety risk (Non-quantitative)	3. Inadequate volume of existing peer-reviewed, evidence-based, scientific literature to establish whether or not a technology, supplies, treatments, procedures, or devices is safe and effective for treating or diagnosing the condition or sickness for which its use is proposed. While there is no formulaic way in which to measure the volume of data needed, study detail is scrutinized using the scientific method of evidence review which is defined by the U.S. General Services Administration as: systematic evidence review attempts to find all published and unpublished evidence related to a specific research or policy question, using literature search methodologies designed to be transparent, unbiased, and reproducible.	3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies
4. Significant variation in Evidence-based practice (Non-quantitative)	4. Significant variation shall be measured as the difference between the lowest and highest utilization patterns, and the frequency or percentage of claims that are above the standard utilization for the specific service, or service bundle of codes. Variation should be assessed at the service bundle level when necessary, and not in the variation of an individual code.	4. Cigna claims data
5. Potential for Fraud, Waste or Abuse (Non-quantitative)	5. An automated peer-based model that compares a provider's billing behavior to their peers and those who score differently is reviewed to determine if an investigation is warranted as evidenced by increased volume.	5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Member, Pharmacy and Prescriber Analytics; Cigna claims data
6. Estimated average cost (Quantitative)	6. Any service where the average service cost, based on an assessment of Cigna Healthcare's historical paid claims, exceeds \$500.	6. Cigna claims data

For a service to require inpatient retrospective review, any of the non-quantitative factors may be considered along with the quantitative factor.

The following definitions are provided by Cigna in relation to the evidentiary standards outlined above:

- **Experimental, investigational or unproven services (EIU)**

Cigna considers medical, surgical, diagnostic, behavioral health or other health care technologies, supplies, treatments, procedures, or devices to be EIU if either of the following criteria is met:

- The technology, supply, treatment, procedure, or device has not been demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing any condition or sickness, regardless of U.S. Food and Drug Administration (FDA) approval status; or
- when subject to FDA or other appropriate regulatory agency review, is not approved to be lawfully marketed for any indication.

- **Potential Benefit Exclusion:**

Cigna health plans, consistent with the industry standard, do not cover services that are not medical in nature or not directly medically-related. Services that are not medical in nature are not eligible for coverage under a health plan and arguably may not be supported for coverage with pretax dollars. Cigna explicitly cites these services in the plan document to be helpful because customers and clients occasionally ask about whether or not they are covered. Cigna have collected this diverse list of services together in one exclusion solely based on their one common element: each is not medical or not directly medically related in nature.

- **Inadequate volume of existing peer-reviewed** refers to instances where evidence-based, scientific literature is not quantifiable. While there is no formulaic way in which to measure the volume of data needed, study detail is scrutinized using the scientific method of evidence review which is defined by the U.S. General Services Administration as: systematic evidence review attempts to find all published and unpublished evidence related to a specific research or policy question, using literature search methodologies designed to be transparent, unbiased, and reproducible.
- **Serious Safety Risk** is any service that is potentially life-threatening according to available clinical evidence (levels of clinical evidence described in Step 4) shall be placed on the Master Precertification List. Examples of safety issues considered to be potentially life-threatening include services such as rapid detoxification under anesthesia, CAR-T therapy, organ transplant, or the use of a service that is the subject of a serious warning or recall (e.g., FDA recall for a device or pharmaceutical product).
- **Significant variation:** A service may be placed on the Master Precertification List when there is evidence of significant variation in evidence-based care, defined as meaningful deviation from established, evidence-supported clinical practice in the use, frequency, intensity, duration, or patient selection for a service. Evaluation is performed at the service category, and not necessarily in the variation between individual code(s). Significant variation in evidence-based care exists when one or more of the following conditions are identified:
 - The service is used inconsistently with the best available clinical evidence, including use outside populations, indications, or clinical circumstances supported by the literature.
 - There is insufficient or inconsistent evidence demonstrating a clinically meaningful improvement in health outcomes attributable to the service, despite widespread or increasing utilization.
 - Practice patterns demonstrate greater variation than expected when compared to evidence-based guidelines or consensus recommendations.
 - Utilization patterns suggest overuse or misuse of a service relative to evidence-based expectations, even when the service itself is not considered experimental or investigational.
- **Potential for Fraud, Waste, or Abuse** is any service associated with a high incidence of fraud, waste, and/or abuse as identified in publications by organizations that track trends regarding fraud/waste/abuse in utilization of healthcare services consistent with applicable law and

regulation or that has been identified as potential anomalies using internal claims data through the Special Investigation's Unit (SIU) may be placed on the Master Precertification List.

If the SIU identifies a trend that may warrant adding a code to the precertification list, it is sent to Payment Policy & Coding (PP&C) (formerly Coverage Policy Unit (CPU)) for evaluation. The PP&C does not have a specific threshold for incidence of fraud, waste, and/or abuse; however, for the sake of clarity "high" unit cost (over \$500) is considered in determining whether or not to add a service to utilization management. It should be noted that a high volume of utilization does not necessarily mean a high incidence of fraud. Incidence is identified by PP&C through:

- Evaluation of provider code utilization patterns through vendor flags that identify industry wide trends regarding providers or codes. Utilization patterns suggest overuse or misuse of a service relative to evidence-based expectations.
- Review and contrast data amongst other similar providers.
- Monitoring unusual billing patterns; unusual means anything that demonstrates greater variation of the practice patterns compared to like providers within the same specialty.

Codes are usually not added to utilization management unless a trend is seen across the industry. Cigna monitors CMS and the competitive landscape including AMA and other specialty societies to identify potential codes.

- **Estimated Average Cost (Quantitative):** Any service where the average unit cost, based on an assessment of Cigna Healthcare's historical paid claims, exceeds \$500, may be placed on the Master Precertification List. Services with an average unit cost not exceeding \$500 **may be** added to the Master Precertification List when:
 - The service is an unlisted or non-specific code where the unit cost may vary from far less than \$500 to far more than \$500; or
 - The service is associated with serial use where the cumulative average use of the services may be represented by a single authorization and therefore exceed the dollar threshold.

Step 3: Description of how factors are used in the design and application of the NQTL.

See [45 CFR 146.137\(c\)\(3\)](#). Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

- (1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;
- (2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;
- (3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;
- (4) If more than one factor is identified and defined in Step 2, an explanation of:
 - (A) How all of the factors relate to each other;

- (B) The order in which all of the factors are applied, including when they are applied;
 - (C) Whether and how any factors are given more weight than others; and
 - (D) The reasons for the ordering or weighting of the factors.
- (5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also [FAQ 45](#) guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [\[Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee\]](#).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Design and Application:

Cigna's Healthcare Medical Assessment Committee ("HMAC") is comprised of licensed clinicians including physicians and nurses from a variety of medical and behavioral disciplines. HMAC also consults with internal Cigna subject matter experts as part of the committee review process. Internal subject matter experts include, but may not be limited to orthopedists, neurologists, neurosurgeons, obstetrician-gynecologists (OBGYNs), oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists and psychiatrists. The committee uses principles of evidence-based medicine in its evaluation of clinical literature, development of its reviews, in its deliberation process, and in preparation of published coverage policies.

Title	Qualifications	Years of Experience
Medical Senior Director	Neurology/Sleep	10+
Medical Senior Director	Internal Medicine	10+
Medical Senior Director	Surgery	10+
Medical Principal	Thoracic and Cardiac Surgery; Surgery	10+
Medical Principal	Pediatrics, Internal Medicine, Clinical Genetics and Genomics	10+
Utilization Review Medical Principal	Physical Medicine and Rehabilitation	10+
Utilization Review Medical Lead	Family Medicine	10+
Medical Director	Psychiatry	10+
Medical Principal	Psychiatry	10+
Medical Director	Psychiatry	10+
Medical Principal	Cardiology	10+
Medical Senior Director	Internal Medicine	10+

Cigna's HMAc implements an evidence-based medicine approach to rank categories of evidence and assign weight to categories with higher levels of scientific evidence. Additional variables used to evaluate the scientific evidence may include study design elements, such as number, power, types of outcomes, comparator intervention, objectiveness of rating tools, and blinding, as well as issues related to conflicts and potential bias of the study authors and institutional associations.

The inclusion of MH/SUD expertise on HMAc and the Coverage Policy approval process ensures MH/SUD Coverage Policies appropriately incorporate generally accepted standards of practice, including consideration of type or duration of treatment or level of care for patients with specific MH/SUD conditions. A Cigna-employed Medical Director with former practice experience as a psychiatrist and expertise in, and dedicated support for, behavioral health matters is consulted to ensure appropriate evaluation of such services considered for application of retrospective review. Comparable representation of expertise in MH/SUD services is essential to ensure the application of the Retrospective Review NQTL is applied to MH/SUD benefits no more stringently than to M/S benefits. Moreover, the frequency of review of the services subject to retrospective review and their continued appropriateness is comparable across MH/SUD and M/S benefits.

Identifying Services for Retrospective Review

Services covered under a Cigna-administered benefit plan, including M/S and MH/SUD benefits, may be subject to retrospective review if a prior authorization or concurrent review request was required but not obtained.

Cigna's Precertification Workgroup is charged with reviewing the Master Precertification List at least annually to determine the addition or removal of codes, for non-delegated services. The Precertification Workgroup is comprised of both medical and behavioral physicians, pharmacists, nurses, and certified coders. For existing codes that are added to precertification and changes that may impose new prior authorization requirements, Cigna provides a written (letter) notification of changes at least ninety (90) days in advance. The addition of new codes may be added to the Master Precertification List upon publication.

The Precertification Workgroup meets monthly to conduct routine activities, including reviewing for the release of new services/codes to determine if code(s) relating to services have been retired

from use/replaced by another service code(s), or a new therapy becomes available. Recommendations are then made to HMAC for approval and inclusion in the appropriate coverage policy, as needed.

Additionally, the Precertification Workgroup consists of Cigna-employed Medical Directors and M/S and MH/SUD professionals who may recommend additions/deletions of services requiring the application of Retrospective Review NQTL to HMAC. HMAC utilizes the following process in their evaluation of evidence. The overall strength of evidence reflects recognition of the hierarchy of evidence, with greater weight assigned to study designs that provide higher confidence in the relationship between the intervention and meaningful clinical outcomes in a defined patient population.

Coverage Policy Development

A lack of statistically significant evidence demonstrating improved health outcomes does not, by itself, establish inappropriate care, but may indicate uncertainty or variability in clinical effectiveness that warrants utilization management oversight. Cigna's Healthcare Medical Assessment Committee implements an evidence-based medicine approach to rank categories of evidence and assign weight to categories with higher levels of scientific evidence as set forth below in Cigna's "Levels of Scientific Evidence" table, adapted from the Oxford Centre for Evidence-Based Medicine, 2011:

Level 1: Systematic reviews with or without meta-analysis

Level 2: Randomized controlled trial (RCT); observational (analytic) study; cross-sectional study

Level 3: Non-consecutive study (i.e., no control group); cohort study; non-randomized controlled cohort study

Level 4: Case series; case-control studies

Level 5: Literature reviews; consensus reports; expert opinion; professional society/organization recommendations when not based on systematic review/meta-analysis.

Following completion of the evidence assessment, findings are presented to the appropriate committee. The committee considers whether the observed variation represents sufficient concern regarding appropriateness, consistency, or value of care to support inclusion of the service on the Master Precertification List. Final determinations regarding coverage criteria are made through the established committee review process.

Where there is no coverage policy, Cigna will assign an inquiry to the Medical Inquiry Unit. The team is staffed by authors who are Registered Nurses with oversight from a Senior Medical director. The authors will conduct an evidence-based review and make recommendations about coverage. The function of the inquiry is to assist the physician reviewer in considering the clinical appropriateness of the specific clinical request in question. Inquiry requests are reviewed periodically by HMAC to determine if a coverage policy should be considered for development. A summary of the evidence or lack thereof is presented to HMAC who will make a final determination.

The inquiry review is based on a search of the body of knowledge available, relevant to the technology in question, and includes specific citations from appropriate sources used in research, which include the following:

- peer-reviewed scientific studies published in journals that meet nationally recognized requirements for scientific manuscripts.
- standard medical reference compendia and authoritative medical textbooks
- findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes in the federal Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH), National Cancer Institute, National Academy of Sciences, Health Care Financing Administration (HCFA), Congressional Office of Technology Assessment, and any national board recognized by the NIH for the purpose of evaluating the medical value of health services.

Cigna's Coverage Policies are reviewed at least once annually; re-review of Coverage Policies and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, frontline reviewers, applicable business teams, and the impetus of new, emerging and evolving technologies.

Step 4: Demonstration of comparability and stringency as written.

See [45 CFR 146.137\(c\)\(4\)](#). The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

- (1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant:
 - (A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and
 - (B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;
- (2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;
- (3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each

- classification to determine which benefits are subject to the NQTL; and
- (4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [\[Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits\]](#):
- (A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;
- (B) In the design of the factors or evidentiary standards; or
- (C) In the application or design of the NQTL.

See also [FAQ 45](#) guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [\[Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review\]](#).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

As Written:

As previously noted, any inpatient admission will meet the estimated average cost threshold of

\$500; this quantitative factor is applied to both M/S and MH/SUD. Any of the non-quantitative factors noted may also apply.

To ensure that Cigna's policies are consistently applied, Cigna conducts a thorough review of policies and procedures at least annually. The annual review includes an analysis of applicable M/S and MH/SUD policies and procedures to identify potential gaps or inconsistencies. In its review as set forth in the policy comparison tables below, Cigna identified opportunities for adjustments to ensure comparability and equivalent stringency in application the Retrospective Review NQTL. Cigna is providing the below Utilization Management policies used in the application of the Retrospective Review NQTL to demonstrate comparability and consistency. As described in policy *OPS-18 Policy and Procedure Maintenance, Review and Approval Process*, these Cigna policies were developed and reviewed according to URAC and NCQA standards, and regulatory requirements.

The UM-12: Qualified Health Professionals Render UM Decisions and the HM-CLN-039: Utilization Management Decisions – Appropriate Professional Assessment policies are reflective of Cigna’s consistent parameters to identify medical directors’ and other licensed clinicians’ roles and responsibilities.

M/S	MH/SUD
UM-12: Qualified Health Professionals Render UM Decisions	HM-CLN-039: Utilization Management Decisions – Appropriate Professional Assessment
Qualified health professionals assess the clinical information used to support UM decisions. Non-clinical staff may provide assistance by performing administrative tasks only.	Policy requires that appropriately licensed behavioral health professionals assess and supervise utilization management decisions. Only psychologists, addictionologists or board-certified psychiatrists are allowed to assess and make medical necessity denial decisions. To ensure that qualified licensed health professionals assess the clinical information used to make appropriate utilization management decisions
RN’s provides clinical oversight to non-clinical and LPN/LVN staff and/or reviews inpatient and outpatient UM services using established, approved, medical criteria, tools and references as well as own clinical training and education in making medical necessity coverage “approval” decisions. RN staff includes Inpatient Case Manager (IPCM) and Pre-service/Post Service Utilization Review Nurse (UM) roles.	Care managers collect data for pre-service, concurrent, and post-service utilization decisions and have the authority to approve but not to deny medical necessity services. In the event that a care manager cannot approve the utilization request, the case is forwarded to an appropriate peer reviewer for assessment and the decision to approve or deny services.
Licensed Physician (i.e., Medical Director) – provides clinical oversight to pharmacist staff where indicated, nurse staff and makes medical necessity UM decisions using evidence-based medical necessity guidelines, new technologies information and board-certified specialty (same or similar) consultants for additional medical expertise as required as well as own clinical training and education in making medical necessity coverage decisions. Medical Director qualification requirements include: Hold an active unrestricted license or certification to practice medicine in a state or territory of the United States	Behavioral Peer Reviewers are Board Certified Psychiatrists, Licensed Clinical Psychologists and Certified Addictionologists who may have the following job titles: - Senior Medical Director - Medical Officer - Medical Director - Medical Principal Qualifications: - Board certified psychiatrist, addictionologists, or doctoral level psychologists with current unrestricted license in the United States or its territories.

• Unless expressly allowed by state or federal regulations, are located in a state or territory of the United States when conducting a peer clinical review. • Are qualified as determined by the Senior Medical Director to render a clinical opinion about the medical condition, procedure and treatment under review. • Hold a current and valid license in the same category as the ordering provider or as a Doctor of Medicine, or as a Doctor of Osteopathic Medicine. Medical Director Areas of Responsibility for UM Decisions; includes, but not limited to the following: • Review and render all medical necessity denials. • Make medical necessity decisions in accordance with state licensure requirements as applicable. • Provide specific reason(s) for denials in case documentation and letter content. • Provide oversight and ongoing consultation to clinical and non-clinical staff. • Complete ongoing education to maintain licensure and update professional skills.	Responsibilities include: • Conducting Pre-service reviews • Concurrent reviews • Post-service reviews • Medical necessity determinations including: ○ Approvals ○ Denials
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In application, both policies require reviewers to be appropriately licensed and act within the scope of their license. As noted in the scope of these policies below, both indicate accountability in the review and determination of denials.

Clinical reviews of MH/SUD and M/S services are performed by clinicians with comparable expertise in MH/SUD treatment and M/S treatment, respectively, such that clinical information submitted by providers in connection with MH/SUD reviews that may be denied are reviewed by MH/SUD experts to the same extent M/S experts review coverage requests for M/S services. Individuals responsible for denying either a MH/SUD or M/S review request must be considered “peer reviewers,” that is, must hold a similar license as the customer’s treating provider. Individuals who issue approvals may be nurses or case managers, as accreditation standards do not dictate that approvals be issued by peer reviewers. The reasons for a clinical review by an appropriate clinical expert – namely, the identification of a potential denial – are identical across MH/SUD and M/S benefits.

UM-39: Timeliness of Health Services Decisions and HM-CLN-035: Timeliness of Utilization Management Decisions and Notifications outline the turnaround times for M/S and MH/SUD.

CATEGORY (APPROVALS AND DENIALS)	Timeline to make Decision	Verbal or Electronic Notification	Timeframe	Written Notification	Timeframe
Retrospective Review	M/S: Within 2 business days of all information	Provider Verbal	Within 2 business days of all information	Provider and Customer	M/S: Within 2 business days of all information

	received date	notification is ONLY required for upheld denials or partial denials on p2p & reconsiderations, and appeals when the reconsideration process is vacated due to provider requesting same or similar specialist review	received date		received date
	MH/SUD: Within 2 business days after receipt of request	Provider	Notify within the decision timeframe	Provider and Customer	MH/SUD: Follow up in writing within 2 business days after the decision

The above referenced policies are illustrative of the annual review conducted to ensure comparability in writing of the application of the Retrospective Review NQTL to M/S and MH/SUD services in the INN Inpatient benefit classifications.

The process by which services are considered for application of retrospective review is comparable in writing across MH/SUD and M/S benefits. As reflected in its written policy, (*Healthcare Medical Assessment and Coverage Process for Determination of Medical Necessity Coverage Criteria Recommendations Policy (OPS-48)*) a committee of Cigna-employed Medical Directors determines which M/S and MH/SUD services are subject to retrospective review. Cigna utilizes a single Healthcare Medical Assessment Committee (“HMAC”) in the development of clinical guidelines and medical necessity criteria (collectively “Coverage Policies”) of M/S and MH/SUD services. HMAC reviews Coverage Policies annually to ensure their continued appropriateness based on prevailing clinical standards of care.

Retrospective Review Processes

Cigna performs distinct and aligned processes in the application of the Retrospective Review NQTL for both M/S and MH/SUD. Services, procedures, drugs, devices, durable medical equipment, and certain therapies (collectively referred to as “services”) that may be subject to retrospective review and are represented by industry accepted procedure codes developed by external sources.

Additionally, all MH/SUD and M/S non-emergency (i.e. pre-scheduled) services in the Inpatient benefit classifications are subject to retrospective review.

For both MH/SUD and M/S, a provider may submit a request for retrospective review via fax, email, or phone.

The case is referred to a nurse reviewer (M/S)/care manager (MH/SUD) who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the service requested, he/she authorizes those services.

If the nurse reviewer/care manager determines that the enrollee does not appear to meet medical necessity criteria for the service requested, he/she refers the case to a peer reviewer.

Proactive peer reviews may not be done retrospectively because it would require Cigna to identify prospective denials and call those providers to offer a live peer review. Since the customer has left the hospital and records have been filed, the provider would then need to request the records and have a good recollection about what transpired to do the review. This process does not seem reasonable or fair to the provider.

Delegates:

As previously noted, Cigna delegates the application of retrospective review to EviCore for the medical necessity review of M/S services for high tech imaging and cardiology, radiation and medical oncology, musculoskeletal management, spinal procedures, vascular intervention, sleep, molecular labs and gastrointestinal endoscopic procedures. EviCore utilizes their own clinical coverage policies (which Cigna reviews, approves and co-brands) when performing utilization reviews. All the data provided is inclusive of utilization reviews conducted by the above-mentioned entities.

The delegation agreement with EviCore outlines the functions delegated and the responsibilities of both parties. Cigna retains the ultimate responsibility for ensuring that the delegated functions are carried out properly. Delegated vendors adhere to Cigna's policies and procedures when performing utilization review.

Cigna and Evernorth do not delegate utilization management for any MH/SUD services to any other entities.

Cigna maintains the *QA_02_Delegation_Policy and Quality Programs* policy to ensure its delegates are adhering to Cigna's policies and procedures when performing utilization review and the application of the Retrospective Review NQTL. The processes include regular monitoring and auditing, reviewing performance against key indicators, regular reporting through standardized committees, and root cause analysis.

The following quality activities are in place to ensure effective monitoring and ongoing adherence to the quality and accreditation requirements established by the program:

- A formal audit of the delegated entity is performed utilizing comprehensive audit tools, which incorporate Cigna, accreditation and regulatory standards. Prior to approval of delegation a thorough pre-delegation audit is performed. Audits are then performed annually or more frequently thereafter as warranted.
- Ongoing review and analysis of key performance indicators are performed to monitor ongoing compliance to established benchmarks. These metrics include a comprehensive list of inpatient and outpatient utilization statistics.
- Active management of corrective action plans for any opportunities identified through delegation oversight process.
- Multi-departmental leadership oversight and monitoring of the delegation oversight programs is approved through appropriate committee. The committee process includes reviewing and approving the annual delegation program documents and reports.
- Joint Operational Committee, which includes both Cigna and the delegate, meets to collaborate and communicate effective tools and to provide feedback to support the delegation process.

Tracking of Denials:

Authorization of requests for payment for behavioral health or medical services may be denied administratively or if they do not meet medical necessity criteria.

Administrative Denials

Administrative denials occur when one or more of the following non-clinical situations is present:

- a. The Customer was not eligible for benefits at the time service was rendered for continued stay reviews.
- b. The Customer has exhausted their benefits. This includes both yearly benefit limits and lifetime maximums.
- c. The service being requested is a specific benefit exclusion under the summary plan documents.
- d. There are no out of network benefits and appropriate clinical resources are available in the network, and request is for convenience reasons.
- e. The facility is not a licensed/certified in accordance with the state laws of the appropriate legally authorized agency.
- f. The provider is not a licensed health care professional acting within the scope of the license or under the direct supervision of a licensed health care professional. (*See HM CLN 001*)

A customer or provider may appeal a decision.

Medical Necessity Denials

Medical Necessity adverse determinations are issued when the clinical information provided does not appear to meet the guidelines/criteria for the level of care or service requested. Medical Necessity denials are tracked in the system of record once a peer reviewer has reviewed the clinical information provided and rendered a determination. As previously noted, only a peer reviewer may issue a medical necessity denial.

Partial Denials

Cigna tracks partial denials as an adverse determination. While case notes will reflect decision outcomes (i.e., approve, denied, partial approval/denial) for data purposes, these denials are not tracked separately.

Extent of Medical Records Required

MH/SUD Policy *HM-CLN-12: Clinical Review* states that Behavioral Health shall make its determination based on benefit availability, medical necessity criteria, the individual needs of the person seeking service, an assessment of the local delivery system and the specific treatment plan being recommended by the attending practitioners to the degree possible. It additionally notes that Behavioral Health shall not require practitioners or providers to designate codes but will recommend the use of the most current DSM, ICD or CPT codes. The policy also states that Behavioral Health does not use Artificial Intelligence (AI) and machine learning (ML) medical software in the UM process and more specifically does not issue non-certifications based on AI and ML. Finally, the policy states that Behavioral Health shall not routinely conduct daily concurrent reviews but will vary the frequency of review based on severity, complexity, or discharge planning needs.

MH/SUD Policy *HM-CLN-009: Clinical and Administrative Information for Making a Determination* outlines the clinical information that is considered in making a determination (the below list is not all inclusive):

- Relevant clinical information (e.g., health and medical history, rationale for treatment, treatment history)
- Co-morbidities and complications
- Psychosocial and home environment considerations
- Discharge planning needs
- Diagnosis and treatment information
- Treatment goals
- Provider information
- Discharge plans

The medical information required for prior authorization is different, but comparable and no more stringent for MH/SUD than for M/S.

In all instances, the following information is required:

- Participant's Name and ID Number
- Participant Date of Birth
- Provider/Physician
- Servicing Provider/Facility
- Provider Network Status (determined by internal systems)
- Medical History/Date of Injury (if applicable)
- Dates of Service (if known)
- Procedure Code/Type of Service
- Diagnosis Code
- Details of who is making the request

In the Inpatient category, the following documentation is required. Information requested is different for MH/SUD than it is for M/S and tailored to ensure the best outcomes for the patient.

For Inpatient M/S, Cigna requires the following:

- Admission Date
- Admitting Diagnosis
- Status being requested (inpatient or observation)
- Past medical history
- Pertinent labs or imaging
- Vital signs or exam findings
- Hospital course and treatment
- Other: Specify

For Inpatient MH/SUD (Psychiatric, Detox, Residential for Substance Use Disorder), Cigna requests the following information, if applicable:

- Clinical reason for admission/continued stay.
- Mental Status Exam
- Substance Use Information/ Substance Use Disorder
- Home medications
- Medication names, dosages, dates changes made while inpatient
- Social Support
- Treatment Plan

Not all the above requirements are necessary for making a decision. The information provided should support a request for continued care/service. While different, they are no more stringent.

Both M/S and MH inpatient admissions are reviewed using MCG™; inpatient SUD requests are reviewed using ASAM®.

Appeal Rights

If a retrospective review request is denied for either M/S or MH/SUD, the customer, his/her authorized representative, or the rendering provider may file an appeal. A Customer can request, orally or in writing, an appeal of any adverse benefit determination, including both initial medical necessity and claim payment-related issues, that the Customer believes is not adequately addressed or resolved by Customer Service. Appeal forms can be located in the forms center on myCigna.com.

The appeals process adheres to state and federal rules. Customers are informed of their appeal rights along with online resources to help guide them through the process. Customers have 180 calendar days from the date of the denial notice to file an appeal. All appeals involve a medical director and are based upon the terms of the benefits plan. Decisions are made within 15 days for preservice and 30 days for post-service unless the request is considered urgent.

The State of Virginia requires specific forms to be submitted, which are the same for MH/SUD as they are for M/S.

Virginia Specific Appointment of Authorized Representative

[PDF] External Review Request Form [PDF]

Physician Certification Expedited External Review Request Form [PDF]

Physician Certification Experimental or Investigational Denials Form [PDF]

Customers who choose to file their own claim may be requested to include documentation supporting the appeal if the denial was based on medical necessity like medical records or statement from the provider describing the service or treatment.

There is a difference in how the MH/SUD appeals process is completed in that Cigna offers an online fillable form option in addition to a print only option, whereas M/S appeals would print the form, complete the form, and submit it.

The same appeals process outlined above also applies to partial denials.

Emergent Admissions

As outlined above in the policy comparison, precertification is not required for emergency services for either M/S or MH/SUD.

Per MH/SUD policy *HM OPS 023 Emergency Services* Behavioral Health shall not require prior authorization for any emergency stabilization services believed to be required for an emergent need. This includes emergency claims submitted by a healthcare professional, facility, an individual or their representative within or outside of the defined service area as part of pre-

service, concurrent, or retrospective/post service reviews.

M/S UM 32 *Emergency Services* policy states that Cigna Health Care shall cover all emergency services, does not require pre-certification of emergency services, nor does it conduct retrospective emergency service medical necessity review or deny emergency service claims absent evidence of fraud.

For both M/S and MH/SUD, if an emergency service results in an inpatient admission Cigna should be notified within 48 hours after the admission.

Step 5: Demonstration of comparability and stringency in operation.

See [45 CFR 146.137\(c\)\(5\)](#). The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

- (1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:
 - (A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;
 - (B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;
 - (C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and
 - (D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was

- considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);
- (2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);
 - (3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:
 - (A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];
 - (B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);
 - (4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:
 - (A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and
 - (5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:
 - (A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and
 - (B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD

benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also [FAQ 45](#) guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

In Operation:

On an annual basis, Cigna reviews applicable operational data with Subject Matter Experts to assess ongoing relevance and makes updates as necessary. Cigna has assessed comparability/equivalent stringency of application of Inpatient In-Network Retrospective Review benefit classifications in-operation by assessing denial rates for benefits subject to retrospective review across the Virginia and Cigna IFP book-of-business during the 2025 calendar year. Data is reviewed by benefit classification and sub-classification to calculate denial rates to ensure comparability.

The data tables below are reflective of Virginia IFP book-of-business data for calendar year 2025.

M/S In-Network IP Retrospective Review	General Hospital	%	Specialty Hospital	%	Inpatient Hospice	%	Skilled Nursing	%
Number of Authorizations Requested	738		0		0		0	

Number of Med Nec and Admin Requests Approved	605	82%	0	0.00%	0	0.00%	0	0.00%
Number of Med Nec and Admin denied	133	18%	0	0.00%	0	0.00%	0	0.00%
Average days or units approved	< 1 day		0		0		0	
Average Turnaround time for Approvals	< 1 day		0		0		0	
Average Turnaround time for Denials	0.53		0		0		0	
Number of Medical Necessity Approvals	605		0	0.00%	0	0.00%	0	0.00%
Of the medical necessity approvals how many were FastCert	4	1%	0	0.00%	0	0.00%	0	0.00%
Number of Medical Necessity denials	113	15%	0	0.00%	0	0.00%	0	0.00%
Number of Administrative Approvals	0	0%	0	0.00%	0	0.00%	0	0.00%
Number of Administrative denials	20	3%	0	0.00%	0	0.00%	0	0.00%
Total requests sent to Physician Review	205	28%	0	0.00%	0	0.00%	0	0.00%
Total requests sent to Physician Review Approved	83	11%	0	0.00%	0	0.00%	0	0.00%
Total requests sent to Physician Review Denied	122	17%	0	0.00%	0	0.00%	0	0.00%
Total Requests sent to P2P	53	7%	0	0.00%	0	0.00%	0	0.00%
Total Requests sent to P2P Approved	14	2%	0	0.00%	0	0.00%	0	0.00%
Total Requests sent to P2P Denied	39	5%	0	0.00%	0	0.00%	0	0.00%

MH In-Network IP Retrospective Review	General Hospital	%	Psychiatric Hospital	%	Residential	%
Number of Authorizations Requested	0		7		1	
Number of Med Nec and Admin Requests Approved	0	0%	5	71%	1	100%
Number of Med Nec and Admin denied	0	0%	2	29%	0	0%
Average days or units approved	0		3.8		34	
Average Turnaround time for Approvals	0		67.4		8	
Average Turnaround time for Denials	0		60		0	
Number of Medical Necessity	0	0%	5	71%	1	100%

Approvals						
Of the medical necessity approvals how many were FastCert	0	0%	0	0%	0	0%
Number of Medical Necessity denials	0	0%	2	29%	0	0%
Number of Administrative Approvals	0	0%	0	0%	0	0%
Number of Administrative denials	0	0%	0	0%	0	0%
Total requests sent to Physician Review	0	0%	2	29%	0	0%
Total requests sent to Physician Review Approved	0	0%	0	0%	0	0%
Total requests sent to Physician Review Denied	0	0%	2	29%	0	0%
Total Requests sent to P2P	0	0%	0	0%	0	0%
Total Requests sent to P2P Approved	0	0%	0	0%	0	0%
Total Requests sent to P2P Denied	0	0%	0	0%	0	0%

SUD In-Network IP Retrospective Review	General Hospital	%	Psychiatric Hospital	%	Residential	%
Number of Authorizations Requested	0		1		0	
Number of Med Nec and Admin Requests Approved	0	0%	1	100%	0	0%
Number of Med Nec and Admin denied	0	0%	0	0%	0	0%
Average days or units approved	0		5		0	
Average Turnaround time for Approvals	0		45		0	
Average Turnaround time for Denials	0		0		0	
Number of Medical Necessity Approvals	0	0%	1	100%	0	0%
Of the medical necessity approvals how many were FastCert	0	0%	0	0%	0	0%
Number of Medical Necessity denials	0	0%	0	0%	0	0%
Number of Administrative Approvals	0	0%	0	0%	0	0%
Number of Administrative denials	0	0%	0	0%	0	0%
Total requests sent to Physician Review	0	0%	0	0%	0	0%
Total requests sent to Physician Review Approved	0	0%	0	0%	0	0%

Total requests sent to Physician Review Denied	0	0%	0	0%	0	0%
Total Requests sent to P2P	0	0%	0	0%	0	0%
Total Requests sent to P2P Approved	0	0%	0	0%	0	0%
Total Requests sent to P2P Denied	0	0%	0	0%	0	0%

The Virginia 2025 IFP data shows neither MH nor SUD having any denials in the in-network inpatient retrospective review benefit classification. MH and SUD did exceed the expected turnaround times. Through internal monitoring, EBH identified a gap in the processing of retrospective reviews which caused timeliness delays. EBH convened a workgroup to evaluate the root cause and identify outcome improvements. All MH and SUD requests were approved at a care manager level and did not require a peer-to-peer review.

Cigna is providing Virginia IFP 2025 appeals results below. The data includes prior authorization, concurrent, and retrospective review appeals.

Level 1 appeals:

In-Network Inpatient	MH/SUD	MH/SUD Rate	M/S	M/S Rate
Total number of Level One Appeal requests	11		0	
Total number overturned	1	9.09%	0	0.00%
Total number upheld	10	90.91%		0.00%
Total number upheld as not medically necessary	10	90.91%	0	0.00%
Total number upheld as EIU	0	0.00%	0	0.00%
Total number administratively upheld as not a covered benefit (administrative)	0	0.00%	0	0.00%
Total number administratively upheld due to ineligibility (administrative)	0	0.00%	0	0.00%

M/S did not have any appeals in the in-network inpatient classification. MH/SUD did not have any in-network inpatient retrospective denials; therefore, the reflected appeals data does not include any appeals for retrospective requests.

The table below is reflective of Cigna's IFP book of business data for calendar year 2025.

In-Network Inpatient Retrospective Review:	MH/SUD	MH/SUD Denial Rate	M/S	M/S Denial Rate
Total Number of In-Network Inpatient Retrospective Review Requests	56		9,192	
Total Number of In-Network Inpatient Retrospective Review Denials	14	25.00%	1,220	13.27%
Total Number of In-Network Inpatient Retrospective Review Requests Administratively Denied	0	0.00%	140	1.52%
Total Number of In-Network Inpatient Retrospective Review Requests Denied as Not Medically Necessary	14	25.00%	1,080	11.75%
Total Number of In-Network Inpatient Retrospective Review Requests Denied as EIU	0	0.00%	0	0.00%

The 2025 Cigna IFP book-of-business data reflects 56 MH/SUD in-network inpatient retrospective review requests and 9,192 M/S requests. Fourteen MH/SUD requests were denied, resulting in an overall denial rate of 25.00%, compared with 1,220 M/S denials and an overall denial rate of 13.27%. All MH/SUD denials were based on medical necessity. For M/S, 1,080 requests were denied as not medically necessary and 140 were administratively denied, corresponding to rates of 11.75% and 1.52%, respectively. Although the MH/SUD overall denial rate was higher, the MH/SUD rate is based on a materially smaller denominator than the M/S rate and is therefore more sensitive to changes in a small number of determinations. Accordingly, the observed rate difference should be interpreted in the context of the substantial disparity in request volumes and does not, by itself, establish that retrospective review was applied more stringently to MH/SUD benefits.

The data below reflects the Cigna IFP turnaround time results for plan year 2025.

Average Turnaround Time	MH/SUD TATs	M/S TATs
In-Network Inpatient Retrospective Approval Review Turnaround Time	59.26 days	<24 hours
In-Network Inpatient Retrospective Denial Review Turnaround Time	63.75 days	<24 hours

The Cigna IFP book of business data reflects a higher turnaround timeframe for MH/SUD inpatient retrospective reviews during the time period. Through internal monitoring, EBH identified a gap in the processing of retrospective reviews which caused timeliness delays. EBH convened a workgroup to evaluate the root cause and identify outcome improvements.

Actions taken include:

- Updating document instructions and internal resources to improve accurate routing and identification of MH/SUD retrospective review requests.
- Conducting ongoing audits to monitor compliance, timeliness, and effectiveness of corrective actions.
- Implementing additional process improvements, including refining retrospective review workflows to support more consistent identification, routing, and processing of requests.

For 2025, the national retrospective review turnaround time was met 58% of the time and the workgroup remains active.

Step 6: Findings and conclusions.

See [45 CFR 146.137\(c\)\(6\)](#). The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

- (1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section 146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

- (2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;
- (3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;
- (4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and
- (5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the [FAQ 45](#) guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Conclusion:

M/S and MH/SUD: The specific findings and conclusions reached by Cigna with respect to the Retrospective Review NQTL, including results of the analyses described in the previous steps, indicate that Cigna is in compliance with the MHPAEA requirements. As demonstrated in this comparative analysis, retrospective review applies to both M/S and MH/SUD and is noted in the plan benefit language. The plan benefit language is not separated between M/S and MH/SUD and does not demonstrate any disparity. The same factors are utilized for both M/S and MH/SUD services to determine which services are subject to retrospective review. Cigna has assessed the processes for application of the Retrospective Review NQTL to MH/SUD and M/S benefits and reviews annually operational policies governing utilization review, including medical necessity as well as policies governing clinical coverage policy development to ensure comparability and equivalent stringency in application, comparable representation of qualified individuals who develop or participate in medical necessity decision-making, and the methodology for the application of retrospective review.

Cigna reviewed and determined the evidentiary standards for the factors used in the application of retrospective review are identical as written and applied no more stringently to MH/SUD services

than to M/S services. Cigna maintains an integrated approach to policy development and maintenance and identified opportunities for adjustments to ensure that standards are consistently applied.

In reviewing its as-written processes, Cigna determined that M/S and MH/SUD maintain comparable policies and procedures regarding roles and responsibilities of individuals performing retrospective review and follow the Virginia required timeliness standards for retrospective reviews.

In operation, the Cigna IFP 2025 book of business data shows slightly higher MH/SUD medical necessity denial rates, however there is a significantly higher volume of M/S requests when compared to MH/SUD. Additionally, while MH/SUD did exceed the expected turnaround times for retrospective review determinations, this was identified through internal monitoring and actions are in place as outlined in step 5 with a continuing workgroup focusing on improvement efforts.

In conclusion, the comparative analysis performed for application of the Retrospective Review NQTL demonstrates overall compliance with the MHPAEA in-writing and in-operation.

Cigna respectfully submits that the processes, strategies, evidentiary standards, and other factors used to determine MH/SUD services subject to retrospective review requirements are comparable to, and no more stringent than those used for the M/S services in all benefit classifications.

This version of the analysis was drafted and performed in 2026 based upon Cigna's and Virginia 2025 book-of-business data, by members of the legal, compliance, and various business teams, including the following individuals:

Mental Health Parity Legal Team including:

Managing Counsel;
Associate Senior Counsel; and
Legal Compliance Senior Advisor

Mental Health Parity Compliance team including:

Legal Compliance Senior Manager;
Legal Compliance Senior Advisor

M/S and MH/SUD subject matter experts including:

Medical Managing Director Evernorth Behavioral Health;
Medical Senior Principal;
Program Management Advisor; and
Legal Compliance Advisor;