

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 Concurrent 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 the In-Network (INN) Inpatient concurrent review parameters applied to mental health/substance use disorder ("MH/SUD") and/or medical/surgical ("M/S") services for the inpatient benefit classifications and is incorporated in plans insured by Cigna Health and Life Insurance Company ("CHLIC"). In the review and analysis of the In-Network Inpatient Concurrent Review NQTL, Cigna reviewed policies applicable to Cigna, Evernorth Behavioral Health (EBH), and Connect Bronze 6500 Indiv Med Deductible plan certificate.

Concurrent review is considered a request for service that occurs after an admission or treatment has begun even if it is the initial request.

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 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.

Concurrent Medical Necessity Determinations

When an ongoing course of treatment has been approved for an Insured Person and they wish to extend the approval, the Insured Person or their representative must request a required concurrent medical necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When the Insured Person or their representative requests such a determination, Cigna Healthcare will notify them of the determination within 24 hours after receiving the request.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. Behavioral Fast Certification (FastCert): A non-clinical, streamlined Prior Authorization/Concurrent process for MH/SUD for initial request when certain pre-set criteria are met.
3. Concurrent Review: A request for service that occurs after an admission or treatment has begun even if it is the initial request.
4. 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.
5. 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.
6. 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.
7. 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](#)
8. 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.
9. 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).

10. 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).
11. Non-Clinical Staff: Any staff that do not hold a license or certification including advocates and care coordinators.
12. Non-Urgent: A situation that is considered routine in nature.
13. 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.
14. 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.
15. 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.
16. 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.
17. 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.
18. Urgent: Any request for medical care or treatment where a delay in making non-urgent care determination:
 - Could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, based on prudent layperson's judgement, or
 - Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or
 - In the opinion of a practitioner with knowledge of the enrollee's medical condition, would

subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the 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 002: Advocates and Care Coordinators Policy	The purpose of this policy is to describe the job functions for Advocates and Care Coordinators, including limitations in their authority to make clinical determinations.
HM CLN 012: Clinical Review Policy	The purpose of this policy is to provide a basis for care managers to make coverage and appropriateness of care determinations. Behavioral Health's care management staff and consultants shall follow the national care management policies, procedures, The ASAM Criteria®, MCG™, Cigna's Coverage Policies, plan documents, applicable state and federal procedures, NCQA/URAC Standards in the performance of care management for Behavioral Health.
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 05: Telephonic and Onsite Inpatient Case Management and Continued Stay Review Policy	The purpose of this policy is to establish a consistent process for evaluating customers in the inpatient setting and provide guidance on discharge planning and case management.
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.
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 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 subject matter experts (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 require concurrent review to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna, as well as verification that a service will be rendered for a covered benefit.

Is NQTL applied to In-Network Inpatient classification?	<i>Medical/Surgical</i>	<i>Mental Health & Substance Use</i>
	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

Review Processes:

In addition to the standard clinical review, Cigna implements a Behavioral Fast Certification (“MH/SUD FastCert”) applicable to MH/SUD services. The clinical algorithms are developed by Cigna/Evernorth medical directors to allow administrative staff to issue authorizations. M/S does not offer a Fast Certification process for in-network inpatient concurrent review.

For a standard clinical review, 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.

These review processes are explained in more detail in step 4.

Cigna does not utilize notification as a form of prior authorization, rather the term is used to reference that a provider is expected to communicate to Cigna when a customer requires either prior authorization.

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 (M/S and MH/SUD)

Cigna utilizes the **factors** outlined below to determine services that are subject to concurrent review. In making and determination of the In-network, Inpatient Concurrent 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

Factors	Sources for Each Factor
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 concurrent 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 Exclusions from Coverage</i> ”	2. Plan Documents
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	4. Cigna claims data

	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.	
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 meet inpatient concurrent review requirements, any of the non-quantitative factors may be considered along with the quantitative factor. As a result, all inpatient admissions will meet the concurrent review requirements.

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 scientific literature** refers to instances where such evidence 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 identified for concurrent review. 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.

The factors, sources, and evidentiary standards do not vary for clinical vs. non-clinical reviews.

FastCert is a streamlined, non-clinical review process that permits authorization determinations based on predefined criteria and parameters established by medical directors. Although FastCert reduces the steps required to complete the review, it does not alter the underlying prior authorization/concurrent review requirements or applicable medical necessity criteria.

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 ensures MH/SUD guidelines 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 who has experience and expertise in direct practice as a psychiatrist treating MH/SUD conditions is consulted to ensure appropriate evaluation of such services considered for the application of Concurrent Review NQTL. Comparable representation of expertise in MH/SUD services is essential to ensure the application of the Concurrent Review NQTL are applied to MH/SUD benefits no more stringently than to M/S benefits. Moreover, the frequency of review of the services subject to concurrent review and their continued appropriateness is comparable across MH/SUD and M/S benefits.

Identifying Services for Concurrent Review

Both M/S and MH/SUD require concurrent review for inpatient stays when a request to extend previously authorized services is received; the services are ongoing; and/or an assessment is required to continue to establish the medical necessity and appropriateness of the current level of care. Concurrent review is also applied for a service that occurs after an admission or treatment has begun even if it is the initial request.

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 Concurrent 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 HMA 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 HMA to determine if a coverage policy should be considered for development. A summary of the evidence or lack thereof is presented to HMA 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:

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 of the Concurrent Review NQTL. Cigna is providing the below Utilization Management policies used in the application of the Concurrent 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 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 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 • 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.	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. Responsibilities include: • Conducting Pre-service reviews • Concurrent reviews • Post-service reviews • Medical necessity determinations including: ○ Approvals ○ Denials

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.

M/S policy *UM-05: Telephonic and Onsite Inpatient Case Management and Continued Stay Review* and MH/SUD policy *HM-CLN-12: Clinical Review Policy* outlines the concurrent review process for clinicians.

M/S	MH/SUD
UM-05: Telephonic and Onsite Inpatient Case Management and Continued Stay Review	HM-CLN-12: Clinical Review Policy
The IPCM/Nurse Clinician is responsible for review of the daily census report or system generated tasks to identify inpatient admissions and continued stays to reviewed for appropriateness of current level of care. The IPCM/Nurse Clinician approves/certifies admissions and continued stay reviews for those customers whose clinical information meets the guidelines as defined in the Cigna Benefit and Coverage Tool policy as appropriate and provides an authorization/certification notification within the timelines and outlined in the Timeliness policy. When the level of care and/or continued stay clearly does not meet guidelines, the designated Medical Director (MD) is contacted for a medical necessity review. When an appropriate guideline is not available and the IPCM/Nurse Clinician is unable to approve/certify, additional clinical information can be requested. If an appropriate guideline is still not available after the additional information is received, the IPCM/Nurse Clinician should consult with the Medical Director. The IPCM/Nurse Clinician can attempt to come to an agreement with the provider managing the case on the appropriate level of care that meets the clinical information provided without a guideline. If a mutual agreement is reached, an approval/certification decision is rendered, if services do not require review. If a mutual agreement cannot be met and admission or continued stay cannot be certified based on the available clinical information, the case is referred to the Medical Director for medical necessity review. When necessary, information is unclear or not available for review, the decision is pended due to lack of clinical information reasonably necessary to make a coverage determination within timelines and notification parameters outlined in the Cigna Concurrent Review Lack of Information policy. Cigna will not reduce or terminate approval for an ongoing course of treatment before the end of the period of time or number of treatments previously approved. The Customer will have continued coverage pending the outcome of the continued stay review decision or be afforded time to request an appeal.	Behavioral Health’s care managers shall be responsible for documenting the results of their Clinical Reviews in Behavioral Health’s care management intake system documenting sufficient clinical and administrative information to support their care management determinations including referencing relevant plan document language used in making any adverse determinations in accord with Clinical and Administrative Information for Making a Determination of Coverage. Behavioral Health’s care managers/consultants shall notify provider staff and specify last covered day (LCD) in the case notes. The care manager shall also include the number of extended days, the next review date, the new total number of days or services approved and the date of admission or onset of any new services. During review of a case, Behavioral Health shall discuss the relevant information and guidelines upon which decisions are based and upon request by a customer, practitioner or provider shall make written copies of the guidelines available. Whenever a Behavioral Health care manager is unable to approve a request for service based on medical necessity the care manager shall refer the case to a peer reviewer as per the Peer Review Policy. Clinical review may be required for pre-service review, concurrent review, or post-services review for all levels of care or services in or out of network unless otherwise specified by contract or regulation: - Behavioral Health shall not routinely conduct daily concurrent review and shall vary the frequency of review based on severity, complexity, or necessary discharge planning activity. - For concurrent review care managers shall place a courtesy call to providers on the day authorization ends for concurrent inpatient, residential, and partial level of care to remind the provider of the need for a request of continued authorization for services if the customer is not being discharged that day.

	Benefit coverage ends the following morning for inpatient and residential levels of care and on the last covered day for all outpatient services
The IPCM/Nurse Clinician will assess discharge planning opportunities and coordinate a discharge plan with the provider that may include facilitating referrals to home health, durable medical equipment, outpatient or other inpatient level of care.	Discharge Planning shall begin at the point Behavioral Health is first notified of an admission.

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. Please note that the table below represents state specific timeliness standards

CATEGORY (APPROVALS AND DENIALS)		Timeline to Make Decision	Verbal or Electronic Notification	Timeframe	Written Notification	Timeframe
Concurrent Urgent	<i>M/S: Request received before last approved day</i>	Within 24 hours of request date	Provider Verbal notification to provider is ONLY required for urgent cancer pain prescription requests	Within 24 hours of request date	Provider and Customer	Within 24 hours of request date
	<i>M/S: Request received on/after last approved day</i>	Within 24 hours of request date	Provider Verbal notification to provider is ONLY required for urgent cancer pain prescription requests	Within 24 hours of request date	Provider and Customer	Within 24 hours of request date
	MH/SUD:	Within 24 hours of receipt of request	Provider	Within 24 hours of receipt of request	Provider and Customer	Upon the earlier of: Within 2 business days of determination or within 3 calendar days of verbal notification
Concurrent Non-Urgent	M/S:	All inpatient requests processed within urgent timeframes.				
	MH/SUD:	All inpatient requests processed within urgent timeframes.				

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

The process by which services are considered for application of concurrent 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 concurrent 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.

Cigna has not identified any discrepancies in operational policies between MH/SUD and M/S benefits that present a comparability or stringency problem within the context of the NQTL requirement. For example, Cigna annually reviews the policies and procedures for concurrent review to assess if adequate processes and controls are in place to ensure Concurrent Review NQTLs are applied to MH/SUD no more stringently than to M/S benefits.

Concurrent Authorization Review Processes

Cigna performs distinct and aligned processes in the application of the concurrent 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 concurrent review and are represented by industry accepted procedure codes developed external sources. All MH/SUD and M/S services in the Inpatient benefit classifications are subject to concurrent review.

Cigna subjects medical and behavioral services to concurrent review for the evaluation of medical necessity and efficacy of the continued service if:

- A request to extend previously authorized services is received.
- The services are ongoing.
- An assessment is required to continue to establish the medical necessity and appropriateness of the current level of care.
- Available clinical demonstrates variations of one or more of the following:
 - Complexity of the condition and if extension, expansion, or reduction of services is appropriate.
 - Expected timeframe for clinical response/outcomes based on literature.
 - Efficacy of the service
 - Progress toward goals of the service
 - Discharge/transition planning is required.

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

MH/SUD:

Cigna implements a FastCert process for MH/SUD to facilitate the in-network inpatient concurrent review. For MH/SUD FastCert, services are identified with a high likelihood of approval based upon previous claims experience. The FastCert processes uses Cigna specific clinical algorithms developed using the applicable medical necessity criteria (MCG™/ ASAM Criteria®). In each instance, the clinical algorithms are developed by Evernorth medical directors to allow administrative staff to issue authorizations.

To streamline authorizations for services that have been identified as having a high likelihood of approval, MH/SUD utilizes a FastCert Process that involves the collection of structured clinical data includes as applicable: diagnosis, procedure codes, drug name, strength and dosage by non-clinical staff who are trained to use these pre-established rules. Evernorth has developed clinical algorithms based on existing medical necessity criteria (MCG™/ASAM Criteria®) that allow the provider/facility to get an authorization quickly if the request meets the pre-set clinical criteria. The clinical algorithms were developed by the medical directors to allow non-clinical staff to issue authorizations within set parameters and set thresholds. The non-clinical staff asks scripted clinical questions developed and approved by clinical program staff and does not go outside of the set parameters and authorization thresholds.

Evernorth utilizes a non-clinical team that is empowered to conduct concurrent FastCert reviews for inpatient mental health and inpatient detox services that have defined thresholds established within clinical guidelines. When the continued stay request (concurrent review) is received, the non-clinical staff verifies within the designated utilization management system basic information such as the requesting provider/doctor, servicing provider/facility, the network status of the providers (determined by internal systems), dates of service, type of service. The non-clinical staff identify whether the FastCert process may be utilized or if a Care Manager must complete the review. The FastCert process dictates the number of days the non-clinical staff may approve. If FastCert requirements are not met, then a Care Manager will review the request for a standard clinical review.

The Care Manager will complete a standard clinical review and utilize MCG™ and ASAM Criteria®, along with the clinical information submitted by the provider. If the clinical information meets the criteria outlined within the applicable clinical coverage policy, the Care Manager may approve the service. If the concurrent review request does not appear to meet medical necessity criteria, the Care Manager will send the case for a medical necessity review (peer-to-peer review) which is conducted between the facility clinician and an EBH medical director who will make a final determination. Only a medical director can deny a request for a covered service as “not medically necessary”.

M/S:

M/S does not offer a FastCert process for inpatient concurrent review.

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

If there are no coverage exclusions as determined by the benefit plan, a first-level clinical review is performed by a nurse Inpatient Case Manager (“IPCM”). IPCMs are empowered to approve concurrent review requests when all medical necessity criteria are met for the extension of covered services. IPCMs utilize MCG™ along with the clinical information submitted by the provider. If the clinical information meets the list of guidelines within the clinical coverage policy the IPCM may approve the service. If the information does not meet the guidelines within the clinical coverage policy the request for authorization is sent for medical director review. IPCMs may not deny

concurrent review requests when medical necessity criteria has not been met for a covered service. If the IPCM cannot approve a covered service that has been requested, the request is then escalated for medical director review. Only a medical director can deny a request for a covered service as “not medically necessary”.

Peer-to-Peer Process

Cigna offers a voluntary peer-to-peer discussion with the requesting provider prior to issuing a denial for all inpatient concurrent review MH/SUD services. The objective of this process is to minimize the risk of issuing a denial when provided clinical information is insufficient. The peer-to-peer process is beneficial for the customer and results in greater approvals and fewer appeals of medical necessity denials.

Cigna’s medical necessity review of MH/SUD services is guided by the ASAM Criteria®, MCG™, and plan documents approved for use in care management determinations. Cigna’s peer-to-peer process is initiated when a care manager receives clinical information that does not appear to meet the applicable guidelines and plan documents for continued authorization for the level of care requested. In this instance, care managers may offer an alternative level of care (“ALOC”) to ensure there is no delay or impediment to care where the medical necessity criteria is met. If that level of care is not accepted by the requesting provider (treating practitioner), the case is referred to peer-to-peer with a behavioral health physician reviewer.

Peer-to-peer is available for any coverage request for which Cigna anticipates issuing a denial. Cigna incorporates into its MH/SUD utilization review process a requirement that – prior to issuing a denial – a Cigna clinician proactively solicits a peer-to-peer with the rendering provider. If the rendering provider is not available for review, fails to call in to the scheduled peer-to-peer, or declines, the Medical Director conducts a “read only” review of the medical files. After completing the peer-to-peer with the rendering provider or read-only review, the Cigna Medical Director makes a decision to approve or deny the requested service, based on all of the clinical information provided. All reconsideration and appeal options are available if a case results in a denial, just as they are available for denials issued for an M/S request. If Cigna’s proactive, volunteer peer-to-peer process were not applicable to MH/SUD services, and such services followed a similar process to the M/S benefit, services that were approved due to the peer-to-peer would have been much more likely to result in a denial without additional information or discussion to meet the Clinical Policy. Cigna’s pro-active peer-to-peer process is more favorable to the customer and the rendering/requesting provider resulting in a less stringent, more advantageous process for MH/SUD claims because it is proactive, as compared to the process for M/S claims whereby any peer-to-peer is, unless otherwise required by state law, conducted reactively, i.e., if the rendering provider outreaches to Cigna.

Case Management:

Customers may be identified for case management during concurrent review requests. For Cigna enrollees with complex medical and/or behavioral health conditions, Cigna provides voluntary case management services which includes providing educational information, assessment/evaluation, planning, facilitation, care coordination, discharge planning and other services to meet an individual’s and family’s comprehensive health care needs through communication and sharing available resources to promote optimal patient care. Health plan enrollees are not required to participate in case management services in order to access their benefits. Participation in case management services is not required, and an enrollee’s participation in case management services

does not limit the scope or duration of benefits for M/S or MH/SUD.

Prior Authorization compared to Concurrent Review:

For both M/S and MH/SUD prior authorization refers to a request for approval before a procedure or inpatient stay is initiated. Concurrent review occurs after a customer has already been admitted to inpatient care.

Cigna tracks Prior Authorization requests separately from Concurrent Review. Various categories are tracked and separated from in-network and out-of-network, MH/SUD and M/S.

Prior Auth and Concurrent Elements	Prior Authorization MH/SUD	Concurrent Review MH/SUD	Prior Authorization M/S	Concurrent Review M/S
Services subject to review	Non-emergent inpatient and residential admissions	All inpatient and residential stays	Non-emergent inpatient (acute and subacute) admissions	All inpatient (acute and subacute) stays
Application of Expedited Review	Behavioral Fast Cert for inpatient mental health and inpatient detox services for specified diagnoses (depression, anxiety, and adjustment disorders)	Behavioral FastCert	Not applicable	Not applicable
Application of clinical review	Yes when FastCert criteria is not met	Yes when FastCert criteria is not met	Yes	Yes
Peer-to-Peer discussion	Proactive approach and by provider request	Proactive approach and by provider request	By provider request	By provider request
Appeal Rights	Yes	Yes	Yes	Yes

Concurrent Review is initiated when any of the below elements are met:

- A request to extend previously authorized services/treatment is received
- The services are ongoing
- An assessment is required to continue to establish continued medical necessity and appropriateness of the current services or level of care
- Available clinical information demonstrates variations of one or more of the following:

- Complexity of the condition and if extension, expansion, or reduction of services is appropriate
- Expected timeframe for clinical response/outcomes based on literature
- Efficacy of the service
- Progress toward goals of the service
- Discharge/transition planning is required

Extent of Medical Records Required

MH/SUD Policy *HM-CLN-012: 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 prior authorization 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](https://mycigna.com).

For individual plans, Customers will only be required to complete one level of internal review before pursuing an external review. For individual plan Customers, the internal appeals process will include resolution of disputes regarding initial eligibility decisions for individuals

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
 - (B) 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 and 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. In operation, M/S and MH/SUD approval process are similar as both utilize medical necessity criteria (ASAM Criteria®, MCG™) to approve/deny care as fully outlined in Step 4 herein. M/S and MH/SUD levels of care and conditions are inherently different and thus not easily comparable. For MH/SUD, Inpatient requests are approved by clinical staff using MCG™/ASAM Criteria® and clinical judgement based on the patient's unique clinical circumstances and presentation which are often not easily measurable through tests/procedures like they might be for medical conditions. Thus, there are no pre-set or standard approved number of days within the MCG™/ASAM Criteria® for the different behavioral levels of care that require concurrent review. In contrast, for some conditions M/S may have routinely approved or recommended days within the M/S MCG™ criteria that are more applicable to medical conditions.

Behavioral Care managers may offer an alternative level of care to ensure there is no delay or impediment to care where the medical necessity criteria is met for MH/SUD which is more advantageous than M/S. Both M/S and MH/SUD follow the same process for completing a peer-to-peer and provide a peer reviewer with licensure and board certification. The MH/SUD peer review process is comparable to and no more stringent than the M/S peer review process.

Cigna has assessed comparability/equivalent stringency of application of concurrent review authorization Inpatient In-network benefit classifications in-operation by assessing denial rates for benefits subject to concurrent review across the Virginia and Cigna 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 Concurrent Review	General Hospital	%	Specialty Hospital	%	Inpatient Hospice	%	Skilled Nursing	%
Number of Authorizations Requested	1877		0		6		218	
Number of Med Nec and Admin Requests Approved	1499	80%	0	0.00%	6	100%	197	90%
Number of Med Nec and Admin denied	378	20%	0	0.00%	0	0%	21	10%
Average days or units approved	2.98		0		54.67		8.71	
Average Turnaround time for Approvals	< 1 day		0		< 1 day		< 1 day	
Average Turnaround time for Denials	< 1 day		0		0		< 1 day	
Number of Medical Necessity	1499	80%	0	0.00%	6	100%	197	90%

Approvals								
Of the medical necessity approvals how many were FastCert	29	2%	0	0.00%	1	17%	0	0%
Number of Medical Necessity denials	365	19%	0	0.00%	0	0%	18	8%
Number of Administrative Approvals	0	0%	0	0.00%	0	0%	0	0%
Number of Administrative denials	13	1%	0	0.00%	0	0%	3	1%
Total requests sent to Physician Review	681	36%	0	0.00%	0	0%	94	43%
Total requests sent to Physician Review Approved	306	16%	0	0.00%	0	0%	75	34%
Total requests sent to Physician Review Denied	375	20%	0	0.00%	0	0%	19	9%
Total Requests sent to P2P	98	5%	0	0.00%	0	0%	7	3%
Total Requests sent to P2P Approved	9	0%	0	0.00%	0	0%	1	0%
Total Requests sent to P2P Denied	89	5%	0	0.00%	0	0%	6	3%

MH In-Network IP Concurrent Review	General Hospital	%	Psychiatric Hospital	%	Residential	%
Number of Authorizations Requested	0		274		2	
Number of Med Nec and Admin Requests Approved	0	0%	266	97%	1	50%
Number of Med Nec and Admin denied	0	0%	8	3%	1	50%
Average days or units approved	0		4.03		3	
Average Turnaround time for Approvals	0		< 24 hours		< 24 hours	
Average Turnaround time for Denials	0		< 24 hours		< 24 hours	
Number of Medical Necessity Approvals	0	0%	266	97%	1	50%
Of the medical necessity approvals how many were FastCert	0	0%	0	0%	0	0%
Number of Medical Necessity denials	0	0%	8	3%	1	50%
Number of Administrative Approvals	0	0%	0	0%	0	0%
Number of Administrative denials	0	0%	0	0%	0	0%
Total requests sent to	0	0%	11	4%	1	50%

Physician Review						
Total requests sent to Physician Review Approved	0	0%	3	1%	0	0%
Total requests sent to Physician Review Denied	0	0%	8	3%	1	50%
Total Requests sent to P2P	0	0%	10	4%	1	50%
Total Requests sent to P2P Approved	0	0%	3	1%	0	0%
Total Requests sent to P2P Denied	0	0%	7	3%	1	50%

SUD In-Network IP Concurrent Review	General Hospital	%	Psychiatric Hospital	%	Residential	%
Number of Authorizations Requested	0		68		98	
Number of Med Nec and Admin Requests Approved	0	0%	65	96%	88	90%
Number of Med Nec and Admin denied	0	0%	3	4%	10	10%
Average days or units approved	0		4.49		5.76	
Average Turnaround time for Approvals	0		< 24 hours		< 24 hours	
Average Turnaround time for Denials	0		< 24 hours		< 24 hours	
Number of Medical Necessity Approvals	0	0%	65	96%	88	90%
Of the medical necessity approvals how many were FastCert	0	0%	1	1%	0	0%
Number of Medical Necessity denials	0	0%	3	4%	10	10%
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%	5	7%	11	11%
Total requests sent to Physician Review Approved	0	0%	2	3%	1	1%
Total requests sent to Physician Review Denied	0	0%	3	4%	10	10%
Total Requests sent to P2P	0	0%	4	6%	6	6%
Total Requests sent to P2P Approved	0	0%	2	3%	1	1%
Total Requests sent to P2P Denied	0	0%	2	3%	5	5%

M/S had an in-network inpatient concurrent denial rate of 20% for acute inpatient and 10% for skilled nursing. MH had a 3% denial rate for acute inpatient and a 50% denial rate for Residential

while SUD had a denial rate of 4% for acute inpatient and a 10% denial rate for Residential. While the highest denial rate was for MH Residential, this is impacted by a very small denominator (2). Overall, MH and SUD did not demonstrate more stringent denial rates when compared to M/S. M/S, MH and SUD all completed determinations in less than one day.

The rate of peer-to-peer reviews was comparable across M/S, MH, and SUD with the exception of SUD Residential which was impacted by the small denominator. MH and SUD had a lower peer-to-peer denial percentage (3%) for inpatient acute care when compared to M/S (5%). The SUD Residential peer to peer denial rate was the highest at 50%; however, as previously noted, the SUD Residential results are impacted by the small denominator.

Across acute inpatient admissions, both MH (4.03) and SUD (4.49) approved a higher number of days on average as compared to M/S (2.98 days). Inpatient hospice, which does not have a comparable MH or SUD service, had the highest number of days approved on average.

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. Across all requests (prior authorization and concurrent; there were no retrospective review denials) the majority of MH/SUD appeals were upheld, meaning that the peer reviewer who completed the appeal agreed with the determination made by the initial peer reviewer.

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

In-Network Inpatient Concurrent Review:	MH/SUD	MH/SUD Denial Rate	M/S	M/S Denial Rate
Total Number of In-Network Inpatient Concurrent Review Requests	15,781		24,452	
Total Number of In-Network Inpatient Concurrent Review Requests Denials	782	4.96%	3,515	14.38%
Total Number of In-Network Inpatient Concurrent Review Requests Administratively Denied	9	0.06%	372	1.52%
Total Number of In-Network Inpatient Concurrent Review Requests Denied as Not Medically Necessary	773	4.90%	3,143	12.85%

Total Number of In-Network Inpatient Concurrent Review Requests Denied as EIU	0	0.00%	0	0.00%
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The Cigna 2025 IFP book of business shows MH/SUD has a lower denial rate in this benefit classification. This is one component of the six-step comparative analysis and supports the conclusion that the Concurrent Review NQTL is applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.

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

Average Approval Turnaround Time	MH/SUD TATs	M/S TATs
In-Network Inpatient Urgent Concurrent Review Turnaround Time	<24 hours	1.72 days
In-Network Inpatient Non-Urgent Concurrent Review Turnaround Time	All inpatient processed within urgent timeframe	All inpatient processed within urgent timeframe
Average Denial Turnaround Time	MH/SUD TATs	M/S TATs
In-Network Inpatient Urgent Concurrent Review Turnaround Time	<24 hours	2.06 days
In-Network Inpatient Non-Urgent Concurrent Review Turnaround Time	All inpatient processed within urgent timeframe	All inpatient processed within urgent timeframe

As evidenced in the table above, MH/SUD consistently completed inpatient concurrent reviews across Cigna's IFP book-of-business within the timeframe.

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:

In completing the comparative analysis for M/S and MH/SUD services, Cigna has determined that the plan benefit language is not separated between M/S and MH/SUD and does not demonstrate any disparity. Both M/S and MH/SUD require concurrent review for inpatient stays when a request to extend previously authorized services is received; the services are ongoing; and/or an assessment is required to continue to establish the medical necessity and appropriateness of the current level of care.

M/S and MH/SUD consider the same factors, sources, and evidentiary standards in determining which services require concurrent review in the in-network inpatient benefit classification.

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 concurrent review and follow the same timeliness standards with both processing requests in the urgent timeframe. A process variance is that MH/SUD offers a streamlined review process for in-network inpatient concurrent requests (FastCert) whereas M/S does not offer a Fastcert review process for inpatient concurrent services. This variance is more beneficial for MH/SUD and not more stringent than M/S as it allows for a more streamlined review process.

In operation, the Cigna IFP 2025 book of business data shows lower MH/SUD denial rates for concurrent reviews in the In-Network Inpatient classification. MH/SUD consistently completed inpatient concurrent reviews within the required timeframe.

Based upon its analysis, Cigna has concluded that the processes, strategies, evidentiary standards, and other factors used to determine MH/SUD services subject to concurrent 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
Counsel

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
Program Management Senior Manager;
Medical Senior Principal;
Legal Compliance Advisor