

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.

Out-of-Network Outpatient (All-Other and Office) Prior Authorization

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 Out-of-Network (OON) Outpatient (All-Other and Office) Prior Authorization parameters applied to mental health/substance use disorder ("MH/SUD") and/or medical/surgical ("M/S") services for the outpatient all-other and office benefit classifications and is incorporated in plans insured by Cigna Health and Life Insurance Company ("CHLIC"). In the review and analysis of the Out-of-Network Outpatient (All-Other and Office) Prior Authorization NQTL, Cigna reviewed policies applicable to Cigna and Evernorth Behavioral Health (EBH), Delegated Vendor(s), and M.C. Dean, Inc. plan certificate.

Prior Authorization is the process by which a provider (physician, hospital, etc.) obtains approval from Cigna before performing a particular procedure and may also be referred to as precertification, predetermination, and pre-approval. Prior Authorization is considered a non-quantitative treatment limitation ("NQTL") under the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") and its implementing regulations and sub-regulatory guidance.

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

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

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

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

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

No third parties or separate related entities played a role in developing the NQTL, its comparative analysis, or the policies and procedures contained in this response. Cigna maintains corporate-wide policies applicable to multiple business segments including Cigna Healthcare (M/S) and Behavioral Health (MH/SUD), and policies applicable to specific business segments only.

The plan language or coverage terms governing Utilization Management is excerpted from the M.C. Dean, Inc. plan certificate and states as follows:

M.C. Dean, Inc. Plan Language

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.¹

Outpatient Certification Requirements – Out-of-Network

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to: those listed in this section when performed as an outpatient in a Free-Standing Surgical Facility, Other Health Care Facility or a Physician's office. You or your Dependent should call the toll-free number on the back of your I.D. card to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or outpatient procedures. Outpatient Certification is performed through a utilization review program by a Review Organization with which Cigna has contracted. Outpatient Certification should only be requested for non-emergency procedures or services, and should be requested by you or your Dependent at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Covered Expenses incurred will be reduced by 50% for charges made for any outpatient diagnostic testing or outpatient procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

Covered Expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or outpatient procedures for which Outpatient Certification was performed, but which was not certified as Medically Necessary.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Outpatient Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

- Advanced radiological imaging – CT Scans, MRI, MRA or PET scans.
- Home Health Care Services.
- Medical Pharmaceuticals.
- Radiation Therapy²

Claim Determination Procedures under ERISA

The following complies with federal law. Provisions of applicable laws of your state may supersede.

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. 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 a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. The Certificate describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care professional) must request prior authorization according to the procedures described below, in the Certificate, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not covered, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described

¹ M.C. Dean, Inc. Plan Booklet pg. 8 of 90

² M.C. Dean, Inc. Plan Booklet pg. 31 of 90

in the Certificate, in your provider's network participation documents as applicable, and in the determination notices.

Note: An oral statement made to you by a representative of Cigna or its designee that indicates, for example, a particular service is a Covered Expense, is authorized for coverage by the plan, or that you are eligible for coverage is not a guarantee that you will receive benefits for services under this plan. Cigna will make a benefit determination after a claim is received from you or your authorized representative, and the benefit determination will be based on, your eligibility as of the date services were rendered to you and the terms and conditions of the plan in effect as of the date services were rendered to you.

Preservice Determinations

When you or your representative requests a required prior authorization, Cigna will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a health care professional with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna will defer to the determination of the treating health care professional regarding whether an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request.

However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative attempts to request a preservice determination, but fails to follow Cigna's procedures for requesting a required preservice determination, Cigna will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.³

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 MH/SUD prior authorization/concurrent review process which allows for a determination based on pre-set criteria.
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 to include 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
M.C. Dean, Inc. 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.
Cigna Master Precertification List	Document that contains the list of all procedures that require authorization.
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.
QA 02: Delegation Policy	The purpose of this policy is to establish an effective oversight process that assures delegated entities performing services meet accreditation, key regulatory and contractual requirements.
UM 09: Precertification of Inpatient Outpatient and Ambulatory Services Policy	The purpose of this policy is to establish a consistent process for responding to precertification of inpatient, outpatient, and ambulatory service requests that: • Proactively reviews requested medical services and/or supplies to determine whether they are covered based upon application of appropriate clinical criteria and other benefit plan provisions. • Ensures that plan participants receive the appropriate level of care in the appropriate setting. • Identifies opportunities for case management services; and • To facilitate timely and accurate payment of claims
UM 12: Qualified Health Professionals Render UM Decisions	The purpose of this policy is to validate licensed professionals supervise and render all levels of utilization management (UM) decisions.

Policy	
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

Outpatient 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 prior authorization 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.

Outpatient Sub-classification

Cigna sub-classifies the outpatient benefit classification into Outpatient-Office Visit and Outpatient-All Other Services for MH/SUD and M/S benefits. For purposes of utilization management, whether a plan sub-classifies its outpatient benefits does not impact the application of the Prior Authorization NQTL. No M/S or MH/SUD benefits in the office visit sub-classification are subject to its application of the NQTL regardless of whether a particular plan sub-classifies its outpatient benefits, accordingly such services are excluded from this analysis.

	<i>Medical/Surgical</i>	<i>Mental Health & Substance Use</i>
Is NQTL applied to Out-of-Network Outpatient-Office sub-classification?	No	No
Is NQTL applied to Out-of-Network Outpatient-All Other sub-classification?	Yes Advanced Radiology Durable Medical Equipment (DME) Home Health Care Lab Services (e.g., genetic testing and molecular lab) Outpatient Surgical Procedures Experimental, Investigational, Unproven (EIU) Procedures Injectable Medications Medical Oncology (e.g., infusions and radiation therapy) Sleep Testing Unlisted Procedures Transplant Musculoskeletal Services (e.g., spinal procedures and major joint surgery and pain management) Gastroenterology	Yes Applied Behavior Analysis Transcranial Magnetic Stimulation Partial Hospitalization (prior authorization requirements removed 01/01/2025)

For complete list of outpatient M/S and MH/SUD codes that may be subject to prior authorization please see attached [Cigna Master Precertification List](#).

Review Processes:

Cigna implements a Behavioral Fast Certification (“FastCert”) process to streamline the review applicable to MH/SUD services whether Inpatient or Outpatient, In Network and Out of Network benefits. M/S does not offer a FastCert review process for out of network.

For a standard clinical review, the case is referred to an M/S Prior Authorization Nurse (PAN) or an MH/SUD care manager 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: Out-of-Network Outpatient Prior Authorization (M/S and MH/SUD)

Cigna utilizes the **factors** outlined below to determine services that are subject to prior authorization. In making and determination of the Out-of-network, Outpatient Prior Authorization NQTL there were no additional factors considered and rejected. These factors are applied uniformly and without weighting and do not operate in a systematically discriminatory manner, as they are not based on data, sources, or evidence that disfavor MH/SUD, including outdated, non-objective, or biased medical guidelines.

Factors	Sources for Each Factor
1. Experimental/Investigational/Unproven service (Non-quantitative)	1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies
2. Potential benefit exclusion (Non-quantitative)	2. Plan documents
3. Serious safety risk (Non-quantitative)	3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies
4. Significant variation in Evidence-based practice (Non-quantitative)	4. Greater frequency of deviation from evidence-based practice compared to Cigna's book of business.
5. Potential for Fraud, Waste or Abuse (Non-quantitative)	5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Member, Pharmacy and Prescriber Analytics; Cigna claims data
6. Estimated average cost (Quantitative)	6. Cigna claims data
7. Return on Investment (ROI) (Quantitative)	7. Cigna claims data, denial rates, and average estimated cost of review

In establishing the factors used to determine what services are subject to prior authorization, 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	1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies

	care costs related to qualified clinical trials.	
2. Potential benefit exclusion (Non-quantitative)	2. CMS.gov: “CMS PUB. 100-02 Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage”	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 percentage of claims that are above the standard utilization for the specific service, or service bundle of codes. Variation should be assessed at the service bundle level when necessary, and not in the variation of an individual code.	4. Cigna claims data
5. Potential for Fraud, Waste or Abuse (Non-quantitative)	5. An automated peer-based model that compares a provider’s billing behavior to their peers and those who score differently is reviewed to determine if an investigation is warranted as evidenced by increased volume.	5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Member, Pharmacy and Prescriber Analytics; Cigna claims data
6. Estimated average cost (Quantitative)	6. Any service where the average service cost, based on an assessment of Cigna Healthcare’s historical paid claims, exceeds \$500.	6. Cigna claims data
7. Return on Investment (Quantitative)	7. Cigna claims data, denial rates, and average estimated cost of review	7. Services with a projected ROI ratio of 7.5 or greater

For inclusion in the Master Precertification List, any of the non-quantitative factors may be

considered; however, in order to meet the quantitative factors for application of prior authorization, both must be met.

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** all refers to instances where evidence-based, scientific literature is not quantifiable. While there is no formulaic way in which to measure the volume of data needed, study detail is scrutinized using the scientific method of evidence review which is defined by the U.S. General Services Administration as: systematic evidence review attempts to find all published and unpublished evidence related to a specific research or policy question, using literature search methodologies designed to be transparent, unbiased, and reproducible.
- **Serious Safety Risk** is any service that is potentially life-threatening according to available clinical evidence (levels of clinical evidence described in Step 4); such services shall be placed on the Master Precertification List. Examples of safety issues considered to be potentially life-threatening include services such as rapid detoxification under anesthesia, CAR-T therapy, organ transplant, or the use of a service that is the subject of a serious warning or recall (e.g., FDA recall for a device or pharmaceutical product).
- **Significant variation:** A service may be placed on the Master Precertification List when there is evidence of significant variation in evidence-based care, defined as meaningful deviation from established, evidence-supported clinical practice in the use, frequency, intensity, duration, or patient selection for a service. Evaluation is performed at the service category, and not necessarily in the variation between individual code(s). Significant variation in evidence-based care exists when one or more of the following conditions are identified:
 - The service is used inconsistently with the best available clinical evidence, including use outside populations, indications, or clinical circumstances supported by the literature.
 - There is insufficient or inconsistent evidence demonstrating a clinically meaningful improvement in health outcomes attributable to the service, despite widespread or increasing utilization.

- Practice patterns demonstrate greater variation than expected when compared to evidence-based guidelines or consensus recommendations.
- Utilization patterns suggest overuse or misuse of a service relative to evidence-based expectations, even when the service itself is not considered experimental or investigational.
- **Potential for Fraud, Waste, or Abuse** is any service associated with a high incidence of fraud, waste, and/or abuse as identified in publications by organizations that track trends regarding fraud/waste/abuse in utilization of healthcare services consistent with applicable law and regulation or that has been identified as potential anomalies using internal claims data through the Special Investigation's Unit (SIU) may be placed on the Master Precertification List. If the SIU identifies a trend that may warrant adding a code to the precertification list, it is sent to Payment Policy & Coding (PP&C) (formerly Coverage Policy Unit (CPU)) for evaluation. The PP&C does not have a specific threshold for incidence of fraud, waste, and/or abuse; however, for the sake of clarity "high" unit cost (over \$500) is considered in determining whether or not to add a service to prior authorization. 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 prior authorization 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.
- **ROI (Quantitative):** As previously noted herein, ROI is not the sole factor used to determine which services should be subject to prior authorization. ROI and cost of treatment are quantitative factors that must be met for a procedure or treatment to be included in the Master Precertification List; non-quantitative must also be present. An exception to the Quantitative Factors may be made for an individual code or code set if:
 1. the code/code set is considered to be integral to the primary procedure.
 2. the code is typically billed with a related code; and
 3. the primary procedure includes code(s) that meet both Quantitative Factors requirements.
 *If any of these three elements are met, an exception can be made.

To ensure consistent use of the ROI requirement for the application of prior authorization to Outpatient All Other Services MH/SUD and M/S services, Cigna reviewed the codes and services including their associated ROIs for both MH/SUD and M/S services. Cigna's review of outpatient services subject to prior authorization revealed known variations between the manner in which

M/S and MH/SUD services are calculated, but such variations do not indicate a more stringent application of the Prior Authorization NQTL to MH/SUD. Specifically, Cigna analyzes the ROI for MH/SUD benefits by category rather than individual codes as for M/S benefits because with respect to MH/SUD benefits, providers can use different codes for the same service, whereas this is generally not the case for M/S services. Cigna does not single out certain services and treat them differently for purposes of the ROI analysis (which in turn is one factor in determining whether to apply prior authorization requirements) based on whether they are MH/SUD or M/S benefits. Rather, Cigna uses a single standard, whether providers can use multiple codes for the same service or only a single code.

M/S and MH/SUD teams conducted a review of services subject to prior authorization utilizing the factors previously mentioned, including ROI. The M/S team removed nearly 600 codes (25%) of outpatient medical services from prior authorization requirements. The behavioral health team removed 1 out of 3 (33%) remaining services in the Master Precertification List. The only MH/SUD outpatient services requiring prior authorization are Applied Behavior Analysis (ABA) and Transcranial Magnetic Stimulation, both of which meet the 7.5 ROI threshold as of March 2025.

Cigna scrutinized the most common reasons to require prior authorization for certain services/codes even when the ROI falls below the 7.5 threshold, which included service coding bundles and services with potential benefit issues. In its review, some codes were used in conjunction with other codes that have a high ROI (e.g., an ROI of 20, 40, or 100 or higher). While a code viewed in isolation may have an ROI that is below the 7.5 threshold Cigna established, it may be appropriate or even required to be billed along with another code that has an ROI significantly higher than 7.5. Along similar lines, certain codes are “add-ons” to another code that already requires prior authorization. Additionally, some of the codes reviewed had an ROI that falls below 7.5, but that ROI calculation was based on a partial year’s data—The ROI for the same codes from previous years is significantly higher.

While an ROI of 7.5 is Cigna's threshold as a factor in determining whether to require prior authorization for an outpatient service, this calculation is performed at a given moment in time and for a finite period of claims. As expected, the precise ROI for every code fluctuates over time and will vary from one year to the next. It is highly improbable that any code’s ROI would remain the same from one year to the next or using any two different time periods for the calculation. While in many cases the ROI will continue to be well above 7.5 for a given service, there may be some hovering right around the threshold that could fall below – or rise above again – over time. For other codes, the ROI may be significantly higher but could precipitously drop for various reasons that are outside Cigna's control. These situations are reviewed amongst Cigna's Precertification Workgroup who discusses updates to this list and sends such recommendations to Cigna’s Healthcare Medical Assessment Committee (“HMAC”) for approval. HMAC’s role will be further described in the Design and Application section.

Lastly, there are codes requiring prior authorization with an ROI of less than 7.5 that are labeled “benefit issue.” These codes are reviewed for medical necessity. If the code does not meet criteria of the coverage policy, they are a non-covered benefit. For example, a benefit plan may exclude a service if it is rendered for cosmetic purposes, but the benefit plan may cover that same service if it is rendered to treat a covered medical or behavioral health condition.

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 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 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
Clinical Program Director	RN	10+
Medical Senior Director	Neurology/Sleep	10+
Medical Managing 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 Lead	Family Medicine	10+
Utilization Review Medical Principal	Obstetrics and gynecology, Medical Geneticist	10+
Medical Principal	Psychiatry	10+
Medical Director	Psychiatry	10+
Medical Principal	Internal Medicine	10+
Program Management Director	Health Equity Subject Matter Expert	20+
Medical Principal	Internal Medicine	20+

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 scientific evidence may include study design elements, such as number, power, types of outcomes, comparator intervention, objectiveness of rating tools, and blinding, as well as issues related to conflicts and potential bias of the study authors and institutional associations.

The inclusion of MH/SUD expertise on HMAC and the Coverage Policy approval process ensures MH/SUD Coverage Policies appropriately incorporate generally accepted standards of practice, including consideration of type or duration of treatment or level of care for patients with specific MH/SUD conditions. A Cigna-employed Medical Director with former practice experience as a psychiatrist and expertise in, and dedicated support for, behavioral health matters is consulted to ensure appropriate evaluation of such services considered for application of prior authorization. Comparable representation of expertise in MH/SUD services is essential to ensure the application of the Prior Authorization 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 prior authorization and their continued appropriateness is comparable across MH/SUD and M/S benefits.

Identifying Services for Prior Authorization

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. Additionally, the ROI exercise described within this analysis is performed annually to assess the ongoing value afforded by prior authorization. This is to ensure that opportunities for removing codes from the utilization management program based on potentially insufficient ROI performance can be identified and assessed for:

- whether removal from the utilization review program is warranted or,
- an opportunity to assess whether the ROI associated with the administration of the utilization management requirement is insufficient because the utilization management process is being administered incorrectly (e.g., unwarranted approvals), and/or
- the costs associated with reviewing requests are unduly high.

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 Prior Authorization NQTL to HMAC. HMAC utilizes the following process in their evaluation of evidence. The overall strength of evidence reflects recognition of the hierarchy of evidence, with greater weight assigned to study designs that provide higher confidence in the

relationship between the intervention and meaningful clinical outcomes in a defined patient population.

Coverage Policy Development

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

Level 1: Systematic reviews with or without meta-analysis

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

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

Level 4: Case series; case-control studies

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

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

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

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

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

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

Step 4: Demonstration of comparability and stringency as written.

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

- (1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;
 - (A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and
 - (B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;
- (2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;
- (3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and
- (4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [\[Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits\]](#):
 - (A) In the definition of the factors, the evidentiary standards used to define the

factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the NQTL.

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

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

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

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

Issuer Response:

As Written:

The table below is provided to demonstrate the factors applied in determining the services subject to outpatient prior authorization.

Category Identifier	Estimated Average Cost >\$500	Return on Investment >7.5	EIU	Service is/may be excluded from coverage	Serious Customer Safety Risk	Variations from Evidence-Based Expected Care	Subject to Abuse and/or Fraud
Mental Health / Substance Use Disorder (MH/SUD) Services							

Applied Behavioral Analysis (ABA) Therapy	X	X	X	X	X	X	X
Repetitive Transcranial Magnetic Stimulation (TMS)*	X	X	X		X	X	X
Medical/Surgical Services							
High Tech (Advanced) Imaging Services (e.g., CT Scans, PET Scans, MRIs, Diagnostic Cardiology)	X	X	X			X	X
Outpatient Surgical Procedures	X	X	X	X		X	X
Durable Medical Equipment (DME) incl. external	X	X		X		X	X
Experimental / Investigational/ Unproven (EIU) Procedures	X	X	X	X	X	X	X
Lab Services (Genetic Testing, Molecular lab)	X	X	X	X		X	X
Home Health Care/Home Infusion Therapy	X	X				X	X
Infused/Injectable Medications	X	X	X		X	X	X
Medical Oncology (Integrated Oncology Management Program)	X	X	X		X	X	X
Musculoskeletal Services (major joint surgery, spinal surgery, and pain management services)	X	X	X	X		X	X
Outpatient Radiation Therapy Services	X	X				X	

Sleep Testing	X	X				X	X
Unlisted Procedures or Services	X	X	X				X
Transplant	X	X	X	X	X	X	
Spinal procedures	X	X	X	X	X	X	X
Gastroenterology	X	X	X		X	X	

*Note – Prior Authorization requirements for in-network TMS were removed 01/01/2025

As noted, all services requiring prior authorization meet the two quantitative factors (estimated average cost and ROI) in addition to one or more non-quantitative factors.

The ROI ratio is calculated using the following formula:

$$\frac{\text{Denial Rate} \times \text{Avg Unit Cost}}{\text{Estimated Cost to Review}}$$

- The actual or anticipated denial rate of the service multiplied by the average unit cost (or, as applicable, cumulative cost) of the service, with the resulting figure divided by the estimated cost to review the total number of services.
- Cigna uses actual denial rates based on claims data. If denial rate is not available due to lack of historic claims data, ex: no service, Cigna uses an anticipated denial rate based on the denial rate for similar services
- The estimated cost to perform a Medical/Surgical (M/S) coverage review is \$40. The estimated cost to perform a MH/SUD coverage review is \$100. Both are informed by costs/expenses such as personnel salaries and time

Policies and Procedures

To ensure that Cigna's policies are consistently applied, Cigna conducts a thorough review of policies and procedures at least annually. The annual review includes an analysis of applicable M/S and MH/SUD policies and procedures to identify potential gaps or inconsistencies. In its review as set forth in the policy comparison tables below, Cigna identified opportunities for adjustments to ensure comparability and equivalent stringency in application the Prior Authorization NQTL. Cigna is providing the below examples of Utilization Management policies used in the application of the prior authorization 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.	Policy requires that appropriately licensed behavioral health professionals assess and supervise utilization management decisions. Only psychologists, addictionologists or board-certified psychiatrists are allowed to assess and make medical necessity denial decisions. To ensure that qualified licensed health professionals assess the clinical information used to make appropriate utilization management decisions
RN's provides clinical oversight to non-clinical and LPN/LVN staff and/or reviews inpatient and outpatient UM services using established, approved, medical criteria, tools and references as well as own clinical training and education in making medical necessity coverage "approval" decisions. RN staff includes Inpatient Case Manager (IPCM) and Pre-service/Post Service Utilization Review Nurse (UM) roles.	Care managers collect data for pre-service, concurrent, and post-service utilization decisions and have the authority to approve but not to deny medical necessity services. In the event that a care manager cannot approve the utilization request, the case is forwarded to an appropriate peer reviewer for assessment and the decision to approve or deny services.
Licensed Physician (i.e., Medical Director) – provides clinical oversight to pharmacist staff where indicated, nurse staff and makes medical necessity UM decisions using 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.	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

• Provide oversight and ongoing consultation to clinical and non-clinical staff. • Complete ongoing education to maintain licensure and update professional skills.	
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In application, both policies require reviewers to be appropriately licensed and act within the scope of their license. As noted in the scope of these policies below, both indicate accountability in the review and determination of denials.

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

UM-09: Precertification of Inpatient, Outpatient and Ambulatory Services and *HM-CLN-012: Clinical Review* reflects the role of non-physician clinicians (i.e., nurses or care managers) in the application of the Prior Authorization NQTL.

M/S	MH/SUD
UM-09: Precertification of Inpatient, Outpatient and Ambulatory Services	HM-CLN-012: Clinical Review
Initial clinical review scope of responsibilities: Cases requiring medical necessity/precertification review are reviewed by a nurse, using the clinical information provided at the time of the request, to the appropriate guideline as defined in the Cigna Benefit and Coverage Tool policy. The nurse approves services for those customers whose clinical information meets the guidelines and generates an authorization notification within the timelines and notification requirements outlined in the Timeliness policy. All services that do not meet the criteria in the guideline and cannot be approved are referred to the Medical Director for review and determination.	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.
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In application, these policies outline the comparable roles and responsibilities of Cigna’s M/S nurses and MH/SUD care managers, each of which are independently licensed clinicians with the ability to approve utilization management decisions. The denial of a utilization management decision, including prior authorization requires medical director/peer review for both M/S and MH/SUD benefits.

UM-39: Timeliness of Health Services Decisions and *HM-CLN-035: Timeliness of Utilization Management Decisions and Notifications* outline the turnaround times for M/S and MH/SUD. 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
PROSPECTIVE URGENT	M/S: Within 2 business days of request date	Provider Verbal notification to provider is only required for urgent cancer pain prescription requests	M/S: Within 2 business days of request date	Provider and Customer	M/S: Within 2 business days of request date
	MH/SUD*: Within 2 business days of receipt of all information or within 72 hours from receipt of request	Provider	MH/SUD: Within 2 business days of receipt of all information or within 72 hours from receipt of request	Provider and Customer	MH/SUD: Within 2 business days of determination or within 3 calendar days from verbal notification
PROSPECTIVE NON-URGENT	M/S: Within 2 business days of all information received date	Provider Verbal notification to provider is only required for upheld denials or partial denials on p2p & reconsiderations and appeals when the reconsideration process is vacated due to provider requesting same or similar specialist review	M/S: Within 2 business days of all information received date	Provider and Customer	M/S: Within 2 business days of all information received date
	MH/SUD: Within 2 business days of receipt of all information or	Provider	MH/SUD: Within 2 business days of receipt of all information or	Provider and	MH/SUD: Within 2 business days of determination or within 10 calendar days of

	within 10 calendar days of receipt of request		within 10 calendar days of receipt of request	Customer	receipt of request
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*Given that MH/SUD outpatient services that require authorization (ABA and TMS) generally do not require an immediate intervention to prevent jeopardizing the health or life of members, they are categorized as non-urgent. An expedited timeframe may be afforded upon request from the provider if they believe a delay might:

- Harm the customer's life OR
- Hinder their ability to regain full health OR
- Cause severe pain that can't be managed without care or treatment

The above referenced policies are illustrative of the annual review conducted to ensure comparability in writing of the application of the Prior Authorization NQTL to M/S and MH/SUD services in the OON Outpatient benefit classification.

The process by which services are considered for application of prior authorization 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 prior authorization. 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 reviews annually the policies and procedures for prior authorization to assess if adequate processes and controls are in place to ensure Prior Authorization NQTLs are applied to MH/SUD no more stringently than to M/S benefits.

Prior Authorization Review Processes

Customers and providers are made aware of their precertification obligations through:

Plan Documents

[Coverage Policies](#)

[Cigna.com](#)

Customer Service

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

Cigna does not require prior authorization for MH/SUD office visits, nor for preventive services. While routine office visits themselves do not require authorization for M/S, some services performed in an office setting may require authorization (e.g., high-tech imaging, outpatient surgery).

For both MH/SUD and M/S, a provider may submit a request for initial authorization via fax, email,

or phone.

Cigna implements a Behavioral Fast Certification (“FastCert”) process to streamline the review applicable to MH/SUD services whether Inpatient or Outpatient, In Network and Out of Network benefits. M/S does not offer a FastCert review process for out of network.

MH/SUD:

Behavioral FastCert streamlines prior authorization for MH/SUD services on the initial request when certain pre-set criteria are met based on clinical algorithms developed by Evernorth medical directors. The non-clinical staff is empowered to conduct MH/SUD FastCert reviews for TMS when the diagnosis is major depressive disorder (MDD) or obsessive-compulsive disorder (OCD) based on pre-established rules (based on Cigna Coverage Policies for TMS). MDD and OCD were selected for FastCert based on FDA (Food and Drug Administration) treatment guidelines. If the request entails a different diagnosis or other exclusionary criteria it is directed to care managers for review. In the event an authorization cannot be approved via FastCert the service undergoes full prior authorization medical necessity review.

In addition to TMS, Cigna implements a FastCert outpatient prior authorization review process for low intensity Applied Behavior Analysis (ABA) services. Cigna defines low intensity (aka focused) services when deficits are more limited or targeted and ranging from 10-25 hours per week of direct treatment consistent with Council of Autism Service Providers (CASP).

To streamline authorizations for ABA services that have been identified as having a high likelihood of approval, Evernorth utilizes a FastCert process based on internal Coverage Policies that allow the provider/facility to obtain authorization quickly. The FastCert criteria were developed by Evernorth medical directors to allow non-clinical staff to issue authorizations within set parameters and set thresholds. The non-clinical staff do not go outside of the set parameters and authorization thresholds.

When the request for authorization of ABA is received, the non-clinical team verifies information including the requesting/servicing providers, provider network status, dates of service, and requested CPT codes. The non-clinical staff are trained to ask scripted questions developed and approved by medical directors, utilize pre-established rules, and authorize services within set parameters for authorization thresholds. If an authorization request does not meet the FastCert criteria the non-clinical staff directs the request to clinicians within the autism team to perform a clinical review.

The clinical algorithms used for Fastcert criteria are based on existing medical necessity criteria (Cigna Coverage Policies) and were developed by Cigna medical directors to allow non-clinical staff to issue authorizations within set parameters and set thresholds. Information collected includes clinical data such as diagnosis, procedure codes, drug name, strength and dosage. Then scripted clinical questions developed and approved by clinical program staff are asked to the requesting provider. Designated non-clinical staff are trained to utilize these pre-established rules and do not go outside of set parameters and authorization thresholds.

When evaluating which services/codes are added to or remain on the FastCert Process, claims data and prior authorization approval request data is collected and analyzed. Services with a high likelihood of approval or that have aligned criteria that do not have high variability can be added to

the FastCert Process. Consideration is also given to codes whereby objective questions can be answered with a yes or no.

In the event an MH/SUD authorization is not able to be approved via FastCert, the service undergoes a standard prior authorization medical necessity review with a MH/SUD care manager. Care Managers utilize Federal and State Mandate information, client specific coverage criteria, and Coverage Policies along with the clinical information submitted by the provider. If the clinical information meets the list of guidelines within the clinical coverage policy the Care Manager may approve the service. If the information does not meet the guidelines within the clinical coverage policy the request for authorization is sent for MH/SUD peer review. Care Managers may not deny prior authorization requests when medical necessity criteria have not been met for a covered service. Only MH/SUD peer reviewers can deny a request for a covered service as “not medically necessary”.

M/S:

M/S does not offer a FastCert review process for out of network.

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.

For M/S, if there are no coverage exclusions as determined by the benefit plan, a first-level clinical review is performed by a prior authorization nurse ("PAN"). PANs are empowered to approve prior authorization requests when all medical necessity criteria are met for covered services. PANs utilize Federal and State Mandate information, client specific coverage criteria, MCG™ and Coverage Policies along with the clinical information submitted by the provider. If the clinical information meets the list of guidelines within the clinical coverage policy the PAN 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. PANs may not deny prior authorization requests when medical necessity criteria have not been met for a covered service. If the PAN reviewer 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”.

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

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

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

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

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

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

Customers may be identified for case management during prior authorization 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.

Tracking of Denials:

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

Administrative Denials

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

- a. The Customer was not eligible for benefits at the time service was rendered for continued stay reviews.

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

A customer or provider may appeal a decision.

Medical Necessity Denials

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

Partial Denials

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

Tracking of Prior Authorization versus 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.

For all MHP reporting requests, Cigna delineates the Utilization Management data as follows:

- In-Network Inpatient
 - Prior Authorization
 - Concurrent Review
 - Retrospective Review
- Out-of-Network Inpatient
 - Prior Authorization
 - Concurrent Review
 - Retrospective Review
- In-Network All Other Outpatient
 - Prior Authorization
 - Concurrent Review
 - Retrospective Review

- In-Network Outpatient Office Visits
 - Prior Authorization
 - Concurrent Review
 - Retrospective Review
- Out-of-Network All Other Outpatient
 - Prior Authorization
 - Concurrent Review
 - Retrospective Review
- Out-of-Network Outpatient Office Visit
 - Prior Authorization
 - Concurrent Review
 - Retrospective Review

Within each of the benefit classifications outlined above, Cigna evaluates each of the following data points for Prior Authorization, Concurrent Reviews, and Retrospective Reviews:

- Total Requests
- Total number of requests denied
 - Total requests administratively denied
 - Total requests denied as not medically necessary
 - Total requests denied as experimental/investigational/unproven

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

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.

M/S and MH/SUD outpatient services are reviewed using Cigna coverage policies. M/S may also use MCG as applicable.

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.

The state of Virginia has a two level internal (with Cigna) appeal process. In the event the internal appeal process is exhausted or the second level internal appeal was not handled timely (and an agreement to the delay in processing not agreed upon by the customer), the customer has the right to an external review as mandated by the Virginia Bureau of Insurance (BOI).

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

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

Virginia Specific Appointment of Authorized Representative

[PDF] External Review Request Form [PDF]

Physician Certification Expedited External Review Request Form [PDF]

Physician Certification Experimental or Investigational Denials Form

[PDF]

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

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

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

Emergent Admissions

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

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

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

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

Step 5: Demonstration of comparability and stringency in operation.

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

- (1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:
 - (A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;

- (B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;
 - (C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and
 - (D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);
- (2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);
 - (3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:
 - (A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A);
 - (B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);
 - (4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:
 - (A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or

measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and

- (5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:
- (A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and
 - (B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

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

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

This FAQ guidance stipulates what plans and issuers should avoid:

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

Issuer Response:**In Operation:**

On an annual basis, Cigna reviews applicable operational data with Subject Matter Experts to assess ongoing relevance and makes updates as necessary. In operation, M/S and MH/SUD approval process are similar as both utilize medical necessity criteria (MCG™, or Cigna-developed) to approve/deny care and the overall high level prior authorization process. M/S and MH/SUD levels of care and conditions are inherently different and thus not easily comparable. For MH/SUD, Outpatient requests are approved by clinical staff using Cigna Coverage Policies/ 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 Cigna Coverage Policies for the different behavioral levels of care that require prior authorization.

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 prior authorization for Out-of-Network Outpatient benefit classifications (all other and office) in-operation by assessing denial rates for benefits subject to prior authorization across Virginia and Cigna's 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 CHILC fully insured book of business data for calendar year 2025.

M/S Out-of-Network OP Prior Authorization	Outpatient Office	%	Outpatient Other	%
Number of Authorizations Requested	82		252	
Number of Med Nec and Admin Requests Approved	61	74%	139	55%
Number of Med Nec and Admin denied	21	26%	113	45%
Average days or units approved	367.69		42994.36	
Average Turnaround time for Approvals	1.46		1.34	
Average Turnaround time for Denials	2.09		2.87	
Number of Medical Necessity Approvals	61	74%	139	55%
Of the medical necessity approvals how many were FastCert	0	0%	26	10%
Number of Medical Necessity denials	13	16%	622	247%
Number of Administrative Approvals	0	0%	0	0%
Number of Administrative denials	8	10%	22	9%
Total requests sent to Physician Review	25	30%	124	49%
Total requests sent to Physician Review Approved	7	9%	48	19%
Total requests sent to Physician Review Denied	18	22%	76	30%
Total Requests sent to P2P	2	2%	96	38%

Total Requests sent to P2P Approved	0	0%	32	13%
Total Requests sent to P2P Denied	2	2%	64	25%

MH Out-of-Network OP Prior Authorization	Outpatient Office	%	Outpatient Other	%
Number of Authorizations Requested	2		10	
Number of Med Nec and Admin Requests Approved	2	100%	7	70%
Number of Med Nec and Admin denied	0	0%	3	30%
Average days or units approved	365		182.29	
Average Turnaround time for Approvals	2 days		1.42 days	
Average Turnaround time for Denials	0		1.67 days	
Number of Medical Necessity Approvals	2	100%	7	70%
Of the medical necessity approvals how many were FastCert	0	0%	2	20%
Number of Medical Necessity denials	0	0%	3	30%
Number of Administrative Approvals	0	0%	0	0%
Number of Administrative denials	0	0%	0	0%
Total requests sent to Physician Review	0	0%	4	40%
Total requests sent to Physician Review Approved	0	0%	1	10%
Total requests sent to Physician Review Denied	0	0%	3	30%
Total Requests sent to P2P	0	0%	0	0%
Total Requests sent to P2P Approved	0	0%	0	0%
Total Requests sent to P2P Denied	0	0%	0	0%

SUD Out-of-Network OP Prior Authorization	Outpatient Office	%	Outpatient Other	%
Number of Authorizations Requested	1		0	
Number of Med Nec and Admin Requests Approved	1	100%	0	0%
Number of Med Nec and Admin denied	0	0%	0	
Average days or units approved	365		0	
Average Turnaround time for Approvals	1.0 day		N/A	
Average Turnaround time for Denials	0		N/A	
Number of Medical Necessity Approvals	1	100%	0	0%
Of the medical necessity approvals how many were FastCert	0	0%	0	0%
Number of Medical Necessity denials	0	0%	0	0%
Number of Administrative Approvals	0	0%	0	0%
Number of Administrative denials	0	0%	0	0%
Total requests sent to Physician Review	0	0%	0	0%
Total requests sent to Physician Review Approved	0	0%	0	0%
Total requests sent to Physician Review Denied	0	0%	0	0%
Total Requests sent to P2P	0	0%	0	0%
Total Requests sent to P2P Approved	0	0%	0	0%
Total Requests sent to P2P Denied	0	0%	0	0%

The Virginia fully insured CHLIC data shows a lower volume of requests for outpatient other MH services as compared to M/S and no requests for SUD outpatient other services. This aligns with the fact that for MH TMS and ABA, both services to treat MH conditions, are the only services that require prior authorization. Additionally, neither MH nor SUD had any denials in the outpatient office classification whereas M/S had a 26% denial rate. In the outpatient all other classification, MH had a 30% denial rate compared to a 45% denial rate for M/S. SUD did not have any denials.

Routine office visits do not require prior authorization for M/S or MH/SUD. However, certain M/S services performed in an office setting, such as high-tech imaging and outpatient surgery, may require prior authorization. Therefore, the reported M/S volume includes Network Exception Requests (NERs) and prior authorization requests for these services, while the MH/SUD volume reflects NERs only.

Given that MH/SUD outpatient services that require authorization (ABA and TMS) generally do not require an immediate intervention to prevent jeopardizing the health or life of members, they are categorized as non-urgent. An expedited timeframe may be afforded upon request from the provider if they believe a delay might:

- Harm the customer's life OR
- Hinder their ability to regain full health OR
- Cause severe pain that can't be managed without care or treatment

MH and SUD met the non-urgent timeframe for both approvals and denials.

While the units used for MH services and M/S services vary by service (units for ABA, visits for TMS; days, visits, units for M/S services), MH/SUD is not more stringent in the units approved as compared to M/S in the outpatient other benefit classification. The high number of units approved in M/S (42994.36) is driven by injectable medications that are administered frequently so a large number of units are approved at a time (ex. injectable drug given every 2 days twice a day for a year approval reflects the total grams of medication in the authorization).

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

Level 1 appeals:

Out-of-Network Outpatient	MH/SUD	MH/SUD Rate	M/S	M/S Rate
Total number of Level One Appeal requests	0		38	
Total number overturned	0	0.00%	7	18.42%
Total number upheld	0	0.00%	31	81.58%
Total number upheld as not medically necessary	0	0.00%	13	34.21%
Total number upheld as EIU	0	0.00%	1	2.63%
Total number administratively upheld as not a covered benefit (administrative)	0	0.00%	17	44.74%
Total number administratively upheld due to ineligibility (administrative)	0	0.00%	0	0.00%

Level 2 appeals:

Out-of-Network Outpatient	MH/SUD	MH/SUD Rate	M/S	M/S Rate
Total number of Level Two Appeal requests	0		1	
Total number overturned	0	0.00%	1	100.00%
Total number upheld	0	0.00%	0	0.00%
Total number upheld as not medically necessary	0	0.00%	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%

While MH had 3 denials, there were no MH/SUD appeals for out-of-network outpatient all other requests. That said, the majority of M/S denials were upheld on appeal, meaning that the physician reviewing the appeal agreed with the initial physician/peer reviewer's determination.

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

Out-of-Network All Other Outpatient:	MH/SUD	MH/SUD Denial Rate	M/S	M/S Denial Rate
Total Number of Out-of-Network All Other Outpatient Prior Authorization Requests	2,771		73,193	
Total Number of Out-of-Network All Other Outpatient Prior Authorization Requests Denied	507	18.30%	20,491	28.00%
Total Number of Out-of-Network All Other Outpatient Prior Authorization Requests Administratively Denied	21	0.76%	4,732	6.47%
Total Number of Out-of-Network All Other Outpatient Prior Authorization Requests Denied as Not Medically Necessary	481	17.50%	15,199	20.77%
Total Number of Out-of-Network All Other Outpatient Prior Authorization Requests Denied as EIU	1	0.04%	560	0.77%
Out-of-Network Outpatient Office Visit:	MH/SUD	MH/SUD Denial Rate	M/S	M/S Denial Rate
Total Number of Out-of-Network Outpatient Office Visit Prior Authorization Requests	1,418		31,718	
Total Number of Out-of-Network Outpatient Office Visit Prior Authorization Requests Denied	273	19.25%	9,335	29.43%
Total Number of Out-of-Network Outpatient Office Visit Prior Authorization Requests Administratively Denied	6	0.42%	3,005	9.47%
Total Number of Out-of-Network Outpatient Office Visit Prior Authorization Requests Denied as Not Medically Necessary	267	18.83%	6,164	19.43%
Total Number of Out-of-Network Outpatient Office Visit Prior Authorization Requests Denied as EIU	0	0.00%	166	0.52%

Due to the significant variance in request volume between MH/SUD (2,771) and M/S (73,193), the ability to draw meaningful conclusions is limited. That said, the Cigna 2025 commercial 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 Prior Authorization NQTL is applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.

Additionally, routine office visits do not require prior authorization for M/S or MH/SUD. However, certain M/S services performed in an office setting, such as high-tech imaging and outpatient surgery, may require prior authorization. Therefore, the reported M/S volume includes Network Exception Requests (NERs) and prior authorization requests for these services, while the MH/SUD volume reflects NERs only.

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

Average Approval Turnaround Time	MH/SUD TATs	M/S TATs
Out-of-Network Office & All Other Outpatient Urgent Prior Authorization Review Turnaround Time	No requests were processed as urgent	3.42 days
Out-of-Network Office & All Other Outpatient Non-Urgent Prior Authorization Review Turnaround Time	4.96 days	4.18 days
Average Denial Turnaround Time	MH/SUD TATs	M/S TATs
Out-of-Network Office & All Other Outpatient Urgent Prior Authorization Review Turnaround Time	No requests were processed as urgent	3.86 days
Out-of-Network Office & All Other Outpatient Non-Urgent Prior Authorization Review Turnaround Time	8.74 days	6.30 days

As illustrated by the data above, the Cigna commercial 2025 book of business data shows MH/SUD and M/S in compliance with approval and denial turnaround times for non-urgent prior authorization. That said, M/S did not meet the timeframes for urgent prior authorization for approvals or denials.

The M/S team continues to monitor and optimize resources to improve turnaround times by:

- Prioritizing reviews
- Engaging additional support
- Re-evaluating process to identify efficiencies.

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. Additionally, MH/SUD does not require prior authorization for routine office visits, whereas M/S has services that may be performed in an office which require authorization. M/S and MH/SUD consider the same factors, sources, and evidentiary standards in determining which services require prior authorization in the out-of-network outpatient 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 prior authorization and follow the same timeliness standards for non-urgent outpatient prior authorization requests. MH/SUD offers a FastCert option for TMS and ABA (low-intensity) services, whereas M/S does not offer any FastCert review options for out-of-network outpatient prior authorization review.

To ensure consistent use of the ROI requirement for the application of the Prior Authorization NQTL to MH/SUD and M/S services, Cigna reviewed the codes and services including their associated ROIs for both MH/SUD and M/S on the Master Precertification List. Outpatient prior authorization only applies to Partial Hospitalization (requirement was removed effective 01/01/2025), Transcranial Magnetic Stimulation ("TMS"), and Applied Behavior Analysis ("ABA") for MH/SUD.

In operation, the Cigna commercial 2025 book of business data shows lower MH/SUD denial rates for prior authorization reviews in the Out-of-Network Outpatient classification. Additionally, MH/SUD met the expected turnaround times for out-of-network outpatient prior authorization determinations for approvals and denials.

Based upon its analysis Cigna has concluded that the processes, strategies, evidentiary standards, and other factors used to determine which MH/SUD services are subject to prior authorization requirements and the application of those factors and requirements to MH/SUD services, are comparable to, and no more stringent in writing or operation than those prior authorization factors and requirements used for the M/S services in the out-of-network outpatient benefit classification.

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