

**Summary of Various Non-Quantitative Treatment Limitations Mental Health Parity and Addiction Equity Act
Highmark Inc. as of 11/30/17**

Non-Quantitative Treatment Limitations	General Medical/Surgical	Behavioral Health
Are services subject to a medical necessity standard?	<p>Nationally recognized evidence-based criteria and corporate medical policies that consider regional and local variations in medical practice and member needs are used to determine the medical necessity and clinical appropriateness of utilization decisions. The InterQual criteria are embedded into the care management system and are available to all medical and behavioral health clinicians. All medical policies can be accessed on-line by providers as well as staff.</p> <p>The Clinical Services Utilization Management staff use the following criteria, guidelines and policies:</p> <ul style="list-style-type: none"> • InterQual (Levels of Care: Acute Adult, Acute Pediatric, Long-term Acute, Sub-acute and SNF, Rehabilitation and Home Care Medical Necessity Criteria) • Highmark Medical Policy • Highmark Medicare Advantage Medical Policy (Includes all CMS national and local coverage decisions) 	<p>Nationally recognized evidence-based criteria and corporate medical policies that consider regional and local variations in medical practice and member needs are used to determine the medical necessity and clinical appropriateness of utilization decisions. The InterQual criteria are embedded into the care management system and are available to all medical and behavioral health clinicians. All medical policies can be accessed on-line by providers as well as staff.</p> <p>The Behavioral Health Clinical Services Utilization Management staff use the following criteria and guidelines:</p> <ul style="list-style-type: none"> • InterQual (Behavioral Health Medical Necessity Criteria) • ASAM (American Society of Addiction Medicine) Patient Placement Criteria for the Treatment of Substance-Related Disorders • Highmark Medical Policy • Highmark Medicare Advantage Medical Policy (Includes all CMS national and local coverage decisions)
How Does the Plan Detect Fraud, Waste and Abuse?	<p>Highmark's Financial Investigations and Provider Review (FIPR) department's mission is to support Highmark's vision of providing affordable, quality health care by ensuring that provider reimbursements are appropriate and to protect Highmark's assets by investigating and resolving suspected incidents of health care insurance fraud, waste, or abuse.</p> <p>In addition to conducting post-payment practice pattern reviews, FIPR also investigates potential member and provider fraud and abuse. Health insurance fraud occurs when a provider or consumer intentionally submits, or causes someone else to submit, false or misleading information to a health insurance company for the intention of changing the amount of health care</p>	<p>Highmark's Financial Investigations and Provider Review (FIPR) department's mission is to support Highmark's vision of providing affordable, quality health care by ensuring that provider reimbursements are appropriate and to protect Highmark's assets by investigating and resolving suspected incidents of health care insurance fraud, waste, or abuse.</p> <p>In addition to conducting post-payment practice pattern reviews, FIPR also investigates potential member and provider fraud and abuse. Health insurance fraud occurs when a provider or consumer intentionally submits, or causes someone else to submit, false or misleading information to a health insurance company for the intention of changing the amount of health care</p>

	<p>benefits paid. Highmark's FIPR unit takes a proactive approach to detecting and investigating potential health care fraud and abuse. When necessary, FIPR takes internal and/or external corrective action regarding fraudulent activity that impacts Highmark, its customers, or members.</p> <p>The Fraud, Waste and Abuse processes that investigate and identify fraud through pre-payment and post-payment reviews are non- quantitative limits that may impact the scope or duration of treatment by affecting the payment of benefits to a provider or member. This limitation may occur through the denial of claims (pre-payment review) and recovery of overpaid claims (post-payment review).</p> <p>Pre-payment review may be applied to the claims or a provider or member for whom there is a basis to suggest irregular or inappropriate services based on the claims submitted, referral tips from the fraud hotline or other means. A pre-payment review entails review of each claim, requests for additional information to support and/or validate the claim and, if necessary, may result in denial of the claim if not substantiated. This process may be applied to any provider or member's claims without regard to the payer, the amount of claim, type of service etc.</p> <p>Post-payment review is conducted when an algorithm, routine claims audit, referral tips from the fraud hotline or other information suggests the need for review of a provider's billing practices and patterns after claims have previously been processed and paid. A post-payment review will involve an audit for a period that will not exceed one year under current policy and uses a sampling and extrapolation methodology. For mental health and substance use disorder claims however, audits are limited to cases where the amount of claims exceeds a \$10,000 threshold as a specified minimum amount involved or potential probable recovery. The audit and investigation will involve review of contemporaneous treatment records as well as member and provider interviews.</p>	<p>benefits paid. Highmark's FIPR unit takes a proactive approach to detecting and investigating potential health care fraud and abuse. When necessary, FIPR takes internal and/or external corrective action regarding fraudulent activity that impacts Highmark, its customers, or members.</p> <p>The Fraud, Waste and Abuse processes that investigate and identify fraud through pre-payment and post-payment reviews are non- quantitative limits that may impact the scope or duration of treatment by affecting the payment of benefits to a provider or member. This limitation may occur through the denial of claims (pre-payment review) and recovery of overpaid claims (post-payment review).</p> <p>Pre-payment review may be applied to the claims or a provider or member for whom there is a basis to suggest irregular or inappropriate services based on the claims submitted, referral tips from the fraud hotline or other means. A pre-payment review entails review of each claim, requests for additional information to support and/or validate the claim and, if necessary, may result in denial of the claim if not substantiated. This process may be applied to any provider or member's claims without regard to the payer, the amount of claim, type of service etc.</p> <p>Post-payment review is conducted when an algorithm, routine claims audit, referral tips from the fraud hotline or other information suggests the need for review of a provider's billing practices and patterns after claims have previously been processed and paid. A post-payment review will involve an audit for a period that will not exceed one year under current policy and uses a sampling and extrapolation methodology. For mental health and substance use disorder claims however, audits are limited to cases where the amount of claims exceeds a \$10,000 threshold as a specified minimum amount involved or potential probable recovery. The audit and investigation will involve review of contemporaneous treatment records as well as member and provider interviews.</p>
<p>Is there Exclusions for Experimental,</p>	<p>Yes, an experimental or investigational procedure is generally defined as the use of a service, supply, drug or device that is not</p>	<p>Yes, an experimental or investigational procedure is generally defined as the use of a service, supply, drug or device that is not</p>

<p>Investigational and Unproven Services?</p>	<p>recognized as standard medical care for the condition, disease, illness or injury being treated as determined by the health plan based on independent review of peer reviewed literature and scientific data. Investigational and experimental (I&E) tests have insufficient data to determine the net health impact, which typically means there is insufficient data to support that a test accurately assesses the outcome of interest (analytical and clinical validity), significantly improves health outcomes (clinical utility), and/or performs better than an existing standard of care medical management option. Such tests are also not generally accepted as standard of care in the evaluation or management of a particular condition.</p> <p>The Medical Policy Department develops and maintains Highmark's commercial and Medicare Advantage clinical policies. These policies address clinical coverage criteria, including medical necessity and investigational/experimental issues. There is an established process for the evaluation of new technology and new applications of existing technology, including those for medical procedures, behavioral health procedures, and devices. The Medical Policy Department prepares in depth summaries on topics under evaluation. These summaries include, but are not limited to, the following information:</p> <ul style="list-style-type: none"> • Published peer-reviewed literature • Decisions and information from the FDA • Blue Cross Blue Shield Association Technical Evaluation Center (TEC) • Other TEC assessments such as AHRQ • Clinical guidelines and position statements from applicable professional medical societies • Professional consultant input • National commercial insurer and Medicare coverage positions 	<p>recognized as standard medical care for the condition, disease, illness or injury being treated as determined by the health plan based on independent review of peer reviewed literature and scientific data. Investigational and experimental (I&E) tests have insufficient data to determine the net health impact, which typically means there is insufficient data to support that a test accurately assesses the outcome of interest (analytical and clinical validity), significantly improves health outcomes (clinical utility), and/or performs better than an existing standard of care medical management option. Such tests are also not generally accepted as standard of care in the evaluation or management of a particular condition.</p> <p>The Medical Policy Department develops and maintains Highmark's commercial and Medicare Advantage clinical policies. These policies address clinical coverage criteria, including medical necessity and investigational/experimental issues. There is an established process for the evaluation of new technology and new applications of existing technology, including those for medical procedures, behavioral health procedures, and devices. The Medical Policy Department prepares in depth summaries on topics under evaluation. These summaries include, but are not limited to, the following information:</p> <ul style="list-style-type: none"> • Published peer-reviewed literature • Decisions and information from the FDA • Blue Cross Blue Shield Association Technical Evaluation Center (TEC) • Other TEC assessments such as AHRQ • Clinical guidelines and position statements from applicable professional medical societies • Professional consultant input • National commercial insurer and Medicare coverage positions
<p>Network Admission Criteria</p>	<p>In selecting and credentialing providers for the associate networks, Highmark does not discriminate in terms of participation or reimbursement against any health care professional who is acting within the scope of their license or certification. In addition, Highmark does not discriminate against professionals who serve high-risk populations or who specialize in the treatment of costly conditions. If Highmark</p>	<p>In selecting and credentialing providers for the associate networks, Highmark does not discriminate in terms of participation or reimbursement against any health care professional who is acting within the scope of their license or certification. In addition, Highmark does not discriminate against professionals who serve high-risk populations or who specialize in the treatment of costly conditions. If Highmark</p>

	<p>declines to include a provider in its networks, Highmark will furnish written notice of the reason for its decision to the affected provider.</p> <p>In Network</p> <p>Providers are initially credentialed prior to network admission and recredentialed at least every three years. Highmark conducts verification of the practitioners as defined by their policies, state and federal regulations, and in accordance with accrediting standards.</p> <ul style="list-style-type: none"> • The following is a general summary of Highmark’s credentialing criteria for all practitioners. <ul style="list-style-type: none"> ○ Active state license in each state in which the practitioner provides services; ○ Acceptable five-year work history for initial credentialing; ○ Professional liability insurance in compliance with regulations in state(s) in which the physician practices (please see the section in this unit on malpractice insurance requirements); ○ Acceptable malpractice history; ○ Written proof of Medicare eligibility and have not opted out of the Medicare Part B program for the Medicare Advantage network(s) (PA and WV); and ○ No Medicare or Medicaid sanctions. ○ In addition, physicians (MDs, DOs, DDSs/DMDs, DPMs, and DCs) must furnish proof of the following: <ul style="list-style-type: none"> • Active Drug Enforcement Agency (DEA) certificate in each state in which the practitioner is prescribing controlled substances; • Privileges at a network or participating Blue Cross Blue Shield hospital, as applicable; and • Availability to see Highmark members at least twenty (20) hours a week (for primary care practitioners) 	<p>declines to include a provider in its networks, Highmark will furnish written notice of the reason for its decision to the affected provider.</p> <p>In Network</p> <p>Behavioral health practitioners are initially credentialed prior to network admission and recredentialed at least every three years. Highmark conducts verification of the practitioners as defined by their policies, state and federal regulations, and in accordance with accrediting standards.</p> <ul style="list-style-type: none"> • The following is a general summary of Highmark’s credentialing criteria for all practitioners. <ul style="list-style-type: none"> ○ Active state license in each state in which the practitioner provides services; ○ Acceptable five-year work history for initial credentialing; ○ Professional liability insurance in compliance with regulations in state(s) in which the physician practices (please see the section in this unit on malpractice insurance requirements); ○ Acceptable malpractice history; ○ Written proof of Medicare eligibility and have not opted out of the Medicare Part B program for the Medicare Advantage network(s) (PA and WV); and ○ No Medicare or Medicaid sanctions. ○ In addition, physicians (MDs, DOs, DDSs/DMDs, DPMs, and DCs) must furnish proof of the following: <ul style="list-style-type: none"> • Active Drug Enforcement Agency (DEA) certificate in each state in which the practitioner is prescribing controlled substances; • Privileges at a network or participating Blue Cross Blue Shield hospital, as applicable; and • Availability to see Highmark members at least twenty (20) hours a week (for primary care practitioners)
<p>What is the Basis for Provider Reimbursement?</p>	<p>Reimbursement will be based on the current plan allowance in place at the time services were rendered.</p>	<p>Reimbursement will be based on the current plan allowance in place at the time services were rendered.</p>
<p>Does the Plan Have Exclusions for</p>	<p>The Pharmacy Benefit does not place exclusions for ‘failure to complete a course of treatment’.</p>	<p>The Pharmacy Benefit does not place exclusions for ‘failure to complete a course of treatment’.</p>

Failure to Complete a Course of Treatment?		
Does the Plan Include Fail First Requirements (also known as step therapy protocols)?	<p>Fail first requirements are required for certain medical and pharmacy medications. Typically, step therapy requirements are imposed only if the drug that members are required to “step through” has similar or improved efficacy or safety over the alternative targeted drug. The implementation of step therapy requirements also considers provider prescribing preferences and the cost of the alternative targeted medications.</p> <p>Step Therapy requirements are applied only when multiple other generic or brand formulations within the same medication category are available. The drugs targeted by step therapy are from a wide breath of therapeutic categories. The Medical and Pharmacy departments apply objective criteria outlined in documented medical and pharmacy policies.</p>	<p>Fail first requirements are required for certain medical and pharmacy medications. Typically, step therapy requirements are imposed only if the drug that members are required to “step through” has similar or improved efficacy or safety over the alternative targeted drug. The implementation of step therapy requirements also considers provider prescribing preferences and the cost of the alternative targeted medications.</p> <p>Step Therapy requirements are applied only when multiple other generic or brand formulations within the same medication category are available. The drugs targeted by step therapy are from a wide breath of therapeutic categories. The Medical and Pharmacy departments apply objective criteria outlined in documented medical and pharmacy policies.</p>
Formulary Design for Prescription Drugs	<p>The formulary status for each individual drug within a class is determined based of its efficacy, safety, patient acceptance, unique clinical characteristics, and local physician experience and input. Drugs must meet the following requirements before being reviewed and considered for a formulary:</p> <ul style="list-style-type: none"> • FDA-approved • Sufficient information must exist in peer reviewed medical literature • Demonstration of a net positive effect or outcome or comparable net health benefit to other therapies <p>An operational policy describing the formulary development and maintenance is reviewed and approved at least annually by a review committee. A pharmacy policy with clinical criteria to allow exceptions for members with a closed formulary to have get access to a nonformulary medication is reviewed annually by the Pharmacy & Therapeutics Committee.</p> <p>The process explained above are applied to all drugs in the same manner, regardless of what therapeutic class the medication is from.</p>	<p>The formulary status for each individual drug within a class is determined based of its efficacy, safety, patient acceptance, unique clinical characteristics, and local physician experience and input. Drugs must meet the following requirements before being reviewed and considered for a formulary:</p> <ul style="list-style-type: none"> • FDA-approved • Sufficient information must exist in peer reviewed medical literature • Demonstration of a net positive effect or outcome or comparable net health benefit to other therapies <p>An operational policy describing the formulary development and maintenance is reviewed and approved at least annually by a review committee. A pharmacy policy with clinical criteria to allow exceptions for members with a closed formulary to have get access to a nonformulary medication is reviewed annually by the Pharmacy & Therapeutics Committee.</p> <p>The process explained above are applied to all drugs in the same manner, regardless of what therapeutic class the medication is from.</p>
Are There Restrictions Based	Yes, there are certain Highmark products that require non-emergency services to be authorized as a condition of coverage.	Yes, there are certain Highmark products that require non-emergency services to be authorized as a condition of coverage.

on Geographic Location?		
Does the Plan Require Notification for Inpatient Admissions?	<p>Providers are required to contact Clinical Services Utilization Management to obtain authorization for in-network inpatient admissions.</p> <p>Members are required to contact Clinical Services Utilization Management to obtain authorization prior to in- network inpatient admissions outside of the Highmark service areas.</p>	<p>Providers are required to contact Clinical Services Utilization Management to obtain authorization for in-network inpatient admissions.</p> <p>Members are required to contact Clinical Services Utilization Management to obtain authorization prior to in- network inpatient admissions outside of the Highmark service areas.</p>
Does the Plan Require Prior Authorization for Inpatient Services?	<p>In Network Effective July 1, 2014, under a new Blue Cross Blue Shield Association (BCBSA) initiative, all Blue Plans must require participating providers to obtain pre-service review for inpatient facility services for out-of-area members. In addition, members are held harmless when pre-service review is required and not obtained by the provider for inpatient facility services (unless an account receives an approved exception).</p> <p>These requirements apply to all fully-insured health benefit plans. However, if a self-funded employer group wishes to keep member precertification penalties in place, a formal exception can be filed with the BCBSA. If an account receives an approved exception, a member penalty could apply if pre-service review is not obtained for inpatient services.</p> <p>Highmark provider contracts require participating providers to obtain pre-service review for inpatient facility services for our members and also out-of-area BlueCard® members. Highmark participating providers are also required to hold members harmless if the member’s plan requires pre-service review and the provider did not attempt to acquire an authorization.</p> <p>Out of Network All inpatient services require notification. When these services are provided out of network, the member is responsible for providing the notification and relevant information. Members should provide notice of notify admissions within 24 hours or as soon as reasonably possible given the circumstances.</p> <p>Members are allowed to delegate their responsibility to provide</p>	<p>For most Highmark products, authorization is required to receive coverage for all inpatient behavioral health services. Although authorization is not required for emergency services, an authorization is required if an emergency service results in an inpatient admission.</p> <p>Beginning with dates of service on or after September 2, 2014, authorization is required for partial hospitalization and for intensive outpatient psychiatric services. The following procedure codes have been added to the “List of Procedures/DME Requiring Authorization”:</p> <ul style="list-style-type: none"> • S0201 – partial hospitalization services, less than 24 hours, per diem • S9480 – intensive outpatient psychiatric services, per diem <p>Highmark’s Behavioral Health Services bases its decisions to authorize care upon the following:</p> <ul style="list-style-type: none"> • Availability to the member of the appropriate behavioral health benefit • Clinical information available to the care manager or physician advisor at the time of review • The safety of the patient and, when applicable, the safety of others • Availability and appropriateness of other effective but less restrictive treatment settings • Application of the appropriate medical necessity criteria

	<p>notification to the non-network facility.</p> <p>Initial notification results in a medical necessity review based on plan requirements and may result in an adverse benefit determination.</p>	
<p>Does the Plan Conduct Concurrent Reviews for Inpatient Services?</p>	<p>Yes, concurrent review, also known as continued stay review, is the process for assessing and determining the ongoing medical necessity and appropriateness for an extension of services that have been previously authorized.</p> <p>Concurrent review is also conducted for all inpatient settings after the initial authorization has been obtained, including acute inpatient, LTAC, SNF, and inpatient rehab. Requests for continued stay should be made no later than the last covered day</p>	<p>Concurrent review, also known as continued stay review, is the process for assessing and determining the ongoing medical necessity and appropriateness for an extension of services that have been previously authorized. Outpatient requests should be made at least twenty-four (24) hours prior to the expiration of the original authorization period (last day of treatment).</p>
<p>Does the Plan Conduct Retrospective Reviews for Inpatient Services?</p>	<p>Retrospective Review (also known as Post-service) is the process of assessing the appropriateness of medical services rendered to a member after the service has been provided.</p> <p>The Medical Review staff review the medical record documentation for medical necessity and appropriateness using established criteria. The review may be conducted for all or part of the treatment/service. The determination is based solely on the medical information available to the attending physician or ordering provider at the time that the medical care was provided. During this process, Care Managers will also identify opportunities for referrals to case management or condition management programs. Physicians are often consulted to review high dollar equipment or services, cosmetic and experimental services or to review potential quality of care concerns.</p>	<p>Retrospective Review (also known as Post-service) is the process of assessing the appropriateness of medical services rendered to a member after the service has been provided.</p> <p>The Medical Review staff review the medical record documentation for medical necessity and appropriateness using established criteria. The review may be conducted for all or part of the treatment/service. The determination is based solely on the medical information available to the attending physician or ordering provider at the time that the medical care was provided. During this process, Care Managers will also identify opportunities for referrals to case management or condition management programs. Physicians are often consulted to review high dollar equipment or services, cosmetic and experimental services or to review potential quality of care concerns.</p>
<p>Does the Plan Require Prior Authorization for Outpatient Services?</p>	<p>All Highmark products, including Medicare Advantage, require that certain services be authorized as a condition of coverage. However, benefits can vary; always confirm authorization requirements under the member's coverage prior to providing services.</p>	<p>All Highmark products, including Medicare Advantage, require that certain services be authorized as a condition of coverage. However, benefits can vary; always confirm authorization requirements under the member's coverage prior to providing services.</p>
<p>Does the Plan Conduct Outlier Management</p>	<p>Yes, concurrent review, also known as continued stay review, is the process for assessing and determining the ongoing medical necessity and appropriateness for an extension of services that have been previously authorized. Outpatient requests should be</p>	<p>Concurrent review, also known as continued stay review, is the process for assessing and determining the ongoing medical necessity and appropriateness for an extension of services that have been previously authorized. Outpatient requests should be</p>

<p>& Concurrent Review for Outpatient Services?</p>	<p>made at least twenty-four (24) hours prior to the expiration of the original authorization period (last day of treatment).</p>	<p>made at least twenty-four (24) hours prior to the expiration of the original authorization period (last day of treatment).</p> <p>Concurrent review is also conducted for all inpatient settings, including behavioral health, after the initial authorization has been obtained, including acute inpatient and inpatient rehab. Requests for continued stay should be made no later than the last covered day.</p>
<p>Does the plan Conduct Retrospective Review for Outpatient Services?</p>	<p>In Network & Out of Network</p> <p>Retrospective review (also known as post-service review) is the process of assessing the appropriateness of medical services rendered to a member after the service has been provided.</p> <p>Network providers have an obligation to cooperate with preservice authorization review procedures. If the provider fails to comply, Highmark has the right to review the service retrospectively. If the service is deemed not medically necessary, then payment may be denied or recovered from the provider.</p> <p>Providers who consistently fail to request authorizations on a preservice basis may be subject to corrective action by the Credentials Committee.</p> <p>Failure to preauthorize or precertify a service or admission may result in a retrospective review. Highmark has the right to review the service retrospectively for medical necessity and appropriateness, and to deny payment when necessary.</p> <p>If a retrospective review is performed, and Highmark's Medical Management & Quality (MM&Q) department determines that the service was medically necessary and appropriate, the claim will be paid.</p> <p>If MM&Q determines that the service was not medically necessary and appropriate, no payment will be made for the claim. In this situation, the network provider must write off the entire cost of the claim and may not bill the member (except for any non-covered services).</p>	<p>In Network & Out of Network</p> <p>Retrospective review (also known as post-service review) is the process of assessing the appropriateness of medical services rendered to a member after the service has been provided.</p> <p>Network providers have an obligation to cooperate with preservice authorization review procedures. If the provider fails to comply, Highmark has the right to review the service retrospectively. If the service is deemed not medically necessary, then payment may be denied or recovered from the provider.</p> <p>Providers who consistently fail to request authorizations on a preservice basis may be subject to corrective action by the Credentials Committee.</p> <p>Failure to preauthorize or precertify a service or admission may result in a retrospective review. Highmark has the right to review the service retrospectively for medical necessity and appropriateness, and to deny payment when necessary.</p> <p>If a retrospective review is performed, and Highmark's Medical Management & Quality (MM&Q) department determines that the service was medically necessary and appropriate, the claim will be paid.</p> <p>If MM&Q determines that the service was not medically necessary and appropriate, no payment will be made for the claim. In this situation, the network provider must write off the entire cost of the claim and may not bill the member (except for any non-covered services).</p>

