Mental Health Parity and Addiction Equity Act Disclosure
Prior Authorization Frequently Asked Questions

This document includes standard responses to questions related to Mental Health Parity (MHP) and Non- Quantitative Treatment Limitations (NQTL). This communication is not intended, nor should it be treated, as legal advice. Federal and state laws and regulations are subject to change. The content provided is for informational purposes only and is not medical advice. Decisions about medical care should be made by the doctor and patient. Please note, your plan documents govern all benefit determinations and in the case of conflict with this document your plan controls. Always refer to the plan documents for specific benefit coverage and limitations or call the toll-free member phone number on the ID card.

The following explanations apply to both medical/surgical benefits and mental health/substance use disorder benefits unless stated otherwise.

What is Prior Authorization?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
Prior Authorization is when the Plan reviews services before you receive them to decide if they are medically necessary (See Medical Necessity FAQ for more information about what is medically necessary. The Plan reviews the type of care, the need for that care, and the place of care.	

Why does my Plan do Prior Authorization?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
The Plan uses Prior Authorization to: • Monitor and prevent potential over-use or under-use of services • Manage high-cost and lengthy services • Decide the appropriate level of care • Decide whether the service meets medical necessity criteria • The Plan can help with decisions about discharge planning from the hospital and/or ongoing management of your condition.	

How do I get Prior Authorization?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
Usually, your provider is responsible for getting Prior Authorization. You and your provider should talk about treatment and coverage before you have the service. If we determine that a service will not be covered by your Plan, you can then decide if you want to have and pay for the service out of your pocket.	

How does your provider ask for Prior Authorization?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
Your provider can ask for Prior Authorization electronically or by phone using the phone number on your insurance card. This information is in your Plan documents.	

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Who decides whether Prior Authorization is approved?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
When your provider asks for Prior Authorization, staff will review the request using medical/behavioral clinical policies and/or external, third-party clinical criteria, and Plan terms, and then make a coverage decision. If it is decided that the admission or service is not medically necessary, and will not be covered by your benefits, you and the provider will be notified as required by state and federal law. Appeal rights will be provided.	

What are the qualifications of the staff who make Prior Authorization decisions?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
Clinical, non-clinical, and administrative staff may participate in the Prior Authorization process. All clinical reviews are made by clinical staff (i.e., nurses, physicians, etc.). All denials are made by Medical Directors.	Clinical, non-clinical, and administrative staff may participate in the Prior Authorization process All clinical reviews are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) All inpatient denials are made by Medical Directors. All outpatient denials are made by Medical Directors or psychologists

What information and guidelines are used to make a Prior Authorization decision?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
Staff make Prior Authorization decisions using objective, evidence-based medical/behavioral clinical policies, and nationally recognized clinical guidelines and criteria.	

What is Step Therapy and how does it affect Prior Authorization?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
Step Therapy is when a plan requires you to first try the least invasive, most cost-effective treatment for a given condition before moving on to more invasive or more costly treatments.	
Step Therapy may be required before your health plan provides Prior Authorization for certain treatments or surgeries. Please see the Pharmacy FAQ for information on Pharmacy Step Therapy.	Step Therapy is not required for mental health/substance use disorder services. Please see the Pharmacy FAQ for information on Pharmacy Step Therapy.

When will my Plan respond to a Prior Authorization request?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
Staff respond to requests as soon as possible and follow timeframe requirements set by state and federal laws.	

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What factors and sources are used to decide if Prior Authorization is required?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
When deciding what services need Prior Authorization, the Plan uses the following factors, sources of information, and evidentiary standards: Factor: Clinical Appropriateness: Defined as those services decided by internal medical experts to be in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines. Evidentiary Standards and Sources: • Clinical criteria from nationally recognized third-party sources (e.g., InterQual® for medical/surgical services, and Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System and Child and Adolescent Service Intensity Instrument (CALOCUS-CASII), Early Childhood Service Intensity Instrument (ECSII), and American Society of Addiction Medicine® (ASAM) for mental health/substance use disorder services) • Objective, evidence-based medical/behavioral clinical policies Factor: Value: Defined as the cost of the service exceeding the administrative costs of subjecting the service to Prior Authorization review by at least 1:1. Evidentiary Standards and Sources: • National internal claims data • National utilization management program operating costs • National utilization management authorization data Factor: Variation (outpatient only): Variability in cost per episode of service relative to other services within the classification of benefits Evidentiary Standards and Sources • National internal claims data	

When the Plan performs a Prior Authorization, does the Plan treat mental health/substance use disorder differently than medical/surgical "as written"?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
No. The Plan's analysis found that the strategies, processes, factors, evidentiary standards, and source information used to subject certain mental health/substance use disorder services to Prior Authorization are comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to subject certain medical/surgical services to Prior Authorization "as written."	

Are mental health/substance use disorder decisions made any differently than medical/surgical decisions in practice ("in operation")?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
No. The Plan takes steps to make sure that both medical/surgical and mental health/substance use disorder decisions are consistently made using evidence-based guidelines by conducting an annual "Inter-rater Reliability" assessment that is described below. The Plan uses this process to make sure that the rules of the Mental Health Parity and Addiction Equity Act (MHPAEA) are followed, and if not, take steps to fix it. The Plan also audits itself to make sure clinical quality outcomes and your expectations are met.	

What is the Inter-rater Reliability (or "IRR") assessment and how is it used?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
Every year, the Plan conducts an IRR assessment of its clinical staff who make decisions based on the nationally recognized guidelines mentioned in this document. The IRR review makes sure that staff use these guidelines consistently, looks for areas where staff can improve, and makes sure that users and leaders receive feedback about the appropriateness of how the guidelines are used. The Plan uses the IRR assessment results to make sure staff receive additional training when needed. Training is required for staff who fail to score 90% or better on the IRR within two (2) tries.	

How does the Plan audit itself?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
The Plan conducts internal audits that look at all parts of the process for making clinical decisions, from when the case is opened to when it is closed. The Plan reviews the information from your case to make sure the rules are followed, as well as internal rules in a way that matches up with your Plan.	