Mental Health Parity and Addiction Equity Act Disclosure
Concurrent Review 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 does Concurrent Review mean?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
Concurrent Review means the Plan looks at the treatment provided to you while you are in the hospital or receiving outpatient services to make sure you are receiving the right care based on your specific health care needs (medically necessary). The Plan reviews the type of care, the need for that care, and the place of care.	

Why does my Plan do Concurrent Reviews?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
The Plan uses Concurrent Review to: • Monitor and prevent potential over-use or under-use of services • Manage high-cost and lengthy services • Verify 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.	

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What is the process for Concurrent Reviews?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
When the Plan is notified that you are receiving a service or were admitted to a hospital or 24-hour treatment center, the Plan completes a Concurrent Review. Concurrent Reviews may be done by telephone, online or by using your electronic medical records. If the staff believe that a service or admission may not be covered, they will ask the provider for more information about your clinical condition, treatment, and ongoing care plan. 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.	

How does my Plan know a Concurrent Review is needed?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
For in-network services, providers let the Plan know when you are receiving care either online or by calling the number on the back of your member ID card. For out-of-network services, providers can let the Plan know of an admission to the hospital or necessary services by calling the number on the back of your member ID card.	

Who decides whether Concurrent Review is approved?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
When your provider asks for Concurrent Review, staff will review the request using clinical policies and/or guidelines, 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.	

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What are the qualifications of the staff who perform Concurrent Review?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
Clinical, non-clinical, and administrative staff may participate in the Concurrent Review 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 Concurrent Review 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 Concurrent Review decision?

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

When will my Plan respond to a Concurrent Review 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 Concurrent Review is required?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
All inpatient admissions need Concurrent Review. When deciding what outpatient services need a Concurrent Review, the Plan uses the following factors, sources of information, and evidentiary standards: Factor: Clinical Appropriateness: The application of Concurrent Review promotes optimal clinical outcomes 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 and behavioral clinical policies Factor: Value: The cost of the service exceeds the associated costs of conducting a Concurrent Review Evidentiary Standards and Sources: • National internal claims data • National utilization management program operating costs • National utilization management authorization data Factor: Variation Identified: 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 Concurrent Review, 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 mental health parity analysis found that the strategies, processes, factors, evidentiary standards, and source information used to subject certain mental health/substance use disorder services to Concurrent Review 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 Concurrent Review "as written."	

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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 assessment 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 percent 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 applicable rules are followed, as well as internal rules in a way that matches up with your plan.	