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<td>1</td>
<td>Aetna Health, Inc.</td>
<td>Medical and Behavioral Health: Chairperson of Aetna National Quality Oversight Committee</td>
<td>Medical: Aetna National Quality Advisory Committee; Behavioral Health: Aetna Behavioral Health Quality Advisory Committee; Reason for different review committees: The process is comparable, with exception of area of expertise.</td>
<td>Internal: Level of Care Assessment Tool for Autism: Aetna Applied Behavioral Analysis Medical Necessity Guidelines; Substance Abuse disorders: External: American Society for Addiction Medicine.</td>
<td>Review criteria approved for use by Aetna National Quality Advisory Committee and Aetna National Quality Oversight Committee. Aetna also develops Clinical Policy Bulletins.</td>
<td>For medical and mental health services, both internal and external review criteria are used.</td>
<td>Aetna Health Quality Advisory Committee, with 6-8 behavioral health practitioners (1 psychiatrist, 1 psychologist, social worker), 1 provider representative, 1 FCP.</td>
<td>Aetna Health Quality Advisory Committee, includes range of practicing practitioners with FCPs and specialists.</td>
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<td>Blue Cross and Blue Shield of Massachusetts, Inc.</td>
<td>Medical and Behavioral Health: Associate Chief Medical Officer</td>
<td>Medical and Behavioral Health: Technical Review Committee comprised of members from all services. Includes specialty committees. Reason for different review committees: Necessary due to specialized clinical expertise.</td>
<td>BMC uses McKesson Corporation’s InterQual criteria in order to maintain consistency – made up of 30 developers, 650 external consultants, 110 experts in mental health.</td>
<td>Review criteria approved for use by Aetna National Quality Advisory Committee and Aetna National Quality Oversight Committee. Aetna also develops Clinical Policy Bulletins.</td>
<td>For medical and mental health services, both internal and external review criteria are used.</td>
<td>Aetna Health Quality Advisory Committee, with 6-8 behavioral health practitioners (1 psychiatrist, 1 psychologist, social worker), 1 provider representative, 1 FCP.</td>
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<td>Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.</td>
<td>Medical and Behavioral Health: Associate Chief Medical Officer</td>
<td>Medical and Behavioral Health: Technical Review Committee comprised of personnel from various fields for both services. More separate committees. Reason for different review committees: Necessary due to specialized clinical expertise.</td>
<td>BMC uses McKesson Corporation’s InterQual criteria in order to maintain consistency – made up of 30 developers, 650 external consultants, 110 experts in mental health.</td>
<td>Review criteria approved for use by Aetna National Quality Advisory Committee and Aetna National Quality Oversight Committee. Aetna also develops Clinical Policy Bulletins.</td>
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<td>Beacon (a CareFirst BlueCross BlueShield company)</td>
<td>Medical Quality Improvement Committee, chaired by Director of Quality Improvement</td>
<td>Medical: Behavioral Health: Beacon’s Level of Care Committee. Reason for different review committees: Necessary to develop specialized clinical expertise.</td>
<td>The review process is the same, using external review criteria. Uses McKesson InterQual criteria, Aetna’s Clinical Policy Bulletins, Level of Care Assessment Tool; for all services.</td>
<td>Review criteria approved for use by Aetna National Quality Advisory Committee and Aetna National Quality Oversight Committee. Aetna also develops Clinical Policy Bulletins.</td>
<td>For medical and mental health services, both internal and external review criteria are used.</td>
<td>Aetna Health Quality Advisory Committee, with 6-8 behavioral health practitioners (1 psychiatrist, 1 psychologist, social worker), 1 provider representative, 1 FCP.</td>
<td>Aetna Health Quality Advisory Committee, includes range of practicing practitioners with FCPs and specialists.</td>
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**Developed by Whom?**

- **Medical**
  - Aetna National Quality Advisory Committee
  - Aetna National Quality Oversight Committee
  - Aetna Behavioral Health Quality Advisory Committee
  - Aetna Behavioral Health Quality Oversight Committee

- **Behavioral Health**
  - Aetna National Quality Advisory Committee
  - Aetna National Quality Oversight Committee
  - Aetna Behavioral Health Quality Advisory Committee
  - Aetna Behavioral Health Quality Oversight Committee

**Reason for different review committees:**

- Specialized nature of behavioral health services
- Different persons: Medical Affairs and Medical Directors, Physician Review Committee, Provider Advisory Council, and Expert Panel
- Specialized clinical experience
- Reporting structure of medical directors
- Range of practicing practitioners

**Developing Criteria:**

- Aetna National Quality Advisory Committee
- Aetna National Quality Oversight Committee
- Aetna Behavioral Health Quality Advisory Committee
- Aetna Behavioral Health Quality Oversight Committee

**Process:**

- Aetna also develops Clinical Policy Bulletins.
- Providers and other representatives are involved in the development of criteria.

**Internal and External Review:**

- Internal and external review criteria are used for medical and mental health services.
- Internal and external review criteria are used for all services.
| No. | Company Name | 1.1 - Utilization Review Person | 1.2 - Utilization Review Committee | 1.3a - Mental Health Utilization Review Criteria - Developed by Who? | 1.3b - Mental Health Utilization Review Criteria - Developed by Who? | 1.3c - Review Differences | 1.4a - Practicing Physician Input - Mental Health | 1.4b - Practicing Physician Input - Medical | 1.4c - Explanation of different process
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<td>7</td>
<td>CellaCare Health Plus of Massachusetts, Inc. Medical and Behavioral Health: Chief Medical Officer</td>
<td>Medical and Behavioral Health: Utilization review criteria are reviewed and approved by the CellaCare Health Quality Improvement Committee, consisting of internal and external members.</td>
<td>Primary source is through external review process using McKesson’s InterQual. Annually, a small minority of policies (Partial Hospital Program and Intensive Outpatient Program) are developed by internal clinicians with review by local external experts via the QIC.</td>
<td>Criteria are developed internally and approved by Quality Improvement Committee, and developed using McKesson’s InterQual criteria.</td>
<td>One approach is the same, and the development and approval process are similar.</td>
<td>InterQual criteria are reviewed using consulting providers. Also, the CellaCare Health Quality Improvement Committee is comprised of CellaCare Health staff and local community board providers.</td>
<td>InterQual criteria are reviewed using consulting providers. Also, the CellaCare Health Quality Improvement Committee is comprised of CellaCare Health staff and local community board providers.</td>
<td>The process for each is the same.</td>
<td></td>
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<td>CIGNA Health and Life Insurance Company Medical and Behavioral Health: Chief Medical Officer</td>
<td>Medical and Behavioral Health: CSQA Medical Technology Assessment Committee. Committee consists of medical/psychiatric and mental health experts. Current chair is a psychiatrist.</td>
<td>Medical Criteria reviewed by Medical Operations Staff, Medical Directors and Behavioral Health Committee.</td>
<td>Criteria developed internally with input of psychiatrists, nurses, psychologists, social workers, and substances abuse doctors. Updated at least every 2 years.</td>
<td>Committee is comprised of medical/psychiatric and mental health experts.</td>
<td>Need to rely on an NCQA to determine medical necessity where CIGNA has not developed its own coverage policy.</td>
<td>CIGNA relies on feedback from network providers.</td>
<td>Feedback from physicians through network, local market CIGNA Medical Director, or Coverage Policy Unit and Technical Assessment Committee.</td>
<td>Similar process, but more inclusive of practicing physicians for mental health process.</td>
</tr>
<tr>
<td>9</td>
<td>ConnectCare of Massachusetts, Inc. Medical: Physician Advisory Committee Medical and Behavioral Health: Chief Medical Officer</td>
<td>Medical and Behavioral Health: Peer Review, the Medical Advisory Committee, and submitted to Beacon for review and approval.</td>
<td>Medical Criteria developed by National Imaging Associates (NIA). Consists of radiologists and radiation oncology.</td>
<td>Criteria developed by the National Imaging Associates (NIA).</td>
<td>Need for subject matter experts.</td>
<td>Opus-obtains input from its National Provider Advisory Council, made up of practicing physicians and other Behavioral Health professionals from outside provider network.</td>
<td>Opus-obtains input from the Behavioral Specialty Advisory Council made up of representation from national behavioral health specialty societies.</td>
<td>ConnectCare obtains input from its Physician Advisory Committee which includes senior practicing physicians (most of whom are employees).</td>
<td>ConnectCare and Opus utilizes similar processes.</td>
</tr>
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<td>10</td>
<td>Fallon Community Health Plus, Inc. Medical: Chief Medical Officer Medical and Behavioral Health: Beacon Vice President of Medical Affairs and Medical Directors.</td>
<td>Medical and Behavioral Health: Beacon Level of Care Committee.</td>
<td>Medical Criteria developed by a Technical Assessment Committee comprised of CeltiCare Health staff and local market CIGNA Medical Director.</td>
<td>Medical Criteria developed by a Technical Assessment Committee comprised of CeltiCare Health staff and local market CIGNA Medical Director.</td>
<td>Need for subject matter experts.</td>
<td>Fallon Community Health Plus, Inc. Medical and Behavioral Health: Beacon Level of Care Committee.</td>
<td>Beacon uses a Technical Assessment Committee that is tasked with reviewing and developing criteria. It is made up of network physicians from various specialty areas.</td>
<td>Fallon Community Health Plus, Inc. Medical and Behavioral Health: Beacon Level of Care Committee.</td>
<td>Both Beacon and FCHP are accredited by NOQA, which requires physician input. While different committees exist for each, the process for both to include physicians in review of criteria is similar.</td>
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<td>Fallon Health &amp; Life Assurance Company Medical: Chief Medical Officer Medical and Behavioral Health: Beacon Vice President of Medical Affairs and Medical Directors.</td>
<td>Medical and Behavioral Health: Beacon Level of Care Committee.</td>
<td>Medical Criteria developed by a Technical Assessment Committee comprised of CeltiCare Health staff and local market CIGNA Medical Director.</td>
<td>Medical Criteria developed by a Technical Assessment Committee comprised of CeltiCare Health staff and local market CIGNA Medical Director.</td>
<td>Need for subject matter experts.</td>
<td>Fallon Community Health Plus, Inc. Medical and Behavioral Health: Beacon Level of Care Committee.</td>
<td>Beacon uses a Technical Assessment Committee that is tasked with reviewing and developing criteria. It is made up of network physicians from various specialty areas.</td>
<td>Beacon uses a Technical Assessment Committee that is tasked with reviewing and developing criteria. It is made up of network physicians from various specialty areas.</td>
<td>Both Beacon and FCHP are accredited by NOQA, which requires physician input. While different committees exist for each, the process for both to include physicians in review of criteria is similar.</td>
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1.2 - Utilization Review Committee

**Harvard Pilgrim Health Care, Inc.**

**Medical** Senior Medical Director, Director for Clinical Policy and Compliance. 
**Behavioral Health** Senior Vice President, Medical Management. 
**Reason for different persons:** Option has subject matter expertise in behavioral health.  Different people because Optum has professional expertise to handle utilization review for mental health.

**Harvard Pilgrim Health** has utilization review committees established and aligned with the scope of local providers through annual reviews by the Clinical Care Assessment Committee (CCAC) and the Behavioral Health Assessment Committee (BHAC), as well as McKesson’s InterQual criteria as these clinical criteria sets are nationally recognized, clinically relevant, and reflective of best practices.

**Harvard Pilgrim** uses both internally created review criteria developed and updated with the input of local physicians through annual review by the CCAC and the BHAC, as well as McKesson’s InterQual criteria as these clinical criteria sets are nationally recognized, clinically relevant, and reflective of best practices.

Harvard Pilgrim’s Utilization Management and Clinical Policy Department develops and periodically reviews clinical guidelines. 

Harvard Pilgrim’s Utilization Management and Clinical Policy Committee (BHAC) reviews this criteria for consistency with federal and state mental health/policy guidelines. 

Options differ because Harvard Pilgrim uses both internally developed and externally licensed criteria for mental health/substance use and medical/surgical services.

Harvard Pilgrim’s Utilization Management and Clinical Policy Committee (BHAC) reviews this criteria for consistency with federal and state mental health/policy guidelines.

While their processes are not exactly the same, Optum’s and Harvard Pilgrim both comply with the Mental Health Parity Laws by obtaining input from practicing physicians regarding their criteria.

1.3 - Mental Health Utilization Review Criteria - Developed by Whom?

**Harvard Pilgrim Health Care, Inc.**

**Medical** Senior Medical Director, Director for Clinical Policy and Compliance. 
**Behavioral Health** Senior Vice President, Medical Management.

**Reason for different persons:** Option has subject matter expertise in behavioral health.  Different people because Optum has professional expertise to handle utilization review for mental health.

Optum develops the utilization review criteria for use by Harvard Pilgrim. Harvard Pilgrim approves criteria by Option for use with Harvard Pilgrim members.

Harvard Pilgrim’s Utilization Management and Clinical Policy Department develops and periodically reviews clinical guidelines. 

Harvard Pilgrim’s Utilization Management and Clinical Policy Committee (BHAC) reviews this criteria for consistency with federal and state mental health/policy guidelines.

Harvard Pilgrim’s Utilization Management and Clinical Policy Committee (BHAC) reviews this criteria for consistency with federal and state mental health/policy guidelines.

Harvard Pilgrim’s Medical Directors work with community physicians to look at utilization review criteria that is being developed or reviewed.  For certain criteria such as psychological testing, Harvard Pilgrim will obtain input from employers such as psychologists.

1.4 - Mental Health Utilization Review Criteria - Review Differences

**Harvard Pilgrim Health Care, Inc.**

**Medical** Senior Medical Director, Director for Clinical Policy and Compliance. 
**Behavioral Health** Senior Vice President, Medical Management.

**Reason for different persons:** Option has subject matter expertise in behavioral health.  Different people because Optum has professional expertise to handle utilization review for mental health.

Options differ because Harvard Pilgrim uses both internally developed and externally licensed criteria for mental health/substance use and medical/surgical services.

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Harvard Pilgrim’s Medical Directors work with community physicians to look at utilization review criteria that is being developed or reviewed.  For certain criteria such as psychological testing, Harvard Pilgrim will obtain input from employers such as psychologists.

While their processes are not exactly the same, Optum’s and Harvard Pilgrim both comply with the Mental Health Parity Laws by obtaining input from practicing physicians regarding their criteria.

1.5 - Review Differences

**Harvard Pilgrim Health Care, Inc.**

**Medical** Chief Medical Officer

**Behavioral Health** Medical Technology Assessment Committee, chaired by CMO, responsible for both.

**Reason for different persons:** Option has subject matter expertise in behavioral health.  Different people because Optum has professional expertise to handle utilization review for mental health.

Options differ because Harvard Pilgrim uses both internally developed and externally licensed criteria for mental health/substance use and medical/surgical services.

Options differ because Harvard Pilgrim uses both internally developed and externally licensed criteria for mental health/substance use and medical/surgical services.

BNE uses a combination of internally developed and externally licensed criteria for both mental health/substance use and medical/surgical services.

Harvard Pilgrim’s Utilization Management and Clinical Policy Department develops and periodically reviews clinical guidelines. 

Harvard Pilgrim’s Utilization Management and Clinical Policy Committee (BHAC) reviews this criteria for consistency with federal and state mental health/policy guidelines.

Harvard Pilgrim’s Medical Directors work with community physicians to look at utilization review criteria that is being developed or reviewed.  For certain criteria such as psychological testing, Harvard Pilgrim will obtain input from employers such as psychologists.

While their processes are not exactly the same, Optum’s and Harvard Pilgrim both comply with the Mental Health Parity Laws by obtaining input from practicing physicians regarding their criteria.

1.6 - Review Differences

**Harvard Pilgrim Health Care, Inc.**

**Medical** Chief Medical Officer

**Behavioral Health** Medical Technology Assessment Committee, chaired by CMO, responsible for both.

**Reason for different persons:** Option has subject matter expertise in behavioral health.  Different people because Optum has professional expertise to handle utilization review for mental health.

Harvard Pilgrim’s Utilization Management and Clinical Policy Committee (BHAC) reviews this criteria for consistency with federal and state mental health/policy guidelines.

Harvard Pilgrim’s Medical Directors work with community physicians to look at utilization review criteria that is being developed or reviewed.  For certain criteria such as psychological testing, Harvard Pilgrim will obtain input from employers such as psychologists.

While their processes are not exactly the same, Optum’s and Harvard Pilgrim both comply with the Mental Health Parity Laws by obtaining input from practicing physicians regarding their criteria.

1.7 - Review Differences

**Harvard Pilgrim Health Care, Inc.**

**Medical** Chief Medical Officer

**Behavioral Health** Medical Technology Assessment Committee, chaired by CMO, responsible for both.

**Reason for different persons:** Option has subject matter expertise in behavioral health.  Different people because Optum has professional expertise to handle utilization review for mental health.

Harvard Pilgrim’s Utilization Management and Clinical Policy Committee (BHAC) reviews this criteria for consistency with federal and state mental health/policy guidelines.

Harvard Pilgrim’s Medical Directors work with community physicians to look at utilization review criteria that is being developed or reviewed.  For certain criteria such as psychological testing, Harvard Pilgrim will obtain input from employers such as psychologists.

While their processes are not exactly the same, Optum’s and Harvard Pilgrim both comply with the Mental Health Parity Laws by obtaining input from practicing physicians regarding their criteria.

1.8 - Review Differences
10 Neighborhood Health Plan, Inc.  
**Medical** - Chief Medical Officer and Medical Directors  
**Behavioral Health** - Vice President of Medical Affairs and Medical Directors  
**Reason for different persons:** Roles and responsibilities are divided at the partner organizations. Two different individuals are responsible because of the need for experience and expertise in the respective fields.  
**Mental Health Utilization Review**  
**Criteria - Developed by Whom?**  
Medical - Technical Assessment Team comprised of CMO, Medical Directors, behavioral and other internal staff.  
**Behavioral Health:** Level of Care Committees comprised of psychiatrists, doctoral and masters-level behavioral health and substance abuse clinicians and licensed social workers.  
**Reason for different review committees:** HBHP contracts with Beacon because they have knowledge and expertise in treatment of mental health and substance use disorders.  
**Review Differences**  
NHP was initially internally created utilization review criteria, as well as McKesson's InterQual Criteria.  
**对外联系**  
Guest input for development and maintenance for behavioral health services from board certified practicing physicians, and health professionals from specialty areas.  
Process is similar to input is solicited from relevant medical professionals.  
11 Network Health, LLC  
**Medical and Behavioral Health** - Senior Vice President and Chief Medical Officer of Network Health Public Plan, Inc.  
**Medical and Behavioral Health** - Technical Assessment Teams that evaluate criteria for changes to criteria. Chief Medical Officer and Medical Director for Behavioral Health are active participants in this committee.  
**Criteria developed internally, as well as through McKesson's InterQual Criteria.**  
**Reason for different review committees:** Different committees due to different areas of expertise, but Medical Technology Assessment Process for both.  
**Summary of Responses to Bulletin 2013-06: Item #1**  
Medical and Behavioral Health - Medical and Behavioral Health: Medical Specialty Policy Advisory Committee (MPTAC), a subcommittee of the Clinical and Medical Technology Review Committee, reviews recommendations from practicing physicians and governmental agency policy. Members are external practicing physicians and internal managers. The Medical Specialty Policy Advisory Committee also provides input to the development and annual review of medical necessity guidelines.  
Process is through internal and external stakeholders for both medical and mental health utilization review.  
12 PalmaCare Health & Life Insurance Company  
**Medical & Life Health** - Senior Vice President and Chief Medical Officer  
**Medical and Behavioral Health** - Senior Vice President and Chief Medical Officer.  
**Medical and Behavioral Health** - Medical Specialty Advisory Council which involves the CMO, Medical Directors, and experienced specialists in their respective fields.  
**Criteria developed internally, as well as through McKesson's InterQual Criteria.**  
**Reason for different review committees:** Different Committees due to different areas of expertise, but Medical Technology Assessment Process for both.  
**Process is similar, as input is solicited from relevant medical professionals.**  
13 UtahHealthcare Insurance Company  
**Medical - National Medical Care Management Company**  
**Behavioral Health - Behavioral Policy & Advisory Committee**  
**Reason for different persons:** It is deemed prudent to have appropriately trained and experienced specialists in their respective fields develop the utilization review criteria and criteria.  
**Signals and Criteria**  
**Medical** - National Medical Care Management Company  
**Behavioral Health:** Behavioral Policy & Advisory Committee as responsible for review.  
**Reason for different review committees:** It is deemed prudent to have appropriately trained and experienced specialists in their respective fields develop the utilization review criteria and criteria.  
**Utilization Criteria**  
OperumDHB violation review criteria are developed by medical/behavioral/medical professionals within OperumDHB.  
**Medical Policy and Technology Assessment Committee (MPTAC), includes practicing physicians from specialty fields. Voting members include external physicians from clinical and academic practices, and internal medical directors. Subcommittee may include physicians external to MPTAC physician and clinical subject matter experts.  
**Process is similar, as input is solicited from relevant medical professionals.**  
14 UPH HealthCare  
**Medical** - Medical Policy and Technology Assessment Committee (MPTAC).  
**Behavioral Health - Behavioral Policy & Advisory Committee**  
**Reason for different persons:** It is deemed prudent to have appropriately trained and experienced specialists in their respective fields develop the utilization review criteria and criteria.  
**Criteria - Developed by Whom?**  
Medical - Technical Assessment Team comprised of CMO, Medical Directors, behavioral and other internal staff.  
**Behavioral Health Level of Care Committees comprised of psychiatrists, doctoral and masters-level behavioral health and substance abuse clinicians and licensed social workers.**  
**Reason for different review committees:** HBHP contracts with Beacon because they have knowledge and expertise in treatment of mental health and substance use disorders.  
**Review Differences**  
NHP was initially internally created utilization review criteria, as well as McKesson's InterQual Criteria.  
**Process is similar, as input is solicited from relevant medical professionals.**  
15 UTx HealthPlan, Inc.  
**Medical** - Chief Medical Officer and Medical Directors  
**Behavioral Health** - Vice President of Medical Affairs and Medical Directors  
**Reason for different persons:** Roles and responsibilities are divided at the partner organizations. Two different individuals are responsible because of the need for experience and expertise in the respective fields.  
**Medical and Behavioral Health**: Behavioral Policy & Integration Committee is responsible for review.  
**Reason for different review committees:** The Analytics Committee is responsible for review.  
**Review Differences**  
Chief Medical Officer and Medical Directors are internally reviewed internally by Medical Health Operations and Policy Committee.  
**Process is similar, as input is solicited from relevant medical professionals.**
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<th>No.</th>
<th>Company Name</th>
<th>Medical and Behavioral Health: Provider Communications; Utilization Management Clinicians and Medical Directors; Network Staff; Utilization Review and Complaint, Grievance and Appeal</th>
<th>Member and Provider notification via denial and appeal determination correspondence</th>
<th>Methods of media used for notification</th>
<th>Instructions for contacting organization</th>
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<td>Medical and Behavioral Health: Providers can contact Aetna via e-mail, phone, fax, or electronically. Instructions are given via methods given in 2.2.</td>
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<td>Blue Cross and Blue Shield of Massachusetts, Inc.</td>
<td>Medical and Behavioral Health: Notify providers through secure online Provider Portal. Network Management Team responsible for all notifications.</td>
<td>Medical and Behavioral Health: Methods are Provider Portal, and news alerts sent via e-mail and regular mail.</td>
<td>Medical and Behavioral Health: Notify providers through secure online Provider Portal. Network Management Team responsible for all notifications.</td>
<td>Medical and Behavioral Health: Notify providers through secure online Provider Portal. Network Management Team responsible for all notifications.</td>
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<td>Boston Medical Center Health Plan, Inc.</td>
<td>Medical and Behavioral Health: Various posting: mail letters, provider newsletters, provider communications; Medical and Behavioral Health: Quality management bulletins.</td>
<td>Medical and Behavioral Health: Various posting: mail letters, provider newsletters, provider communications; Medical and Behavioral Health: Quality management bulletins.</td>
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Medical and Behavioral Health: Various posting: mail letters, provider newsletters, provider communications; Medical and Behavioral Health: Quality management bulletins.
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<th>No.</th>
<th>Company Name</th>
<th>2.1 - Notification Process: Who is Responsible?</th>
<th>2.2 - Methods of media used for notification</th>
<th>2.3 - Instructions for contacting organization</th>
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<tr>
<td>1</td>
<td>CeltiCare Health Plan of Massachusetts, Inc.</td>
<td>Medical and Behavioral Health: VP, Network Contracting for CeltiCare Health.</td>
<td>Medical and Behavioral Health: Multi, e-mail, website notifications, provide partial information, and provider newsletters.</td>
<td>Medical and Behavioral Health: Instructions are provided in the provider manuals that any provider may contact the applicable clinical departments to voice concerns, make suggestions for policy changes. Additionally, a form is available on the CeltiCare Health website that a provider may complete and fax to the plan for consideration.</td>
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<tr>
<td>2</td>
<td>HUS Health and Life Insurance Company</td>
<td>Medical and Behavioral Health: Vice President of Total Health and Network is responsible. Senior Director of Provider Contracting for Specialty Services, including Behavioral Health, and the Senior Director of Provider Contracting for CIGNA HealthCares both report to the VP of Total Health and Network.</td>
<td>Medical: Articles in electronic quarterly newsletter, e-mail notices, copy of criteria on CIGNAforHCP.com. Copies of these coverage policies and the CIGNA Reference Guide are available to healthcare professionals upon request. Behavioral Health: Articles in electronic quarterly newsletter, e-mail notices, copy of criteria on CIGNAforHCP.com. Copies of Medical Necessity Guidelines (includes mental health and substance abuse utilization criteria) and Medical Management Program are also available to healthcare professionals upon request.</td>
<td>Medical and Behavioral Health: CIGNA instructs carriers to give feedback through website, through the CIGNA Medical Directors in their market, or directly to the Coverage Policy Team and Medical Technology Assessment Committee.</td>
</tr>
<tr>
<td>3</td>
<td>ConnectCare of Massachusetts, Inc.</td>
<td>Medical: Manager of Operations Communications and Quality with input from Healthcare Management staff. Behavioral Health: Outreach Manager &amp; Analytics Committee.</td>
<td>Medical: ConnectCare's provider website. Behavioral Health: Optum provider website.</td>
<td>Medical: Comments can be made through the Physician Advisory Committee or directly to a ConnectCare Medical Director or Chief Medical Officer. Behavioral Health: Comments can be made through the Behavioral Specialty Advisory Council or directly to an Optum Medical Director.</td>
</tr>
<tr>
<td>6</td>
<td>Harvard Pilgrim Health Care, Inc.</td>
<td>Medical: Editor for Provider Communications and Education is responsible for these notifications to providers. Behavioral Health: Optum’s Behavioral Policy &amp; Analytics Committee is responsible for availability of clinical guidelines to providers. Reason for difference: Since Optum develops and maintains hospital/insurance use criteria, it is appropriate for Optum to have different people responsible for notification to providers.</td>
<td>Medical: Providers through Provider manual, through Provider Web site - monthly e-newsletter; through provider website <a href="http://www.harvardpilgrim.org/providers">www.harvardpilgrim.org/providers</a>, through Provider Service Center. Behavioral Health: Providers through Level of Care Guidelines available on Optum’s provider website and by request (for paper copies).</td>
<td>Medical: Medical Directors have periodic provider meetings. Provider manual also has instructions on contacting Physician Call Center. Behavioral Health: Input directly solicited from Optum’s National Provider Advisory Council and Behavioral Specialty Advisory Council.</td>
</tr>
<tr>
<td>7</td>
<td>Health New England, Inc.</td>
<td>Medical and Behavioral Health: Under Managed Care Manager – Utilization Management is responsible.</td>
<td>Medical and Behavioral Health: Internally developed criteria posted on website, also posted on our website criteria updated and posted on provider blog. Hard copy available upon request.</td>
<td>Medical and Behavioral Health: Instructions on how to contact HNE are provided in the Provider Manual. Instructions are the same for both medical/surgical utilization review providers and mental/substance use providers.</td>
</tr>
</tbody>
</table>
To: [Insert Company Name]

Subject: Summary of Responses to Bulletin 2013-06: Item #2

Dear [Company Name],

This letter summarizes the responses received from different companies regarding Item #2 of Bulletin 2013-06, which focuses on the notification process for mental health and addiction equity.

**2.1 - Notification Process: Who is Responsible?**

- **HPHC Insurance Company, Inc.**
  - **Medical:** Editor for Provider Communications and Education is responsible for these notifications to providers.
  - **Behavioral Health:** Optum’s Behavioral Policy & Analytics Committee is responsible for availability of clinical guidelines to providers.
  - **Reason for difference:** Since Optum develops mental health/substance use criteria, it is appropriate for Optum to have different people responsible for notification to providers.

- **Minuteman Health, Inc.**
  - **Medical and Behavioral Health:** Minuteman Health works with its leased provider network, Provider Network Alliance (PNA), to provide any required notifications to its participating providers.
  - **Reason for difference:** NHP contracts with Beacon because of their knowledge and expertise in treatment of mental health and substance use disorders.

- **Network Health, LLC (now known as Tufts Health Public Plans, Inc.)**
  - **Medical and Behavioral Health:** Tufts Health Plan - Network Health Marketing and Communications, Medical Management and Behavioral Health Departments are responsible for providing notifications regarding utilization criteria.

**2.2 - Methods of media used for notification**

- **Minuteman Health, Inc.**
  - **Medical and Behavioral Health:** When criteria are developed, revised, or updated, Minuteman Health, via PNA, notifies its participating providers. In addition to a mailing, the information is also posted on Minuteman Health’s website. Providers may access and view criteria on Minuteman Health’s website or may request a hard copy if changes occur.

**2.3 - Instructions for contacting organization**

- **Network Health, LLC (now known as Tufts Health Public Plans, Inc.)**
  - **Medical and Behavioral Health:** Tufts Health Plan - Network Health instructs providers to contact them via the Tufts Health Plan - Network Health website and the Provider Manual.

Please review the above information and let us know if you have any further questions or comments.

Best regards,

[Your Name]
<table>
<thead>
<tr>
<th>No.</th>
<th>Company Name</th>
<th>Medical and Behavioral Health:</th>
<th>Notification Process: Who is Responsible?</th>
<th>Methods of media used for notification</th>
<th>Instructions for contacting organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>Tufts Associated Health Maintenance Organization, Inc.</td>
<td>Tufts Health Plan Provider Communications and Education Department is responsible for notification.</td>
<td>Tufts Health Plan: The Provider Update quarterly newsletter mailed to Plan providers; an electronic copy is emailed to all registered users of Tufts Health Plan's secure Provider website, and articles posted on the public Provider website <a href="http://www.tuftshealthplan.com/provider">www.tuftshealthplan.com/provider</a>.</td>
<td>Tufts Health Plan Commercial Provider Manual.</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Tufts Insurance Company</td>
<td>Tufts Health Plan Provider Communications and Education Department is responsible for notification.</td>
<td>Tufts Health Plan: The Provider Update quarterly newsletter mailed to Plan providers; an electronic copy is emailed to all registered users of Tufts Health Plan's secure Provider website, and articles posted on the public Provider website <a href="http://www.tuftshealthplan.com/provider">www.tuftshealthplan.com/provider</a>.</td>
<td>Tufts Health Plan Commercial Provider Manual.</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>UniCare Life &amp; Health Insurance Company</td>
<td>Department of Provider Communications is responsible for notification.</td>
<td>Monthly newsletter to providers; e-mails, regular mail; provider website.</td>
<td>Providers can send information requests via mail, e-mail or fax.</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>UnitedHealthcare Insurance Company</td>
<td>Medical Management Operations Teams are responsible for notifications. Behavioral Health: Optum/UBH Medical Management Teams are responsible for notifications.</td>
<td>Providers are notified on the provider portal, via telephone, or in writing by UHC or Optum/UBH, Medical Directors.</td>
<td>Instructions are available in the administrative guideline/policies, Provider Portal, Telephone or by writing to Medical Directors.</td>
<td></td>
</tr>
</tbody>
</table>
3.1 - Person Responsible

- **Medical and Behavioral Health:** Director; Clinical Director of Utilization Management.
- **Medical:** Medical Director of Medical Surgery Utilization Management, Medical Surgical Physician Review Unit.
- **Behavioral Health:** Director of a mental Health Division for administration of Utilization Management, Medical Director for Mental Health/Behavioral Health Division for Mental Health/Behavioral Health Utilization Review.

3.2 - Average Number and Medical Expertise

- **Medical and Behavioral Health:** On average 25 independently licensed mental health professionals, including RN's, social workers, professional counselors, therapists and psychiatric medical directors. On average 67 staff members, including RN's, social workers, professional counselors, therapists and psychiatric medical directors.
- **Medical:** On average 67 staff members, including RN's, social workers, professional counselors, therapists and psychiatric medical directors.
- **Behavioral Health:** On average 67 staff members, including RN's, social workers, professional counselors, therapists and psychiatric medical directors.

3.3 - Systems Used for Request for Services

- **Medical and Behavioral Health:** Primarily sends authorization requests through Electronic Data Interchange, secure provider website, mail, and fax. For non-urgent matters, sometimes via phone calls. For non-urgent matters, sometimes via phone calls.
- **Medical:** Primarily sent via fax for both medical and mental health requests 8:30 AM - 4:30 PM on weekdays. Utilization Requests not conducted outside of those business hours of 8AM-5PM, M-F. For urgent matters, available 24/7.
- **Behavioral Health:** Primarily sent via fax for both medical and mental health requests 8:30 AM - 4:30 PM on weekdays. Utilization Requests not conducted outside of those business hours of 8AM-5PM, M-F. For urgent matters, available 24/7.

3.4 - Types of Information

- **Medical and Behavioral Health:** Types of information are the same for both - only difference is the choice of communications, written bulletins, orientations and follow-up letters.
- **Medical:** Types of information are the same for both - only difference is the choice of communications, written bulletins, orientations and follow-up letters.
- **Behavioral Health:** Types of information are the same for both - only difference is the choice of communications, written bulletins, orientations and follow-up letters.

3.5 - Additional Information for Utilization Review

- **Medical and Behavioral Health:** Through Electronic Data Interchange, secure provider website, mail, telephone, fax and through Phone
- **Medical:** Through Electronic Data Interchange, secure provider website, mail, telephone, fax and through Phone.
- **Behavioral Health:** Through Electronic Data Interchange, secure provider website, mail, telephone, fax and through Phone.

3.7 - Different Type of Information

- **Medical and Behavioral Health:** Clinical history.
- **Medical:** Clinical history.
- **Behavioral Health:** Clinical history.

3.8 - Instructions for communication

- **Medical and Behavioral Health:** Via phone, fax, mail or electronically.
- **Medical:** Via phone, fax, mail or electronically.
- **Behavioral Health:** Via phone, fax, mail or electronically.

3.9 - Other Administrative or Utilization Review

- **Medical and Behavioral Health:** [No specific information provided.]
- **Medical:** [No specific information provided.]
- **Behavioral Health:** [No specific information provided.]
### 3.4 - Working Hours and Off-Hours

- **Medical and Behavioral Health**
  - Executive Vice President/Chief Medical Officer: M-F 8am-5pm
  - Senior Vice President of Medical Affairs: M-F 8am-5pm
  - Overseen by Senior Vice President of Healthcare Management in conjunction with various Vice Presidents of other departments.

- **Behavioral Health**
  - Behavioral Health: Senior Clinical Compliance Manager:
    - Certified in their specialty, perform medical/surgical reviews.
    - Reponsible for physicians and utilization management.
  - Behavioral Health: Utilization Management:
    - Senior Medical Director: 3+ years clinical experience, 5+ years experience in managed care.
      - Senior Management Specialists; 2 Data Entry Clerks; and 3 Appeals Managers (RNs); 6 Utilization Management Assistants; 5 Utilization Management Specialists; 1.0 FTE Secure E-mail/Provider Portal.
      - Senior Clinical Compliance Manager: 5.5 licensed behavioral health clinicians; 1.0 FTE Secure Provider Portal.

- **Medical**
  - Senior Medical Director: 2 Management Level personnel; 3 supervisors; 12 Utilization Management Assistants; 5 Utilization Management Specialists; 0.5 FTE, licensed as required at their level, with 3+ years clinical experience, 2+ years experienced in managed care.
    - 100 licensed RN available 24/7.
    - Behavioral Health clinician available 24/7 and a nurse available 24/7.

- **ConnectiCare**
  - 24-hour a day, 7 days a week, licensed RN available 24/7.
  - Behavioral health/substance use reviews.

### 3.5 - Staffing Levels

- **Medical**
  - Average of 166 care managers hold MA or PhD degrees.  
    - Average of 38 nurses, with RN license available 24/7.

### 3.6 - Methods of Communication for Utilization Review

- **Medical**
  - Utilization Review Supervisor: 24 hours a day, 7 days a week.
  - Utilization Management Supervisor: 24 hours a day, 7 days a week.
  - Utilization Management Specialist: 5.5, licensed RN available 24/7.
  - Utilization Management Specialist: 5, licensed RN available 24/7.
  - Utilization Management Specialist: 1.0 FTE Secure Provider Portal.

- **Behavioral Health**
  - Behavioral Health: Via telephone, electronically or written.
  - Behavioral Health: Via telephone, electronically or written.
  - Behavioral Health: Via telephone, electronically or written.
  - Behavioral Health: Via telephone, electronically or written.
  - Behavioral Health: Via telephone, electronically or written.
  - Behavioral Health: Via telephone, electronically or written.
  - Behavioral Health: Via telephone, electronically or written.
  - Behavioral Health: Via telephone, electronically or written.

### 3.7 - Summary of Responses to Bulletin 2013-06: Item #3

- **Medical**
  - Information transmitted via paper, fax or electronic means, transmitted via paper, fax, or electronic means.
  - Policies are available by request and will be transmitted via paper, fax, or electronic means.

- **Behavioral Health**
  - Information requested via telephone or fax.
  - Information requested via telephone or fax.
  - Information requested via telephone or fax.
  - Information requested via telephone or fax.
  - Information requested via telephone or fax.
  - Information requested via telephone or fax.
  - Information requested via telephone or fax.
  - Information requested via telephone or fax.

### 3.8 - Instructions for Communication

- **Medical**
  - Instructions given through provider website and online provider manual.
  - Instructions given through provider website and online provider manual.
  - Instructions given through provider website and online provider manual.
  - Instructions given through provider website and online provider manual.
  - Instructions given through provider website and online provider manual.
  - Instructions given through provider website and online provider manual.
  - Instructions given through provider website and online provider manual.
  - Instructions given through provider website and online provider manual.

- **Behavioral Health**
  - Instructions given through provider website and online provider manual.
  - Information transmitted via paper, fax, or electronic means.
  - Information transmitted via paper, fax, or electronic means.
  - Information transmitted via paper, fax, or electronic means.
  - Information transmitted via paper, fax, or electronic means.
  - Information transmitted via paper, fax, or electronic means.
  - Information transmitted via paper, fax, or electronic means.
  - Information transmitted via paper, fax, or electronic means.
  - Information transmitted via paper, fax, or electronic means.

- **ConnectiCare**
  - Information transmitted via paper, fax, or electronic means.
  - Information transmitted via paper, fax, or electronic means.
  - Information transmitted via paper, fax, or electronic means.
  - Information transmitted via paper, fax, or electronic means.
  - Information transmitted via paper, fax, or electronic means.
  - Information transmitted via paper, fax, or electronic means.
  - Information transmitted via paper, fax, or electronic means.
  - Information transmitted via paper, fax, or electronic means.

### 3.9 - Follow-up

- **Medical**
  - Follow-up requested that allows for a review of the information requested via telephone or fax.
  - Follow-up requested that allows for a review of the information requested via telephone or fax.
  - Follow-up requested that allows for a review of the information requested via telephone or fax.
  - Follow-up requested that allows for a review of the information requested via telephone or fax.
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  - Follow-up requested that allows for a review of the information requested via telephone or fax.
  - Follow-up requested that allows for a review of the information requested via telephone or fax.

### 3.10 - Written Bulletins

- **Medical**
  - Written bulletins, general provider orientations and written bulletins are available by request and will be transmitted via paper, fax, or electronic means.
  - Written bulletins, general provider orientations and written bulletins are available by request and will be transmitted via paper, fax, or electronic means.
  - Written bulletins, general provider orientations and written bulletins are available by request and will be transmitted via paper, fax, or electronic means.
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  - Written bulletins, general provider orientations and written bulletins are available by request and will be transmitted via paper, fax, or electronic means.

### 3.11 - Electronic Communications

- **Medical**
  - Electronic communications, including web-based, telephone, fax, and mail available through the secure provider web portal.
  - Electronic communications, including web-based, telephone, fax, and mail available through the secure provider web portal.
  - Electronic communications, including web-based, telephone, fax, and mail available through the secure provider web portal.
  - Electronic communications, including web-based, telephone, fax, and mail available through the secure provider web portal.
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  - Electronic communications, including web-based, telephone, fax, and mail available through the secure provider web portal.
  - Electronic communications, including web-based, telephone, fax, and mail available through the secure provider web portal.
  - Electronic communications, including web-based, telephone, fax, and mail available through the secure provider web portal.

### 3.12 - Other Information

- **Medical**
  - Information may call with additional information, but are asked to FAX additional clinical documentation in order to complete the UR process. The providers are asked to FAX additional clinical documentation in order to complete the UR process. The providers are asked to FAX additional clinical documentation in order to complete the UR process. The providers are asked to FAX additional clinical documentation in order to complete the UR process. The providers are asked to FAX additional clinical documentation in order to complete the UR process. The providers are asked to FAX additional clinical documentation in order to complete the UR process. The providers are asked to FAX additional clinical documentation in order to complete the UR process. The providers are asked to FAX additional clinical documentation in order to complete the UR process.
2015 Mental Health Parity and Addiction Equity Supplemental Response Letter

Summary of Response to Bulletin Number 2015-013: Item #3

<table>
<thead>
<tr>
<th>Company</th>
<th>Medical</th>
<th>Behavioral Health</th>
<th>3.1 - Person Responsible</th>
<th>3.2 - Different Type of Information Requested</th>
<th>3.3 - Methods of Communication for Authorization Requests</th>
<th>3.4 - Frequency of Training for Authorization Request Process</th>
<th>3.5 - Methods of Communication for Different Types of Information</th>
<th>3.6 - Instructions for Communication of Requested Information</th>
<th>3.7 - Different Type of Information Requested</th>
<th>3.8 - Instructions for Communication of Requested Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fallon Health &amp; Life Assurance Company</td>
<td>Medical: Fallon Health, Director of Medical Affairs; Behavioral Health: Fallon Health &amp; Life Assurance Company, Medical Director</td>
<td>Fallon Health &amp; Life Assurance Company, Medical and Behavioral Health: Fallon Health, Director of Medical Affairs; Fallon Health, Medical Director</td>
<td>Fallon Health: Integrated Care Manager of Utilization Review; Behavioral Health: Fallon Health &amp; Life Assurance Company, Medical Director</td>
<td>Medical: Fallon Health: SNF/Rehab Utilization Review Nurse/Specialist. Behavioral Health: Fallon Health &amp; Life Assurance Company, Medical Director.</td>
<td>Fallon Health: Medical: Via telephone or secure e-mail. Behavioral Health: Via telephone or secure e-mail.</td>
<td>Fallon Health: Medical: Via telephone or fax. Behavioral Health: Via telephone or fax.</td>
<td>Fallon Health: Medical: Via telephone, electronically, or by mail. Behavioral Health: Via telephone, electronically, or by mail.</td>
<td>Fallon Health: Medical: Via fax. Behavioral Health: Via telephone fax, or mail.</td>
<td>Fallon Health: Medical: SNF/Rehab Utilization Review Nurses/Specialists. Behavioral Health: Fallon Health &amp; Life Assurance Company, Medical Director.</td>
<td>Fallon Health: Medical: SNF/Rehab Utilization Review Nurses/Specialists. Behavioral Health: Fallon Health &amp; Life Assurance Company, Medical Director.</td>
</tr>
<tr>
<td>Health Net, Inc.</td>
<td>Medical: Fall Health &amp; Life Assurance Company, Behavioral Health: Fallon Health &amp; Life Assurance Company</td>
<td>Fallon Health &amp; Life Assurance Company, Medical and Behavioral Health: Fallon Health, Director of Medical Affairs; Fallon Health, Medical Director</td>
<td>Fallon Health: Integrated Case Manager of Utilization Management</td>
<td>Fallon Health &amp; Life Assurance Company, Medical Director</td>
<td>Fallon Health: Medical: Via telephone or secure e-mail. Behavioral Health: Via telephone or secure e-mail.</td>
<td>Fallon Health: Medical: Via telephone or fax. Behavioral Health: Via telephone or fax.</td>
<td>Fallon Health: Medical: Via telephone, electronically, or by mail. Behavioral Health: Via telephone, electronically, or by mail.</td>
<td>Fallon Health: Medical: Via fax. Behavioral Health: Via telephone fax, or mail.</td>
<td>Fallon Health: Medical: SNF/Rehab Utilization Review Nurse/Specialists. Behavioral Health: Fallon Health &amp; Life Assurance Company, Medical Director.</td>
<td>Fallon Health: Medical: SNF/Rehab Utilization Review Nurse/Specialists. Behavioral Health: Fallon Health &amp; Life Assurance Company, Medical Director.</td>
</tr>
<tr>
<td>Health Net, Inc.</td>
<td>Medical: Fall Health &amp; Life Assurance Company, Behavioral Health: Fallon Health &amp; Life Assurance Company</td>
<td>Fallon Health &amp; Life Assurance Company, Medical and Behavioral Health: Fallon Health, Director of Medical Affairs; Fallon Health, Medical Director</td>
<td>Fallon Health: Integrated Case Manager of Utilization Management</td>
<td>Fallon Health &amp; Life Assurance Company, Medical Director</td>
<td>Fallon Health: Medical: Via telephone or secure e-mail. Behavioral Health: Via telephone or secure e-mail.</td>
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<td>Fallon Health: Medical: Via telephone, electronically, or by mail. Behavioral Health: Via telephone, electronically, or by mail.</td>
<td>Fallon Health: Medical: Via fax. Behavioral Health: Via telephone fax, or mail.</td>
<td>Fallon Health: Medical: SNF/Rehab Utilization Review Nurse/Specialists. Behavioral Health: Fallon Health &amp; Life Assurance Company, Medical Director.</td>
<td>Fallon Health: Medical: SNF/Rehab Utilization Review Nurse/Specialists. Behavioral Health: Fallon Health &amp; Life Assurance Company, Medical Director.</td>
</tr>
</tbody>
</table>
### 3.2 - Average Number and Medical Expertise

<table>
<thead>
<tr>
<th>Company</th>
<th>Medical</th>
<th>Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tufts Health Plan</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>Minuteman Health</td>
<td>20</td>
<td>18</td>
</tr>
<tr>
<td>Health New England</td>
<td>18</td>
<td>16</td>
</tr>
</tbody>
</table>

**Reason this is acceptable:**
- Minuteman Health delegates medical and behavioral health management to Massachusetts’ licensed and NCQA accredited health plan, Health New England.
- The letter equals the sum of UM, Beneficiary Care Services, and Peer Panel.

### 3.3 - Number and Types of Staff Involved

<table>
<thead>
<tr>
<th>Company</th>
<th>Medical</th>
<th>Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minuteman Health</td>
<td>241 MD’s and DO’s; 1,917 RN’s 110 LPN/LVN’s</td>
<td>15 RN’s (5 with CCM), and Psychologist Clinical Reviewer, 0.25 FTE.</td>
</tr>
<tr>
<td>Health New England</td>
<td>18 FTE Registered Nurses; 1.5 FTE Physician Reviewers.</td>
<td>18 FTE Registered Nurses; 1.5 FTE Physician Reviewers.</td>
</tr>
<tr>
<td>Tufts Health Plan</td>
<td>1:77,000. MedSolutions, Inc.: 1:10,000. SMS: 1:50,000.</td>
<td>1:77,000. MedSolutions, Inc.: 1:10,000. SMS: 1:50,000.</td>
</tr>
</tbody>
</table>

**Reason for difference:**
- Different number of staff is due to different level and types of services.
- Different number of staff is due to different level and types of services.
- Different number of staff is due to different level and types of services.

### 3.4 - Instructions for Communications

<table>
<thead>
<tr>
<th>Company</th>
<th>Medical</th>
<th>Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tufts Health Plan</td>
<td>Via phone, fax and/or electronic communication.</td>
<td>Via phone, fax and/or electronic communication.</td>
</tr>
<tr>
<td>Minuteman Health</td>
<td>Via phone, fax and/or electronic communication.</td>
<td>Via phone, fax and/or electronic communication.</td>
</tr>
<tr>
<td>Health New England</td>
<td>Via phone, fax and/or electronic communication.</td>
<td>Via phone, fax and/or electronic communication.</td>
</tr>
</tbody>
</table>

**Reason for different:**
- Number of methods used for communication.
- Number of methods used for communication.
- Number of methods used for communication.

### 3.5 - Conclusion

- The Tufts Health Care System’s Provider Manual and the Health New England Provider Manual are available from 8:30AM to 5:00PM.
- For off-hours emergency, members can contact Beacon staff are available on weekends and on call during afterhours Monday through Thursday 5:30 PM - 8:30 AM and Friday and on call during afterhours Monday through Friday 5:30 AM - 5:30 AM.
- All admission and utilization decisions are made by a licensed clinician.
- The letter equals the sum of UM, Beneficiary Care Services, and Peer Panel.
<table>
<thead>
<tr>
<th>No.</th>
<th>Company Name</th>
<th>Medical and Behavioral Health:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Aetna Health, Inc.</td>
<td>Federal Parity Task Force, a cross-functional leadership group, consisting of about 50 members.</td>
</tr>
<tr>
<td>2</td>
<td>Aetna Health Insurance Company</td>
<td>Federal Parity Task Force, a cross-functional leadership group, consisting of about 50 members.</td>
</tr>
<tr>
<td>3</td>
<td>Aetna Life Insurance Company</td>
<td>Federal Parity Task Force, a cross-functional leadership group, consisting of about 50 members.</td>
</tr>
<tr>
<td>4</td>
<td>Blue Cross and Blue Shield of Massachusetts, Inc.</td>
<td>At least 36 people involved in the review of compliance with federal parity standards, with a combination of medical and behavioral health expertise.</td>
</tr>
<tr>
<td>5</td>
<td>Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.</td>
<td>At least 36 people involved in the review of compliance with federal parity standards, with a combination of medical and behavioral health expertise.</td>
</tr>
<tr>
<td>6</td>
<td>Boston Medical Center Health Plan, Inc.</td>
<td>Chief Medical Officer; Vice President of Quality and Clinical Program Oversight; Manager of Inpatient Utilization Management; Director of Utilization Management; Director of BH Programs; Compliance Officer; and Associate General Counsel. Behavioral Health: Beacon Vice President, Medical Affairs; Beacon Senior Vice President of Quality Management; Assistant Vice President of Quality; Beacon Assistant Vice President of Clinical; Beacon Senior Director of Utilization Management - Clinical; Beacon Vice President of Client Partnerships; Beacon Assistant Vice President of Network Operations.</td>
</tr>
<tr>
<td>No.</td>
<td>Company Name</td>
<td>Medical and Behavioral Health:</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>7</td>
<td>CeltiCare Health Plan of Massachusetts, Inc.</td>
<td>Chief Medical Officer, Medical Director of Behavioral Health, Vice President of Clinical Operations.</td>
</tr>
<tr>
<td>8</td>
<td>CIGNA Health and Life Insurance Company</td>
<td>Group of 15 people with a combination of medical and behavioral health expertise.</td>
</tr>
<tr>
<td>9</td>
<td>ConnectiCare of Massachusetts, Inc.</td>
<td>VP, Chief Medical Officer; Clinical Relationship Manager, Delegation; Clinical Compliance Manager; Senior VP, Health Care Management.</td>
</tr>
<tr>
<td>10</td>
<td>Fallon Community Health Plan, Inc.</td>
<td>Sr. Medical Director, Medical Affairs; Behavioral Health Director; Manager, Prior Authorization; Regulatory Affairs Director; Vice President, Regulatory Affairs and Compliance.</td>
</tr>
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<td></td>
<td></td>
<td><strong>Behavioral Health:</strong> Vice President of Quality Management; Director of Quality Management; Assistant Vice President of Clinical Operations; Senior Clinical Director, Utilization Review; Vice President, Medical Affairs; Director of Network Operations; State Program Director - MA; and Associate General Counsel.</td>
</tr>
<tr>
<td>11</td>
<td>Fallon Health &amp; Life Assurance Company</td>
<td>Sr. Medical Director, Medical Affairs; Behavioral Health Director; Manager, Prior Authorization; Regulatory Affairs Director; Vice President, Regulatory Affairs and Compliance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Behavioral Health:</strong> Vice President of Quality Management; Director of Quality Management; Assistant Vice President of Clinical Operations; Senior Clinical Director, Utilization Review; Vice President, Medical Affairs; Director of Network Operations; State Program Director - MA; and Associate General Counsel.</td>
</tr>
<tr>
<td>No.</td>
<td>Company Name</td>
<td>4.1 - Who Conducted Federal Parity Review?</td>
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<td>------------------------------------------</td>
</tr>
</tbody>
</table>
| 12  | Harvard Pilgrim Health Care, Inc. | **Medical:** Sr. Vice President Provider Network and Health Services (initial meetings, then kept apprised of project); Medical Director, Network Medical Management (is also a practicing psychiatrist); Director, Quality and Clinical Compliance; Sr. Vendor Relations Specialist in Health Services Administration, Associate General Counsel and Legislative Consultant.  
**Behavioral Health:** Optum’s Regional Vice President (who is a M.D.), the Clinical Operations Director, the Senior Director of Clinical Operations, the Vice President for Strategic Accounts, and the Strategic Account Executive. The Behavioral Policy & Analytic Committee conducted an analysis of the federal parity standards and the review of any differences with those standards. |
| 13  | Health New England, Inc.         | Medical and Behavioral Health: Vice President & General Counsel |
| 14  | HPHC Insurance Company, Inc.     | **Medical:** Sr. Vice President Provider Network and Health Services (initial meetings, then kept apprised of project); Medical Director, Network Medical Management (is also a practicing psychiatrist); Director, Quality and Clinical Compliance; Sr. Vendor Relations Specialist in Health Services Administration, Associate General Counsel and Legislative Consultant.  
**Behavioral Health:** Optum’s Regional Vice President (who is a M.D.), the Clinical Operations Director, the Senior Director of Clinical Operations, the Vice President for Strategic Accounts, and the Strategic Account Executive. The Behavioral Policy & Analytic Committee conducted an analysis of the federal parity standards and the review of any differences with those standards. |
<p>| 15  | Minuteman Health, Inc.           | Medical and Behavioral Health: For 2014, MHI engaged outside counsel. In addition, MHI's regulatory counsel reviews changes to relevant federal and MA laws. |
| 16  | Neighborhood Health Plan         | Medical and Behavioral Health: Vice President, Medical Affairs; Vice President, Clinical Operations; MA Medical Director; AVP, Clinical; various Directors and Senior Directors; Chief Actuary; Actuarial Analyst; Senior Clinical Analyst; Director of Regulatory Affairs and Compliance; Manager, Appeals and Grievances; and Assistant Legal Counsel. |</p>
<table>
<thead>
<tr>
<th>No.</th>
<th>Company Name</th>
<th>4.1 - Who Conducted Federal Parity Review?</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Network Health, LLC (now known as Tufts Health Public Plans, Inc.)</td>
<td>Medical and Behavioral Health: Regulatory Affairs Manager; Government Affairs Manager; Director of Behavioral Health; Director of Medical Management.</td>
</tr>
<tr>
<td>18</td>
<td>Tufts Associated Health Maintenance Organization, Inc.</td>
<td>Medical and Behavioral Health: Manager of Regulatory Licensing and Reporting; Associate General Counsel; and other Directors and Managers.</td>
</tr>
<tr>
<td>19</td>
<td>Tufts Insurance Company</td>
<td>Medical and Behavioral Health: Manager of Regulatory Licensing and Reporting; Associate General Counsel; and other Directors and Managers.</td>
</tr>
<tr>
<td>20</td>
<td>UniCare Life &amp; Health Insurance Company</td>
<td>Medical and Behavioral Health: Anthem uses a cross-functional team, including legal department. A similar cross-function team, including many of the same members, has been put together to implement the MHP regulations.</td>
</tr>
<tr>
<td>21</td>
<td>UnitedHealthcare Insurance Company</td>
<td>Medical and Behavioral Health: Optum's CMO, chair of Behavioral Policy &amp; Analytics Committee, leads the team that concludes the federal Mental Health Parity standards reviews.</td>
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<tr>
<td></td>
<td>No. of Requests Made (5a)</td>
<td>No. of Services Requested (5b)</td>
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<td>----------------------</td>
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<td>-------------------------------</td>
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<tr>
<td><strong>Medical</strong></td>
<td></td>
<td></td>
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<tr>
<td>Medical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Days</td>
<td>597,846</td>
<td>343,630</td>
</tr>
<tr>
<td>Outpatient Visits / Services</td>
<td>546,459</td>
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<tr>
<td>Total # of Services</td>
<td>1,141,133</td>
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<tr>
<td><strong>Behavioral Health</strong></td>
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<tr>
<td>Behavioral Health</td>
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<tr>
<td>Inpatient Days</td>
<td>148,930</td>
<td>95,361</td>
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<tr>
<td>Outpatient Visits / Services</td>
<td>4,164,646</td>
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<tr>
<td>Total # of Services</td>
<td>2,316,547</td>
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</table>

1Reported information is for all 2015 non-governmental insured coverage issued in Massachusetts for requests made and appeals heard during calendar year 2015.
2Information as reported by carriers in response to Bulletin 2013-06, Item 5, was submitted as part of annual mental health parity certifications required under 211 CMR 154.00.

The information is aggregated based on responses from the following carriers:

- Aetna Health Inc.
- Aetna Health Insurance Company
- Aetna Life Insurance Company
- Blue Cross and Blue Shield of Massachusetts, Inc.
- Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
- Boston Medical Center Health Plan, Inc.
- CeliCare Health Plan of Massachusetts, Inc.
- Fallon Community Health Plan, Inc.
- Fallon Health & Life Assurance Company, Inc.
- Harvard Pilgrim Health Care, Inc.
- HPHC Insurance Company, Inc.
- Health New England, Inc.
- Minuteman Health, Inc.
- Neighborhood Health Plan, Inc.
- Unicare Life & Health Insurance Company
- UnitedHealthcare Insurance Company
- Tufts Associated Health Maintenance Organization, Inc.
- Tufts Health Maintenance Organization, Inc.
- Tufts Health Public Plans, Inc.
- Unicare Life & Health Insurance Company
- UnitedHealthcare Insurance Company
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- Tufts Health Public Plans, Inc.
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<tr>
<th>No.</th>
<th>Company Name</th>
<th>Medical and Behavioral Health:</th>
<th>Medical and Behavioral Health:</th>
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<th>Medical and Behavioral Health:</th>
<th>Medical and Behavioral Health:</th>
<th>Medical and Behavioral Health:</th>
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<tbody>
<tr>
<td>1</td>
<td>Aetna Health, Inc.</td>
<td>Medical and Behavioral Health:</td>
<td>Reported information for plans issued or renewed in Massachusetts.</td>
<td>The information presented for report Item 5 does not include requests for prescription medications.</td>
<td>Medical and Behavioral Health: Entire inpatient stay = one request for inpatient service; any services for outpatient event = one request.</td>
<td>Medical and Behavioral Health: No differences in definition.</td>
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<tr>
<td>2</td>
<td>Aetna Health Insurance Company</td>
<td>Medical and Behavioral Health:</td>
<td>Reported information for plans issued or renewed in Massachusetts.</td>
<td>The information presented for report Item 5 does not include requests for prescription medications.</td>
<td>Medical and Behavioral Health: Entire inpatient stay = one request for inpatient service; any services for outpatient event = one request.</td>
<td>Medical and Behavioral Health: No differences in definition.</td>
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<tr>
<td>3</td>
<td>Aetna Life Insurance Company</td>
<td>Medical and Behavioral Health:</td>
<td>Reported information for plans issued or renewed in Massachusetts.</td>
<td>The information presented for report Item 5 does not include requests for prescription medications.</td>
<td>Medical and Behavioral Health: Entire inpatient stay = one request for inpatient service; any services for outpatient event = one request.</td>
<td>Medical and Behavioral Health: No differences in definition.</td>
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<td>4</td>
<td>Blue Cross and Blue Shield of Massachusetts, Inc.</td>
<td>Medical and Behavioral Health:</td>
<td>Reported information for plans issued or renewed in Massachusetts.</td>
<td>The information presented for report Item 5 does not include requests for prescription medications.</td>
<td>Medical and Behavioral Health: Unique authorizations requiring prior authorization other than prescription drugs.</td>
<td>Medical and Behavioral Health: No differences. Based on total requested length of stay measured in either inpatient days or outpatient visits.</td>
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<tr>
<td>5</td>
<td>Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.</td>
<td>Medical and Behavioral Health:</td>
<td>Reported information for plans issued or renewed in Massachusetts.</td>
<td>The information presented for report Item 5 does not include requests for prescription medications.</td>
<td>Medical and Behavioral Health: Unique authorizations requiring prior authorization other than prescription days.</td>
<td>Medical and Behavioral Health: No differences. Based on total requested length of stay measured in either inpatient days or outpatient visits.</td>
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<td>6</td>
<td>Boston Medical Center Health Plan, Inc.</td>
<td>Medical and Behavioral Health:</td>
<td>Reported information for plans issued or renewed in Massachusetts.</td>
<td>The information presented for report Item 5 does not include requests for prescription medications.</td>
<td>Medical and Behavioral Health: A submitted prior authorization request which contains enough information to allow carrier to respond to request.</td>
<td>Medical and Behavioral Health: Within inpatient, 1 unit = 1 day; within outpatient, 1 unit has multiple units depending on type of service requested.</td>
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<tr>
<td>No.</td>
<td>Company Name</td>
<td>Summation of Responses to Bulletin 2013-06: Item #5</td>
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<td>7</td>
<td>CitiCare Health Plan of Massachusetts, Inc.</td>
<td>5.3 - Confirm Massachusetts Lives Only&lt;br&gt;Medical and Behavioral Health: Reported information for plans issued or renewed in Massachusetts. 5.4 - Confirm Excludes Prescription Medications&lt;br&gt;Medical and Behavioral Health: The information presented for report Item 5 does not include requests for prescription medications. 5.5.a - Number of Requests for Authorization of Services Definition&lt;br&gt;Medical and Behavioral Health: Each individual service or procedure that requires prior authorization is counted as one request. When a request for services spans multiple dates of services, the entire block is counted as one service request. 5.5.b - Differences in Definition of Number of Services Requested&lt;br&gt;Medical and Behavioral Health: Imputed services measured on a number of days basis. The outpatient services are aggregated by service type over the requested date span as one service.</td>
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<td>8</td>
<td>Citgo NA Health and Life Insurance Company</td>
<td>5.2 - Confirm Fully Insured Only&lt;br&gt;Medical and Behavioral Health: Reported information for fully insured members only. 5.3 - Confirm Massachusetts Lives Only&lt;br&gt;Medical and Behavioral Health: Reported information for plans issued or renewed in Massachusetts. 5.4 - Confirm Excludes Prescription Medications&lt;br&gt;Medical and Behavioral Health: The information presented for report Item 5 does not include requests for prescription medications. Medical: Request for review of services for medical necessity. Behavioral Health: Request for specific treatment for authorization of coverage under enrolled member's benefits. 5.5.a - Number of Requests for Authorization of Services Definition&lt;br&gt;Medical and Behavioral Health: Each inpatient admission = 1 service. 5.5.b - Differences in Definition of Number of Services Requested&lt;br&gt;Medical and Behavioral Health: No differences in definition.</td>
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<td>9</td>
<td>Connecticare of Massachusetts, Inc.</td>
<td>5.2 - Confirm Fully Insured Only&lt;br&gt;Medical and Behavioral Health: Reported information for fully insured members only. 5.3 - Confirm Massachusetts Lives Only&lt;br&gt;Medical and Behavioral Health: Reported information for plans issued or renewed in Massachusetts. 5.4 - Confirm Excludes Prescription Medications&lt;br&gt;Medical and Behavioral Health: The information presented for report Item 5 does not include requests for prescription medications. Medical: Request for specific treatment for authorization of coverage under enrolled member's benefits. Behavioral Health: Request for pre-service reviews, concurrent reviews, and post-service (medical necessity) reviews. 5.5.a - Number of Requests for Authorization of Services Definition&lt;br&gt;Medical and Behavioral Health: The number of authorization requests both approved and denied. Behavioral Health: 1 service can have multiple units. 5.5.b - Differences in Definition of Number of Services Requested&lt;br&gt;Medical and Behavioral Health: No differences in definition.</td>
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<tr>
<td>10</td>
<td>Fallon Community Health Plan, Inc.</td>
<td>5.2 - Confirm Fully Insured Only&lt;br&gt;Medical and Behavioral Health: Reported information for fully insured members only. 5.3 - Confirm Massachusetts Lives Only&lt;br&gt;Medical and Behavioral Health: Reported information for plans issued or renewed in Massachusetts. 5.4 - Confirm Excludes Prescription Medications&lt;br&gt;Medical and Behavioral Health: The information presented for report Item 5 does not include requests for prescription medications. Medical: Request made by a provider for a service that requires prior approval by the plan and is reviewed against medical review criteria. Behavioral Health: 1 service can have multiple units. 5.5.a - Number of Requests for Authorization of Services Definition&lt;br&gt;Medical and Behavioral Health: The number of authorization requests both approved and denied. Behavioral Health: 1 service can have multiple units. 5.5.b - Differences in Definition of Number of Services Requested&lt;br&gt;Medical and Behavioral Health: No differences in definition.</td>
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<tr>
<td>11</td>
<td>Fallon Health &amp; Life Assurance Company</td>
<td>5.3 - Confirm Massachusetts Lives Only&lt;br&gt;Medical and Behavioral Health: Reported information for plans issued or renewed in Massachusetts. 5.4 - Confirm Excludes Prescription Medications&lt;br&gt;Medical and Behavioral Health: The information presented for report Item 5 does not include requests for prescription medications. Medical and Behavioral Health: Request made by a provider for a service that requires prior approval by the plan and is reviewed against medical review criteria. Behavioral Health: 1 service can have multiple units. 5.5.a - Number of Requests for Authorization of Services Definition&lt;br&gt;Medical and Behavioral Health: The number of authorization requests both approved and denied. Behavioral Health: 1 service can have multiple units. 5.5.b - Differences in Definition of Number of Services Requested&lt;br&gt;Medical and Behavioral Health: No differences in definition.</td>
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<td>12</td>
<td>Harvard Pilgrim Health Care, Inc.</td>
<td>5.3 - Confirm Massachusetts Lives Only&lt;br&gt;Medical and Behavioral Health: Reported information for plans issued or renewed in Massachusetts. 5.4 - Confirm Excludes Prescription Medications&lt;br&gt;Medical and Behavioral Health: The information presented for report Item 5 does not include requests for prescription medications. Medical and Behavioral Health: Request made by a provider for a service that requires prior approval by the plan and is reviewed against medical review criteria. Behavioral Health: 1 service can have multiple units. 5.5.a - Number of Requests for Authorization of Services Definition&lt;br&gt;Medical and Behavioral Health: No differences in definition.</td>
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<tr>
<td>13</td>
<td>Health New England, Inc.</td>
<td>5.2 - Confirm Fully Insured Only&lt;br&gt;Medical and Behavioral Health: Reported information for fully insured members only. 5.3 - Confirm Massachusetts Lives Only&lt;br&gt;Medical and Behavioral Health: Reported information for plans issued or renewed in Massachusetts. 5.4 - Confirm Excludes Prescription Medications&lt;br&gt;Medical and Behavioral Health: The information presented for report Item 5 does not include requests for prescription medications. Medical and Behavioral Health: Request made by a provider for a service that requires prior approval by the plan and is reviewed against medical review criteria. Behavioral Health: 1 service can have multiple units. 5.5.a - Number of Requests for Authorization of Services Definition&lt;br&gt;Medical and Behavioral Health: No differences in definition.</td>
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<td>14</td>
<td>HIPHC Insurance Company, Inc.</td>
<td>5.3 - Confirm Massachusetts Lives Only&lt;br&gt;Medical and Behavioral Health: Reported information for plans issued or renewed in Massachusetts. 5.4 - Confirm Excludes Prescription Medications&lt;br&gt;Medical and Behavioral Health: The information presented for report Item 5 does not include requests for prescription medications. Medical and Behavioral Health: Request made by a provider for a service that requires prior approval by the plan and is reviewed against medical review criteria. Behavioral Health: 1 service can have multiple units. 5.5.a - Number of Requests for Authorization of Services Definition&lt;br&gt;Medical and Behavioral Health: No differences in definition.</td>
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<tr>
<td>No.</td>
<td>Company Name</td>
<td>Medical and Behavioral Health: Reported information for fully insured members only.</td>
<td>Medical and Behavioral Health: Reported information for plans issued or renewed in Massachusetts.</td>
<td>Medical and Behavioral Health: The information presented for report Item 5 does not include requests for prescription medications.</td>
<td>Medical and Behavioral Health: Submission of prior authorization request form.</td>
<td>Medical and Behavioral Health: No differences given.</td>
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<td>15</td>
<td>Minuteman Health, Inc.</td>
<td>Medical and Behavioral Health: Reported information for fully insured members only.</td>
<td>Medical and Behavioral Health: Reported information for plans issued or renewed in Massachusetts.</td>
<td>Medical and Behavioral Health: The information presented for report Item 5 does not include requests for prescription medications.</td>
<td>Medical and Behavioral Health: No differences given.</td>
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<td>16</td>
<td>Neighborhood Health Plan</td>
<td>Medical and Behavioral Health: Reported information for fully insured members only.</td>
<td>Medical and Behavioral Health: Reported information for plans issued or renewed in Massachusetts.</td>
<td>Medical and Behavioral Health: The information presented for report Item 5 does not include requests for prescription medications.</td>
<td>Medical and Behavioral Health: Information included initial requests, modified requests, notifications and requests denied.</td>
<td>Medical: inpatient: 1 unit = 1 day. For other categories, the number of units can vary. Behavioral Health: 1 unit = 1 day. For other categories, the number of units can vary.</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Network Health, LLC (now known as Tufts Health Public Plans, Inc.)</td>
<td>Medical and Behavioral Health: Reported information for fully insured members only.</td>
<td>Medical and Behavioral Health: Reported information for plans issued or renewed in Massachusetts.</td>
<td>Medical and Behavioral Health: The information presented for report Item 5 does not include requests for prescription medications.</td>
<td>Medical and Behavioral Health: Receipt of a request by phone, fax or other electronic means.</td>
<td>Medical and Behavioral Health: No differences in definition.</td>
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<td>18</td>
<td>Tufts Associated Health Maintenance Organization, Inc.</td>
<td>Medical and Behavioral Health: Reported information for fully insured members only.</td>
<td>Medical and Behavioral Health: Reported information for plans issued or renewed in Massachusetts.</td>
<td>Medical and Behavioral Health: The information presented for report Item 5 does not include requests for prescription medications.</td>
<td>Medical and Behavioral Health: Count of valid request for services in which a decision was made.</td>
<td>Not applicable</td>
<td></td>
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<tr>
<td>19</td>
<td>Tufts Insurance Company</td>
<td>Medical and Behavioral Health: Reported information for fully insured members only.</td>
<td>Medical and Behavioral Health: Reported information for plans issued or renewed in Massachusetts.</td>
<td>Medical and Behavioral Health: The information presented for report Item 5 does not include requests for prescription medications.</td>
<td>Medical and Behavioral Health: Count of valid request for services in which a decision was made.</td>
<td>Not applicable</td>
<td></td>
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<td>20</td>
<td>UniCare Life &amp; Health Insurance Company</td>
<td>Medical and Behavioral Health: Reported information for fully insured members only.</td>
<td>Medical and Behavioral Health: Reported information for plans issued or renewed in Massachusetts.</td>
<td>Medical and Behavioral Health: The information presented for report Item 5 does not include requests for prescription medications.</td>
<td>Medical and Behavioral Health: Certain services require prior authorization. When notification is sent to the carrier it is considered a request for authorization.</td>
<td>Medical and Behavioral Health: Breakdown of service days requested between inpatient and outpatient.</td>
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<td>21</td>
<td>UnitedHealthcare Insurance Company</td>
<td>Medical and Behavioral Health: Reported information for Massachusetts fully insured members only.</td>
<td>Medical and Behavioral Health: Reported information for plans issued or renewed in Massachusetts.</td>
<td>Medical and Behavioral Health: The information presented for report Item 5 does not include requests for prescription medications.</td>
<td>Medical and Behavioral Health: Number presents the amount of requests received by UBH or OptumUBH for review of a benefit or review for coverage of a health service.</td>
<td>Medical and Behavioral Health: A request could be for more than 1 day of visit, the request is counted as 1 request for a day/days or a service/services.</td>
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<td>No.</td>
<td>Company Name</td>
<td>5.5.a - Definition of Number of Requests Authorised</td>
<td>5.5.d - Definition of Number of Requests Modified</td>
<td>5.5.e - Definition of Number of Requests Denied</td>
<td>5.5.f - Definition of Requests Denied or Modified Sent for Internal Review</td>
<td>5.5.g - Definition of Internally Appealed Requests Approved</td>
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<td>1</td>
<td>Aetna Health, Inc.</td>
<td>Medical and Behavioral Health: Authorization is approval of all services requested.</td>
<td>Medical and Behavioral Health: Modification is a denial of service or level of care, but alternative service or less intensive level of care is authorized.</td>
<td>Medical and Behavioral Health: Denial is full or partial denial of the service or level of care requested.</td>
<td>Medical and Behavioral Health: A denial or written request to change initial determination decision.</td>
<td>Medical and Behavioral Health: A reversal of the initial determination or subsequent appeal determination.</td>
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<td>2</td>
<td>Aetna Health Insurance Company</td>
<td>Medical and Behavioral Health: Authorization is approval of all services requested.</td>
<td>Medical and Behavioral Health: Modification is a denial of service or level of care, but alternative service or less intensive level of care is authorized.</td>
<td>Medical and Behavioral Health: Denial is full or partial denial of the service or level of care requested.</td>
<td>Medical and Behavioral Health: A denial or written request to change initial determination decision.</td>
<td>Medical and Behavioral Health: A reversal of the initial determination or subsequent appeal determination.</td>
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<td>3</td>
<td>Aetna Life Insurance Company</td>
<td>Medical and Behavioral Health: Authorization is approval of all services requested.</td>
<td>Medical and Behavioral Health: Modification is a denial of service or level of care, but alternative service or less intensive level of care is authorized.</td>
<td>Medical and Behavioral Health: Denial is full or partial denial of the service or level of care requested.</td>
<td>Medical and Behavioral Health: A denial or written request to change initial determination decision.</td>
<td>Medical and Behavioral Health: A reversal of the initial determination or subsequent appeal determination.</td>
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<td>4</td>
<td>Blue Cross and Blue Shield of Massachusetts, Inc.</td>
<td>Medical and Behavioral Health: Those requests that have been approved for both medical surgical and mental health/substance use disorder services.</td>
<td>Medical: Partial denials and diversions to lower level of care. Behavioral Health: Partial denials. Modified mental health/substance use service requests processed through clinical peer review not lower level of care.</td>
<td>Medical and Behavioral Health: Requests that are given final denial.</td>
<td>Medical and Behavioral Health: A reversal of the initial determination or subsequent appeal determination.</td>
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<td>5</td>
<td>Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.</td>
<td>Medical and Behavioral Health: Those requests that have been approved for both medical surgical and mental health/substance use disorder services.</td>
<td>Medical: partial denials and diversions to lower level of care. Behavioral Health: partial denials. Modified mental health/substance use service requests processed through clinical peer review not lower level of care.</td>
<td>Medical and Behavioral Health: Requests that are given final denial.</td>
<td>Medical and Behavioral Health: Appeals that have been overturned internally due to additional clinical information. Does not include partially upheld appeals.</td>
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<td>6</td>
<td>Boston Medical Center Health Plan, Inc.</td>
<td>Medical and Behavioral Health: Number of requests authorized is when at completion of authorization request review, medical necessity criteria was met, and approval letter was issued.</td>
<td>Medical and Behavioral Health: Modification is a reduction in the number of visits or units that both parties agree is sufficient to meet the medical needs of the member.</td>
<td>Medical and Behavioral Health: A denial is when after completion of authorization request review, medical necessity criteria is not met and an adverse determination letter is issued to member.</td>
<td>Medical and Behavioral Health: The internal appeal is considered approved if a Plan physician reviews overcomes the initial Adverse Determination.</td>
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<tr>
<td>No.</td>
<td>Company Name</td>
<td>5.5.a - Definition of Number of Requests Authorized</td>
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<td>1</td>
<td>CIGNA Health and Life Insurance Company</td>
<td>Medical and Behavioral Health: Request determined to be authorized when all services requested which require prior authorization or medical necessity review have been approved. No difference in definition.</td>
<td>Medical and Behavioral Health: The modified services are those in which only some, but not all, of the requested amount of services are approved, and the remainder is denied. No difference in definition.</td>
<td>Medical and Behavioral Health: The denied services are requests where all of the services requested are denied. No difference in definition.</td>
<td>Medical and Behavioral Health: The appeals are approved when the requested appealed services are approved in whole or in part. No difference in definition.</td>
<td>Medical and Behavioral Health: The appeals are approved when the requested appealed services are approved in whole or in part. No difference in definition.</td>
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<td>2</td>
<td>Fallon Community Health Plan, Inc.</td>
<td>Medical: Service has been approved. Behavioral Health: Approval of a request for services that requires prior approval.</td>
<td>Medical: Approval of a request for services that has not been approved and has not been modified.</td>
<td>Medical: Approval of a request for services that has not been approved and has not been modified.</td>
<td>Medical: Approval of a request for services that has not been approved and has not been modified.</td>
<td>Medical: Approval of a request for services that has not been approved and has not been modified.</td>
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<tr>
<td>3</td>
<td>Fallon Health &amp; Life Assurance Company</td>
<td>Medical and Behavioral Health: Request has been authorized when it has been approved. Partial of modified requests not included in authorizations.</td>
<td>Medical and Behavioral Health: Authorization for services for fewer units than requested. Does not include when different level of care is authorized.</td>
<td>Medical and Behavioral Health: Approval of a request for services that requires prior approval that was either partially approved or denied, or modified to a lower level of care while still meeting member's needs, or reduced from original number of visit requests.</td>
<td>Medical and Behavioral Health: Approval of a request for services that has not been approved or denied, or modified to a lower level of care while still meeting member's needs, or reduced from original number of visit requests.</td>
<td>Medical and Behavioral Health: Approval of a request for services that has not been approved or denied, or modified to a lower level of care while still meeting member's needs, or reduced from original number of visit requests.</td>
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<tr>
<td>4</td>
<td>Harvard Pilgrim Health Care, Inc.</td>
<td>Medical and Behavioral Health: Approval of a request for services that requires prior approval.</td>
<td>Medical and Behavioral Health: A request that requires prior approval that was either partially approved or denied, or modified to a lower level of care while still meeting member's needs, or reduced from original number of visit requests.</td>
<td>Medical and Behavioral Health: The denial of authorization or payment or UM physician ends coverage because Medical Review Criteria have not been met.</td>
<td>Medical and Behavioral Health: The denial of request for coverage is denied. Appeal may be sent to either Behavioral Health Access Center in the case of mental health/substance use requests and forwarded to Harvard Pilgrim, and directly to Harvard Pilgrim for medical/surgical requests.</td>
<td>Medical and Behavioral Health: Approval of a request for services that has not been approved or denied, or modified to a lower level of care while still meeting member's needs, or reduced from original number of visit requests.</td>
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<td>5</td>
<td>Health New England, Inc.</td>
<td>Medical and Behavioral Health: Approval of a request without modification.</td>
<td>Medical and Behavioral Health: A modification of the request, such as approval of service, but not for amount or frequency of care authorized.</td>
<td>Medical and Behavioral Health: A denial is not approved because it did not meet the Medical Review Criteria.</td>
<td>Medical and Behavioral Health: Approval of a request for services that was either denied or modified and was sent internally for appeal.</td>
<td>Medical and Behavioral Health: Approval of a request for services that was either denied or modified and was sent internally for appeal.</td>
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<td>6</td>
<td>HIPPI Health Company, Inc.</td>
<td>Medical and Behavioral Health: Approval of a request for services that requires prior approval.</td>
<td>Medical and Behavioral Health: A request that requires prior approval that was either partially approved or denied, or modified to a lower level of care while still meeting member's needs, or reduced from original number of visit requests.</td>
<td>Medical and Behavioral Health: The denial of authorization or payment or UM physician ends coverage because Medical Review Criteria have not been met.</td>
<td>Medical and Behavioral Health: Internal appeal may be filed when request for coverage is denied. Appeal may be sent to either Behavioral Health Access Center in the case of mental health/substance use requests and forwarded to Harvard Pilgrim, and directly to Harvard Pilgrim for medical/surgical requests.</td>
<td>Medical and Behavioral Health: Approval of a request for services that was either denied or modified and was sent internally for appeal.</td>
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<td>No.</td>
<td>Company Name</td>
<td>5.5.a - Definition of Number of Requests Authorized</td>
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<td>5.5.e - Definition of Number of Requests Denied</td>
<td>5.5.f - Definition of Requests Denied or Modified Sent for Internal Review</td>
<td>5.5.g - Definition of Internally Apposed Requests Approved</td>
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<td>15</td>
<td>Minuteman Health, Inc.</td>
<td>Medical and Behavioral Health: Approval of request without modification.</td>
<td>Medical and Behavioral Health: A modification of the request, such as approval of service, but not for amount or frequency requested.</td>
<td>Medical and Behavioral Health: A denial is when the company did not approve any of the services as requested.</td>
<td>Medical and Behavioral Health: A request for service that was either denied or modified and was sent internally for appeal.</td>
<td>Medical and Behavioral Health: When all requested services have been reviewed in full, with no reduction in the amount or frequency of services that were requested.</td>
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<td>16</td>
<td>Neighborhood Health Plan</td>
<td>Medical: Requests authorized are initial and modified requests approved and may include services requests that resulted in partial approval. Partially approved requests would then be counted under the number of requests authorized and the number denied. Behavioral Health: Requests authorized are initial and modified requests approved.</td>
<td>Medical: Only modified approved requests. A subsequent/concurrent request resulting in a denial is not included. A subsequent/concurrent request resulting in a denial is included in &quot;requests denied&quot;. Behavioral Health: Adverse Determination/Modifications where lesser units are authorized than requested. Does not include instances where a different level of care is authorized than requested, which are counted under denials, and then authorizations.</td>
<td>Medical and Behavioral Health: Requests denied include denial determinations made as the result of a medical necessity review and denial determinations based on administrative reasons. Partial denials are also included.</td>
<td>Medical: Withdrawn appeals are not accounted for in this total. Behavioral Health: Withdrawn appeals are not accounted for in this total. Appeals are inclusive of denials and modifications.</td>
<td>Medical and Behavioral Health: Requests in which, after further investigation by a different reviewer of the initial denial upon a member’s appeal, it is determined that initial denial decision should be reversed and approved in favor of the member.</td>
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<td>17</td>
<td>Network Health, LLC (now known as Tufts Health Public Plans, Inc.)</td>
<td>Medical and Behavioral Health: Tufts Health Plan - Network Health defines an authorized request as a request that has been reviewed and met medical necessity for that service.</td>
<td>Medical and Behavioral Health: Tufts Health Plan - Network Health defines a modified request as an approval of services that are less than the requested service.</td>
<td>Medical and Behavioral Health: Tufts Health Plan - Network Health defines that a request has been denied when it has been reviewed by a medical director and determined to not meet medical necessity.</td>
<td>Medical and Behavioral Health: Tufts Health Plan - Network Health defines that a request has been denied and sent for review through the internal appeals process when there is an adverse determination and a member or provider expresses that they believe that the denied service is medically necessary.</td>
<td>Medical and Behavioral Health: Tufts Health Plan - Network Health defines that an internal appeal request has been approved when the original denial of services is overturned, because the services are determined to be medically necessary.</td>
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<td>18</td>
<td>Tufts Associated Health Maintenance Organization, Inc.</td>
<td>Medical and Behavioral Health: Of those services counted in 5.5.a, the number authorized.</td>
<td>Medical and Behavioral Health: Of those services counted in 5.5.a, the number denied.</td>
<td>Medical and Behavioral Health: Of those services counted in 5.5.a, the number denied.</td>
<td>Medical and Behavioral Health: Internal member appeal of a Utilization Management decision.</td>
<td>Medical and Behavioral Health: Off those counted as 5.5.f, the number of initial denials in which the appeal decision was to overturn or partially pay.</td>
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<td>19</td>
<td>Tufts Insurance Company</td>
<td>Medical and Behavioral Health: Of those services counted in 5.5.a, the number authorized.</td>
<td>Medical and Behavioral Health: Of those services counted in 5.5.a, the number denied.</td>
<td>Medical and Behavioral Health: Of those services counted in 5.5.a, the number denied.</td>
<td>Medical and Behavioral Health: Internal member appeal of a Utilization Management decision.</td>
<td>Medical and Behavioral Health: Off those counted as 5.5.f, the number of initial denials in which the appeal decision was to overturn or partially pay.</td>
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<td>20</td>
<td>UniCare Life &amp; Health Insurance Company</td>
<td>Medical and Behavioral Health: Request has been authorized once utilization review department has reviewed clinical information from provider and determined that request meets requirements for coverage.</td>
<td>Medical and Behavioral Health: Modification is an initial denial, but during reconsideration, some of requested services are approved.</td>
<td>Medical and Behavioral Health: Upon review, the request for service does not meet the criteria for coverage.</td>
<td>Medical and Behavioral Health: Internal appeal is considered an initial or first appeal upon review of services that were initially denied or modified.</td>
<td>Medical and Behavioral Health: Appropriate consideration of request, clinical information, and medical necessity criteria received to support internal appeal and determine if coverage can be approved based on clinical guidelines.</td>
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<td>21</td>
<td>UnitedHealthCare Insurance Company</td>
<td>Medical and Behavioral Health: The number represents the amount of decisions to cover the health care service, meaning the health care service was authorized.</td>
<td>Medical and Behavioral Health: Not applicable.</td>
<td>Medical and Behavioral Health: Number represents the amount of reviews performed that result in adverse decision (modification, reduction, or denial of a health care service based on failure to meet the medical necessity criteria). Non-coverage determinations are those denials that are based on policy terms such as eligibility, non-payment of premiums, etc.</td>
<td>Medical and Behavioral Health: Number represents the amount of requests for clinical review that were requested, which are counted under denials, and then authorizations.</td>
<td>Medical and Behavioral Health: The number represents the amount of approvals resulting from a request for review of an adverse decision.</td>
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<td>No.</td>
<td>Company Name</td>
<td>5.5.h - Definition of Internally Appealed Requests Denied</td>
<td>5.5.i - Definition of Internally Appealed Requests Sent for External Appeal</td>
<td>5.5.j - Definition of External Appeals Overturned</td>
<td>5.5.k - Definition of External Appeals Upheld</td>
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<td>1</td>
<td>Aetna Health, Inc.</td>
<td>Medical and Behavioral Health: An internal appeal denial can be a partial denial or a full denial of the original request.</td>
<td>Medical and Behavioral Health: A consumer external appeal of partial or full denial of the appeal determination.</td>
<td>Medical and Behavioral Health: A decision by external reviewer to overturn the initial internal appeal decision.</td>
<td>Medical and Behavioral Health: A decision by external review to agree with the initial internal appeal decision.</td>
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<td>2</td>
<td>Aetna Health Insurance Company</td>
<td>Medical and Behavioral Health: An internal appeal denial can be a partial denial or a full denial of the original request.</td>
<td>Medical and Behavioral Health: A consumer external appeal of partial or full denial of the appeal determination.</td>
<td>Medical and Behavioral Health: A decision by external reviewer to overturn the initial internal appeal decision.</td>
<td>Medical and Behavioral Health: A decision by external review to agree with the initial internal appeal decision.</td>
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<td>3</td>
<td>Aetna Life Insurance Company</td>
<td>Medical and Behavioral Health: An internal appeal denial can be a partial denial or a full denial of the original request.</td>
<td>Medical and Behavioral Health: A consumer external appeal of partial or full denial of the appeal determination.</td>
<td>Medical and Behavioral Health: A decision by external reviewer to overturn the initial internal appeal decision.</td>
<td>Medical and Behavioral Health: A decision by external review to agree with the initial internal appeal decision.</td>
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<td>4</td>
<td>Blue Cross and Blue Shield of Massachusetts, Inc.</td>
<td>Medical and Behavioral Health: Upheld denial of appeals.</td>
<td>Medical and Behavioral Health: Member appeals sent for external review.</td>
<td>Medical and Behavioral Health: Member appeals that are overturned by an external third party organization.</td>
<td>Medical and Behavioral Health: All upheld appeals, fully upheld appeals, and partially upheld appeals.</td>
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<td>5</td>
<td>Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.</td>
<td>Medical and Behavioral Health: Upheld denial of appeals.</td>
<td>Medical and Behavioral Health: Member appeals sent for external review.</td>
<td>Medical and Behavioral Health: Member appeals that are overturned by an external third party organization.</td>
<td>Medical and Behavioral Health: All upheld appeals, fully upheld appeals, and partially upheld appeals.</td>
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<td>6</td>
<td>Boston Medical Center Health Plan, Inc.</td>
<td>Medical and Behavioral Health: If after review of all information a Plan physician reviewer upholds the initial denial, the appeal is considered denied.</td>
<td>Medical and Behavioral Health: If the initial decision to deny services is upheld after internal review process, the member is notified of option to request an external appeal through the Office of Patient Protection.</td>
<td>Medical and Behavioral Health: When an external review agency approves, in part or in whole, the services initially requested which had been denied.</td>
<td>Medical and Behavioral Health: When an external review agency upholds, in whole, the initial decision to deny the services requested.</td>
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<td>No.</td>
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<td>5.5.j - Definition of External Appeals Overturned</td>
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<td>1</td>
<td>CitiCare Health Plan of Massachusetts, Inc.</td>
<td>Medical and Behavioral Health: The appeals are counted as denied when all appealed services are denied. No difference in definition.</td>
<td>Medical and Behavioral Health: Internally appealed requests sent for external appeal once the member has requested an external appeal. No difference in definition.</td>
<td>Medical and Behavioral Health: The external appeals are overturned when the requested appealed services are overturned by the external appeal body in whole or in part. No difference in definition.</td>
<td>Medical and Behavioral Health: The external appeals are upheld when all appealed services are upheld. No difference in definition.</td>
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<td>2</td>
<td>CIGNA Health and Life Insurance Company</td>
<td>Medical and Behavioral Health: Review by external review panel of internal appeal that was denied in whole or in part.</td>
<td>Medical and Behavioral Health: Review by external review panel of internal appeal that was denied in whole or in part.</td>
<td>Medical and Behavioral Health: External appeals that the external review panel overturns or partially overturns.</td>
<td>Medical and Behavioral Health: External appeals that the external review panel does not partially or fully overturn.</td>
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<td>3</td>
<td>Connecticare of Massachusetts, Inc.</td>
<td>Medical and Behavioral Health: Determinations made through the internal appeals process to uphold the original decision.</td>
<td>Medical and Behavioral Health: External appeal has been assigned by the Office of Patient Protection to an external review agency.</td>
<td>Medical and Behavioral Health: An externally appealed adverse determination has been overturned when the external review agency makes the decision to reverse Connecticare’s adverse determination.</td>
<td>Medical and Behavioral Health: An externally appealed adverse determination has been upheld when the external review agency makes the decision to affirm Connecticare’s adverse determination.</td>
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<td>4</td>
<td>Fallon Community Health Plan, Inc.</td>
<td>Medical and Behavioral Health: Reverser upholds initial decision of adverse determination.</td>
<td>Medical and Behavioral Health: Reverser upholds initial decision of adverse determination.</td>
<td>Medical and Behavioral Health: Reverser upholds initial decision of adverse determination.</td>
<td>Medical and Behavioral Health: Reverser upholds initial decision of adverse determination.</td>
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<tr>
<td>5</td>
<td>Fallon Health &amp; Life Assurance Company</td>
<td>Medical and Behavioral Health: external appeal is a request from member to have HPC’s OPP review the initial requests denial after internal appeal.</td>
<td>Medical and Behavioral Health: external appeal is a request from member to have HPC’s OPP review the initial requests denial after internal appeal.</td>
<td>Medical and Behavioral Health: external appeal is a request from member to have HPC’s OPP review the initial requests denial after internal appeal.</td>
<td>Medical and Behavioral Health: external appeal is a request from member to have HPC’s OPP review the initial requests denial after internal appeal.</td>
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<td>6</td>
<td>Harvard Pilgrim Health Care, Inc.</td>
<td>Medical and Behavioral Health: Denial of internal appeal has taken place when Harvard Pilgrim sends letter to member in writing informing member of the decision of the appeal after investigation and review of appeal.</td>
<td>Medical and Behavioral Health: Denial of internal appeal has taken place when Harvard Pilgrim sends letter to member in writing informing member of the decision of the appeal after investigation and review of appeal.</td>
<td>Medical and Behavioral Health: Denial of internal appeal has taken place when Harvard Pilgrim sends letter to member in writing informing member of the decision of the appeal after investigation and review of appeal.</td>
<td>Medical and Behavioral Health: Denial of internal appeal has taken place when Harvard Pilgrim sends letter to member in writing informing member of the decision of the appeal after investigation and review of appeal.</td>
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<td>7</td>
<td>Health New England, Inc.</td>
<td>Medical and Behavioral Health: Upheld original decision.</td>
<td>Medical and Behavioral Health: Upheld original decision.</td>
<td>Medical and Behavioral Health: Upheld original decision.</td>
<td>Medical and Behavioral Health: Upheld original decision.</td>
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<td>8</td>
<td>HIPHC Insurance Company, Inc.</td>
<td>Medical and Behavioral Health: Denial of internal appeal has taken place when Harvard Pilgrim sends letter to member in writing informing member of the decision of the appeal after investigation and review of appeal.</td>
<td>Medical and Behavioral Health: Denial of internal appeal has taken place when Harvard Pilgrim sends letter to member in writing informing member of the decision of the appeal after investigation and review of appeal.</td>
<td>Medical and Behavioral Health: Denial of internal appeal has taken place when Harvard Pilgrim sends letter to member in writing informing member of the decision of the appeal after investigation and review of appeal.</td>
<td>Medical and Behavioral Health: Denial of internal appeal has taken place when Harvard Pilgrim sends letter to member in writing informing member of the decision of the appeal after investigation and review of appeal.</td>
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<td>15</td>
<td>Minuteman Health, Inc.</td>
<td>Medical and Behavioral Health: Upheld original decision.</td>
<td>Medical and Behavioral Health: Upheld original decision and member exercised external appeal rights.</td>
<td>Medical and Behavioral Health: External appeal where original decision is overturned, allowing member to receive original service or item requested.</td>
<td>Medical and Behavioral Health: External appeal where original decision upheld, leaving decision to deny service or item requested intact.</td>
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<td>16</td>
<td>Neighborhood Health Plan</td>
<td>Medical and Behavioral Health: Requests in which, after further investigation by a different reviewer of the initial denial upon a member’s appeal, it is determined that the initial denial should remain.</td>
<td>Medical and Behavioral Health: Requests in which a member’s appeal was upheld and the member exercised their right to have the decision reviewed by an external entity.</td>
<td>Medical and Behavioral Health: Requests in which, after further review of the member’s appeal, it is determined by the external entity that the upheld denial decision should be reversed and approved in favor of the member.</td>
<td>Medical and Behavioral Health: Requests in which, after further review of the member’s appeal, it is determined by the external entity that the upheld denial should remain.</td>
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<td>17</td>
<td>Network Health, L.L.C. (now known as Tufts Health Public Plans, Inc.)</td>
<td>Medical and Behavioral Health: Tufts Health Plan - Network Health defines that an internal appeal request has been denied when after a medical director has reviewed the appeal and decided that the original denial was upheld.</td>
<td>Medical and Behavioral Health: Tufts Health Plan - Network Health defines that an appeal has been denied and been sent by the consumer to external appeals when a request is received from the Office of Patient Protection that a member is requesting an external appeal and that additional information is be be provided on the original denial.</td>
<td>Medical and Behavioral Health: Tufts Health Plan - Network Health defines that an externally appealed adverse determination has been upheld when notice is received from the external review agency to overturn the decision.</td>
<td>Medical and Behavioral Health: Tufts Health Plan - Network Health defines that an externally appealed adverse determination has been upheld when notice is received from the external review agency that the member’s denial has been upheld.</td>
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<td>18</td>
<td>Tufts Associated Health Maintenance Organization, Inc.</td>
<td>Medical and Behavioral Health: Of those counted in 5.5.f., the number of initial denials upheld.</td>
<td>Medical and Behavioral Health: Counts of external member appeals of a Utilization Management decision.</td>
<td>Medical and Behavioral Health: Counts of external member appeals in which the decision was to overturn or partially pay.</td>
<td>Medical and Behavioral Health: Counts from external appeals in which the decision was to uphold.</td>
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<td>19</td>
<td>Tufts Insurance Company</td>
<td>Medical and Behavioral Health: Of those counted in 5.5.f., the number of initial denials upheld.</td>
<td>Medical and Behavioral Health: Counts of external member appeals of a Utilization Management decision.</td>
<td>Medical and Behavioral Health: Counts of external member appeals in which the decision was to overturn or partially pay.</td>
<td>Medical and Behavioral Health: Counts from external appeals in which the decision was to uphold.</td>
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<td>20</td>
<td>UniCare Life &amp; Health Insurance Company</td>
<td>Medical and Behavioral Health: Appropriate clinical specialist clinical information received to support internal appeal and determine if coverage can be changed based on carrier guidelines.</td>
<td>Medical and Behavioral Health: External appeal is a request from member to have HPC’s OPP review the initial requests denial after internal appeal.</td>
<td>Medical and Behavioral Health: When HPC’s OPP overturns the initial decision to deny or modify the authorization for services.</td>
<td>Medical and Behavioral Health: When HPC’s OPP confirms or upholds the initial decision to deny or modify the authorization for services.</td>
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<td>21</td>
<td>UnitedHealthcare Insurance Company</td>
<td>Medical: UHC Indicated 17 internal appeals denied. Medical and Behavioral Health: The number represents the amount of appeals of an adverse decision that were denied or portion of health care service denied.</td>
<td>Medical and Behavioral Health: When Office of Patient Protection submits notice of an external review of an adverse decision.</td>
<td>Medical and Behavioral Health: External appeal overturned decisions are those that those external review overturns the health care service that was denied by UHC or OptumUBH.</td>
<td>Medical and Behavioral Health: External appeal upheld decisions are those that external reviewer continues to deny the health care service that was denied by UHC or Optum/UBH.</td>
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<td>No.</td>
<td>Company Name</td>
<td>6.1 - Out of Network Authorizations - Who is Responsible?</td>
<td>6.2 - Methods Used for Out of Network Requests</td>
<td>6.3 - Differences in Information Requested for Out of Network Requests</td>
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<td>1</td>
<td>Aetna Health, Inc.,</td>
<td>Medical and Behavioral Health: Northeast Regional Medical Director</td>
<td>Medical and Behavioral Health: Electronic Data Interchange (secure online provider portal); mail; telephone; fax.</td>
<td>Medical and Behavioral Health: Aetna asks what services are being requested and why provider believes why not reasonably available in-network.</td>
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<td>Aetna Health Insurance Company</td>
<td>Medical and Behavioral Health: Northeast Regional Medical Director</td>
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<td>Aetna Life Insurance Company</td>
<td>Medical and Behavioral Health: Northeast Regional Medical Director</td>
<td>Medical and Behavioral Health: Electronic Data Interchange (secure online provider portal); mail; telephone; fax.</td>
<td>Medical and Behavioral Health: Aetna asks what services are being requested and why provider believes why not reasonably available in-network.</td>
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<td>4</td>
<td>Blue Cross and Blue Shield of Massachusetts, Inc.</td>
<td>Medical: Medical Director for Utilization and Case Management. Behavioral Health: Medical Director for Behavioral Health. Reason for difference: Difference is because process goes through different departments each comprised of clinicians with the appropriate expertise required to make appropriate medical necessity determinations. The processes are comparable and both Medical Directors report to Associate Chief Medical Officer.</td>
<td>Medical and Behavioral Health: Faxed or mailed standardized out of network services request form.</td>
<td>Medical and Behavioral Health: Out of network service requests are approved when 1) urgent need of care; 2) service otherwise not available in network; 3) transition of care after enrolling from other plan.</td>
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<td>5</td>
<td>Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.</td>
<td>Medical: Medical Director for Utilization and Case Management. Behavioral Health: Medical Director for Behavioral Health. Reason for difference: Difference is because process goes through different departments each comprised of clinicians with the appropriate expertise required to make appropriate medical necessity determinations. The processes are comparable and both Medical Directors report to Associate Chief Medical Officer.</td>
<td>Medical and Behavioral Health: Faxed or mailed standardized out of network services request form.</td>
<td>Medical and Behavioral Health: Out of network service requests are approved when 1) urgent need of care; 2) service otherwise not available in network; 3) transition of care after enrolling from other plan.</td>
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<td>6</td>
<td>Boston Medical Center Health Plan, Inc.</td>
<td>Medical: BMCCHP Chief Medical Officer; medical directors; Vice President of Quality and Medical Management; and Director of Utilization Management oversee authorization for out-of-network requests for service. Behavioral Health: Beacon's Vice President of Medical Affairs, medical directors; and clinicians. Reason for difference: Although they are in different entities with different titles, they are respective counterparts.</td>
<td>Medical and Behavioral Health: Requests for coverage via fax or phone.</td>
<td>Medical: demographic information, requested service/procedure, member diagnosis, and others. Behavioral health: Minimum amount necessary to make decision from: current symptomatology, current and prior agency involvement, current and prior treatment history, medical history and individual needs, substance use history and others. Reason for difference: There are differences based on individual needs. Outcome need not be the same, but the process is the same.</td>
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<td>7</td>
<td>CeltiCare Health Plan of Massachusetts, Inc.</td>
<td>Medical and Behavioral Health: Chief Medical Officer</td>
<td>Medical and Behavioral Health: The system that non-participating providers can access are all of the same systems as participating providers to request authorization: Toll-free line, Fax, secure web portal, mail.</td>
<td>Medical and Behavioral Health: There is no difference in the information requested</td>
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<td>8</td>
<td>CIGNA Health and Life Insurance Company</td>
<td>Medical and Behavioral Health: OON treated the same way as in-network. Therefore, the same people are responsible.</td>
<td>Medical and Behavioral Health: OON treated the same way as in-network. Therefore, the same methods are used.</td>
<td>Medical and Behavioral Health: The information requested is the same for medical and mental health services. OON is treated the same way as in-network services.</td>
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<td>9</td>
<td>ConnectiCare of Massachusetts, Inc.</td>
<td>Medical: Overseen by Senior Vice President of Healthcare Management in conjunction with Vice President, Chief Medical Officer, Director of Utilization Management, and Clinical Compliance Manager. Behavioral Health: Overseen by the Senior Vice President of Operations in conjunction with various Vice Presidents of other departments.</td>
<td>Medical: Phone, fax or mail. Behavioral Health: Phone, fax or mail.</td>
<td>Depending on type of service requested, information such as presence of suicidal/homicidal ideation, substance use history, and mental status.</td>
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<td>10</td>
<td>Fallon Community Health Plan, Inc.</td>
<td>Medical: Chief Medical Officer and Associate Medical Directors. Behavioral Health: Beacon's Vice President of Medical Affairs and Medical Directors. Reason for difference: These are comparable positions within each entity.</td>
<td>Medical: Via fax or telephone. Behavioral Health: Via fax, telephone, or e-mail. Reason for difference: The methods are comparable for each entity.</td>
<td>Medical and Behavioral Health: Information requested is the information clinically necessary to make a utilization review determination.</td>
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<td>11</td>
<td>Fallon Health &amp; Life Assurance Company</td>
<td>Medical: Chief Medical Officer and Associate Medical Directors. Behavioral Health: Beacon's Vice President of Medical Affairs and Medical Directors. Reason for difference: These are comparable positions within each entity.</td>
<td>Medical: Via fax or telephone. Behavioral Health: Via fax, telephone, or e-mail. Reason for difference: The methods are comparable for each entity.</td>
<td>Medical and Behavioral Health: Information requested is the information clinically necessary to make a utilization review determination.</td>
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<td>12</td>
<td>Harvard Pilgrim Health Care, Inc.</td>
<td>Medical: Senior Medical Director. Behavioral Health: Senior Vice President at Optum. Reason for difference: Differences exist based on different entities responsible for each type of service.</td>
<td>Medical: Providers can call Provider Service Center; or visit website. Behavioral Health: For OON services requiring pre-authorization, via telephone. For those not requiring pre-authorization, providers submit claims for processing.</td>
<td>Medical and Behavioral Health: Process same as for in-network requests for authorization of services. Differences between medical and behavioral health services exist due to different entities responsible for each.</td>
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<td>13</td>
<td>Health New England, Inc.</td>
<td>Medical: Medical requests reviewed by Medical Director who is licensed physician. Behavioral Health: Mental health requests reviewed by Medical Director who is licensed psychiatrist. Reason for difference: Both report to HNE Integrated Care Manager - Utilization Management.</td>
<td>Medical: via fax or, for inpatient admission, submit notification after admission. Behavioral Health: No notification necessary prior to inpatient admission for mental health service. Reason for Difference: In-network and OON processes are the same; same for mental health and medical service.</td>
<td>Medical and Behavioral Health: current treatment plan, treatment history and clinical documentation.</td>
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<td>14</td>
<td>HPHC Insurance Company, Inc.</td>
<td>Medical: Senior Medical Director. Behavioral Health: Senior Vice President at Optum.</td>
<td>Medical: Providers can call Provider Service Center, or visit website. Behavioral Health: For OON services requiring pre-authorization, via telephone. For those not requiring pre-authorization, providers submit claims for processing.</td>
<td>Medical and Behavioral Health: Process same as for in-network requests for authorization of services. Differences between medical and behavioral health services exist due to different entities responsible for each.</td>
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<td>15</td>
<td>Minuteman Health, Inc.</td>
<td>Medical and Behavioral Health: Minuteman Health (MHI) delegates medical and behavioral health management to Massachusetts' licensed and NCQA accredited health plan, Health New England (HNE). HNE’s Integrated Care Manager – Utilization Management is responsible for overseeing the process for authorization of out-of-network services for both medical/surgical and behavioral health/substance abuse disorder services.</td>
<td>Minuteman Health (MHI) delegates medical and behavioral health management to Massachusetts’ licensed and NCQA accredited health plan, Health New England (HNE). Medical: via fax or, for inpatient admission, submit notification after admission. Behavioral Health: No notification necessary prior to inpatient admission for mental health service. Reason for Difference: In-network and OON processes are the same, same for mental health and medical service.</td>
<td>Medical and Behavioral Health: Minuteman Health (MHI) delegates medical and behavioral health management to Massachusetts’ licensed and NCQA accredited health plan, Health New England (HNE). HNE, on behalf of MHI, requests the same types of information to be submitted for both mental health/substance use services as for medical/surgical services, as needed to determine whether utilization management criteria have been satisfied.</td>
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<td>16</td>
<td>Neighborhood Health Plan</td>
<td>Medical: Chief Medical Officer and Medical Directors. Behavioral Health: Vice President of Medical Affairs and Medical Directors. Reason for difference: Roles and responsibilities are parallel at the partner organizations. Two different individuals are responsible because of the need for experience and expertise in the respective fields.</td>
<td>Medical and Behavioral Health: Requests for coverage via fax, telephone, or mail.</td>
<td>Medical and Behavioral Health: Same as in-network, plus supportive documents to support necessity for service delivery including evidence of prior relationship, provider qualification specific to condition, evidence of ongoing treatment for an acute or chronic condition, or treatment for terminal conditions. Medical Only: verification of pregnancy and whether provider is a PCP. Reason for difference: Pregnancy and PCP care is only for medical because Behavioral health providers are not PCPs or OB providers.</td>
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<td>17</td>
<td>Network Health, LLC</td>
<td>Medical and Behavioral Health: Tufts Health Plan - Network Health Medical Directors oversee the authorization of out-of-network mental health/substance use disorder services and out-of-network medical/surgical services.</td>
<td>Medical and Behavioral Health: Out-of-network mental health/substance use providers and medical/surgical providers have the ability to submit requests for authorization via fax, telephone, and through the web (Tufts Health Plan - Network Health Connect).</td>
<td>Medical and Behavioral Health: Tufts Health Plan - Network Health requests information to conduct the utilization review that is pertinent to the services being requested.</td>
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<td>18</td>
<td>Tufts Associated Health Maintenance Organization, Inc.</td>
<td>Medical and Behavioral Health: Tufts Health Plan Medical Directors</td>
<td>Medical and Behavioral Health: Via fax or telephone.</td>
<td>Medical and Behavioral Health: Information is requested that is pertinent to the service being requested.</td>
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<td>19</td>
<td>Tufts Insurance Company</td>
<td>Medical and Behavioral Health: Tufts Health Plan Medical Directors</td>
<td>Medical and Behavioral Health: Via fax or telephone.</td>
<td>Medical and Behavioral Health: Information is requested that is pertinent to the service being requested.</td>
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<td>20</td>
<td>UniCare Life &amp; Health Insurance Company</td>
<td>Medical and Behavioral Health: Review of out of network services is the same as for in-network, and is overseen by Senior VP of Care Management.</td>
<td>Medical and Behavioral Health: Mailed claim form, telephone, e-mail, internet portal.</td>
<td>Medical and Behavioral Health: Patient diagnosis; provider name; license type, address, and other information necessary to process a claim for services.</td>
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<td>21</td>
<td>UnitedHealthcare Insurance Company</td>
<td>Medical: National Vice President of Inpatient Care Management and National Vice President of Clinical Operations. Behavioral Health: Optum’s Senior Vice President of Medical Operations.</td>
<td>Medical: Telephone, internet, and/or fax. Behavioral Health: telephone.</td>
<td>Medical and Behavioral Health: For both UHC and Optum, the information requested is specific to the service requested. Medical: Providers can view the information on UHC website. Behavioral Health: Providers can find this information on UBH website.</td>
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<td>No.</td>
<td>Company Name</td>
<td>7.1 - List of Any Differences in Cost-sharing Features</td>
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<td>1</td>
<td>Aetna Health, Inc.</td>
<td>For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.</td>
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<td>2</td>
<td>Aetna Health Insurance Company</td>
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<td>Aetna Life Insurance Company</td>
<td>For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.</td>
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<td>4</td>
<td>Blue Cross and Blue Shield of Massachusetts, Inc.</td>
<td>Use of copayments, co-insurance, deductible, out of pocket maximums, and other benefit limitations for mental health are either the same as, or more beneficial than those for medical services.</td>
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<td>Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.</td>
<td>Use of copayments, co-insurance, deductible, out of pocket maximums, and other benefit limitations for mental health are either the same as, or more beneficial than those for medical services.</td>
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<td>6</td>
<td>Boston Medical Center Health Plan, Inc.</td>
<td>There are no differences in any cost-sharing features between medical/surgical and mental health/substance use services in any of the plans offered.</td>
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<td>7</td>
<td>CeltiCare Health Plan of Massachusetts, Inc.</td>
<td>Use of copayments, co-insurance, deductible, out of pocket maximums, and other benefit limitations for mental health are either the same as, or more beneficial than those for medical services.</td>
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<td>CIGNA Health and Life Insurance Company</td>
<td>For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.</td>
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<td>9</td>
<td>ConnectiCare of Massachusetts, Inc.</td>
<td>For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.</td>
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<td>Fallon Community Health Plan, Inc.</td>
<td>Use of copayments, co-insurance, deductible, out of pocket maximums, and other benefit limitations for mental health are either the same as, or more beneficial than those for medical services.</td>
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<td>Fallon Health &amp; Life Assurance Company</td>
<td>Use of copayments, co-insurance, deductible, out of pocket maximums, and other benefit limitations for mental health are either the same as, or more beneficial than those for medical services.</td>
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<td>12</td>
<td>Harvard Pilgrim Health Care, Inc.</td>
<td>Use of copayments, co-insurance, deductible, out of pocket maximums, and other benefit limitations for mental health are either the same as, or more beneficial than those for medical services.</td>
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<td>13</td>
<td>Health New England, Inc.</td>
<td>For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.</td>
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<td>14</td>
<td>HPHC Insurance Company, Inc.</td>
<td>Use of copayments, co-insurance, deductible, out of pocket maximums, and other benefit limitations for mental health are either the same as, or more beneficial than those for medical services.</td>
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<td>Neighborhood Health Plan</td>
<td>Use of copayments, co-insurance, deductible, out of pocket maximums, and other benefit limitations for mental health are either the same as, or more beneficial than those for medical services.</td>
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<td>Network Health, LLC (now known as Tufts Health Public Plans, Inc.)</td>
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<tr>
<td>18</td>
<td>Tufts Associated Health Maintenance Organization, Inc.</td>
<td>For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.</td>
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<tr>
<td>19</td>
<td>Tufts Insurance Company</td>
<td>For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.</td>
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<tr>
<td>20</td>
<td>UniCare Life &amp; Health Insurance Company</td>
<td>For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.</td>
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<tr>
<td>21</td>
<td>UnitedHealthcare Insurance Company</td>
<td>For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.</td>
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</tbody>
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