NQTL ANALYSES
BEST PRACTICE EXAMPLES OF COMPLIANT NQTL ANALYSES,
TESTING AND DOCUMENTATION

As a public service, the Mental Health Treatment and Research Institute LLC (“MHTARI”), a not-for-profit subsidiary of The Bowman Family Foundation, has funded the development of the following examples demonstrating NQTL compliant analyses, testing and disclosure. Additional examples may be added as an update to this document from time to time. The current version of this document can be found at https://www.mhtari.org/Best_Practice_Examples_NQTL_Compliance.pdf. These best practice examples are prototypical and are derived from many resources, including regulatory and sub-regulatory guidance issued by the Departments of Labor and Health and Human Services, and the Center for Consumer Information and Insurance Oversight (see in particular, the Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)), as well as multiple recommendations by industry stakeholders.

EXAMPLE 1

Pre-Authorization and Concurrent Review of SUD Non-hospital Inpatient/Residential Rehabilitation - Compliant in the development and application of these NQTLs

NQTL Type: The plan uses pre-authorization and concurrent utilization review (UR) processes for inpatient/residential rehabilitation for substance use disorders (SUDs).

Facts: The plan provides the following information and documentation for this NQTL.

Step 1. The plan provides a statement that these NQTLs of pre-authorization and concurrent review for SUD non-hospital inpatient/residential care were applied to both medical/surgical (M/S) and SUD benefits with a list of the non-hospital inpatient/residential rehabilitation services (levels of care, facility type) subject to this NQTL in the same inpatient benefit classification.

Step 2. The plan identifies two key factors: a) “high cost growth” and b) “excessive length of stay” that were used to develop the NQTLs for both MH/SUD and M/S inpatient benefits. The plan identifies and provides references to a national study that discussed and identified high cost growth and excessive lengths of stay for both M/S and SUD non-hospital inpatient/residential rehabilitation services as the rationale for the plan’s use of these factors.

Step 3. The plan provides documents that show the evidentiary standards used to define these factors for both SUD and M/S non-hospital based inpatient/residential rehabilitation categories of services as follows:

a) Based on internal claims data, “high cost growth” was defined as more than 15% annual increases for any non-hospital inpatient/residential rehabilitation services for the plan’s two (2) most recent fiscal years, as compared to the benchmark of the plan’s fiscal year three (3) years back.

b) “Excessive length of stay” was defined as at least 20% longer than the average length of stay, occurring at least 10% of the time in the plan’s most recent fiscal year.

Each service type that met both of these definitions was deemed subject to the prior authorization and concurrent review NQTLs.
Step 4. The plan listed the testing and audits it had conducted to assess and validate a comparable and no more stringent application of these NQTLs, as written, to both non-hospital inpatient/residential rehabilitation M/S and SUD services. The plan analyzed the above factors and evidentiary standards by use of its own internal data and claims experience, and identified and disclosed the results obtained and the conclusions reached. The plan’s analyses and claims review revealed that each of the non-hospital inpatient service types for both M/S and SUD benefits, subjected to pre-authorization and concurrent review, had shown both high cost growth and excessive lengths of stay as defined in Step 3. In addition, the results of these analyses showed that high cost growth occurred in M/S non-hospital inpatient/residential rehabilitation service categories within one (1) standard deviation of high cost growth occurring in SUD non-hospital inpatient/residential rehabilitation service categories. The plan also analyzed the comparability and stringency in application of its written policies and procedures for its pre-authorization and concurrent review processes, e.g., utilization review criteria and criteria hierarchy, UM manuals, UM committee notes, written treatment plan requirements, etc. The plan concluded that the factors and evidentiary standards utilized in designing and implementing these NQTLs were comparable and no more stringently applied, as written.

Step 5. The plan listed the testing and audits it had conducted to assess and validate a comparable and no more stringent application of these NQTLs, in operation, to both non-hospital inpatient/residential rehabilitation M/S and SUD services. The plan conducted an audit of denial rates for these services according to the definitions and methodologies set forth in the Model Data Request Form (“MDRF”), which can be found at Appendix A and at http://www.mhntari.org/Model_Data_Request_Form.pdf. The plan analyzed the number of denials and percent of denials for MH/SUD services compared to M/S services as follows:

(A) Denials for which no claim was submitted (i.e. authorization for coverage of service was requested and denied; service was either not delivered or self-paid), shown as a percentage (%):

(1) Numerator: Pre-authorization and concurrent review denials based on lack of medical necessity for services requested in the particular setting noted.

Denominator: All pre-authorization and concurrent reviews conducted for the particular setting noted.

(2) Numerator: Pre-authorization and concurrent review denials based on administrative reasons for services requested in the particular setting noted.

Denominator: All pre-authorization and concurrent reviews conducted for the particular setting noted.

(B) Claims denials (i.e., authorization for coverage of service was requested and denied; service was delivered and claim was submitted), shown as a percentage (%) (Counted as one denial for each unique claim, not counting denials on resubmissions of the same claim):

(1) Numerator: Claims denied for lack of medical necessity upon pre-authorization and concurrent review in the particular setting noted.

Denominator: Total claims submitted for the particular setting noted.

(2) Numerator: Claims denied for administrative reasons upon pre-authorization and concurrent review in the particular setting noted.

Denominator: Total claims submitted for the particular setting noted.

The plan determined that SUD pre-authorization and concurrent reviews resulted in denials (of any type) 23% of the time, and M/S reviews resulted in denials (of any type) 21% of the time, which constituted a disparity in denial rates of less than 5 percentage points, which the plan deemed comparable. The plan also listed the results
of an audit from a random sample of utilization reviews by its contracted MBHO and its internal UR medical staff, which showed that:

1. The frequency of reviews were on average every three (3) days for both SUD and M/S, and when approved, an average of three (3) additional days of services were authorized;

2. The physician-to-physician reviews occurred on average 10% of the total of all admissions for SUD and 8% of the total of all admissions for M/S;

3. The average time taken for the SUD telephonic reviews was 5 minutes and the average time for M/S telephonic reviews was 3 minutes;

4. The plan conducted inter-rater reliability surveys for individuals conducting UR for both SUD and M/S and confirmed that all persons conducting UR for the plan for both SUD (MBHO) and M/S (medical UR) had been scored. Any utilization reviewer with deficient scores was required to complete additional training.

5. The SUD reviews did not require any types of written information that was different from, or more frequently required, than for M/S reviews.

**Step 6.** The plan disclosed a detailed summary explanation of the analyses it had conducted and the results of its testing and audits, and how the plan concluded that these NQTLs of pre-authorization and concurrent review were developed and applied comparably and no more stringently.

**Conclusion:** The plan is in compliance with NQTL analyses, testing and documentation for the development and application of these NQTLs for non-hospital inpatient/residential rehabilitation services, both as written and in operation.

**EXAMPLE 2**

**Setting of Outpatient Provider Rates for MH/SUD services: Compliant in the development and application of Provider Reimbursement Rates NQTL.**

**Facts:** The plan provided the following analyses and documentation for compliance testing of this NQTL:

**Step 1.** The plan sets provider rates/fee schedules for in-network, outpatient office visit services for both MH/SUD and M/S benefits.

**Step 2.** The plan used as factors for both MH/SUD and M/S outpatient office visits, Medicare Allowable Charges (MAC) as its benchmark, specialty group demand, and access to services.

**Step 3.** The plan made upward adjustments of between 20% and 30% to MAC depending on specialty group demand and access for both MH/SUD and M/S outpatient providers.

**Step 4.** The processes and strategies for analyzing these factors and evidentiary standards, the results obtained and conclusions reached were identified and disclosed, and demonstrated comparability and no more stringency in the written processes, standards and methodologies used by the plan.

The plan used the table below, with the instructions for completing the table and conducting a comparability analysis from the MDRF, and to ascertain the comparability of rate adjustments it had made:
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network Office Visits only (non-facility based)</td>
<td>CPT 99213</td>
<td>CPT 99214</td>
<td>CPT 90834</td>
<td>CPT 90837</td>
<td>Provider allowed amounts relative to National Medicare Fee Schedule Amounts, expressed as a percentage</td>
</tr>
<tr>
<td>Plan data: Weighted average allowed amount for primary care physicians (“PCPs”) and non-psychiatrist medical/surgical specialist physicians</td>
<td>(a) $98.41</td>
<td>(a) $142.27</td>
<td>Data not required</td>
<td>Data not required</td>
<td>(b) 99213</td>
</tr>
<tr>
<td>Plan data: Weighted average allowed amount for PCPs</td>
<td>(a) $98.41</td>
<td>(a) $142.27</td>
<td>Data not required</td>
<td>Data not required</td>
<td>Data not required</td>
</tr>
<tr>
<td>Plan data: Weighted average allowed amount for non-PCP, non-psychiatrist medical/surgical specialist physicians</td>
<td>(a) $98.41</td>
<td>(a) $142.27</td>
<td>Data not required</td>
<td>Data not required</td>
<td>Data not required</td>
</tr>
<tr>
<td>Plan data: Weighted average allowed amount for psychiatrists</td>
<td>(a) $92.70</td>
<td>(a) $136.80</td>
<td>Data not required</td>
<td>Data not required</td>
<td>Data not required</td>
</tr>
<tr>
<td>Plan data: Weighted average allowed amount for psychologists</td>
<td>N/A</td>
<td>N/A</td>
<td>(a) $110.70</td>
<td>(a) $166.05</td>
<td>(d) 90834 125% 90837 125%</td>
</tr>
<tr>
<td>Plan data: Weighted average allowed amount for clinical social workers</td>
<td>N/A</td>
<td>N/A</td>
<td>(a) $79.70</td>
<td>(a) $119.56</td>
<td>(f) 90834 120% 90837 120%</td>
</tr>
<tr>
<td>National Medicare Fee Schedule allowed amount for participating physicians in Row 1</td>
<td>$74.16</td>
<td>$109.44</td>
<td>Data not required</td>
<td>Data not required</td>
<td></td>
</tr>
<tr>
<td>National Medicare Fee Schedule allowed amount for participating psychologists</td>
<td>N/A</td>
<td>N/A</td>
<td>$88.56</td>
<td>$132.84</td>
<td></td>
</tr>
<tr>
<td>National Medicare Fee Schedule allowed amount for participating clinical social workers</td>
<td>N/A</td>
<td>N/A</td>
<td>$66.42</td>
<td>$99.63</td>
<td></td>
</tr>
</tbody>
</table>

The plan’s comparison of Row 1, columns A and B, with Row 4, columns A and B, revealed a minor disparity between the allowed amounts for PCPs and medical specialists vs. psychiatrists for the same CPT codes: 99213 - $98.41 vs. $92.70; and 99214 - $142.27 vs. $136.80.
The plan’s comparison of Row 1, column E and Rows 5a and 5b, column E, revealed a disparity between the percentages relative to Medicare for “PCPs and non-psychiatrist medical/surgical specialist physicians” as compared to psychologists: 132.7% and 130% vs. 125%; and as compared to clinical social workers: 132.7% and 130% vs. 120%.

**Step 5.** The plan also conducted essential testing to determine whether the NQTL of provider rates was being applied, in operation, in a comparable and no more stringent manner. For example, the plan tested geographic access for both psychiatrists and psychologists as compared to primary care medical and specialty providers. The plan found that wait times for access to first appointments were on average 45 days longer for MH/SUD. This adjustment was comparable to the upward adjusted range for PCPs and M/S specialists. The plan further tested its out-of-network use of outpatient services as set forth in the **MDRF** as follows:

<table>
<thead>
<tr>
<th></th>
<th>Plan Data for January 1, 2018 through December 31, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting</td>
<td>% OON claims submitted for Medical/Surgical Services</td>
</tr>
<tr>
<td></td>
<td>% OON claims submitted for MH/SUD Services</td>
</tr>
<tr>
<td>Office Visits</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td>34%</td>
</tr>
<tr>
<td>Action Plan</td>
<td>Action Plan to address level of disparity if absolute difference is greater than 5 percentage points</td>
</tr>
</tbody>
</table>

The results from this testing showed that OON use for MH/SUD services was 2x higher (or double) the OON use for M/S services. The plan therefore adjusted its psychiatrist, psychologist and social worker rates upward to 130% of the Medicare Allowable Fee Schedule benchmark. This adjustment was comparable to the upward adjusted range the plan had made for PCPs and M/S specialists.

**Step 6.** The plan disclosed the methodologies by which it applied adjustment factors to MAC. The plan also disclosed internal guidance given to its staff that outlined how NQTLs, including provider reimbursement rates, should be developed in a parity compliant manner, and disclosed that it continued to monitor wait times, specialty group demand, and out-of-network use every 6 months.

**Conclusion:** The plan is in compliance with the development, testing and implementation of its outpatient provider rates by using and disclosing the comparable factors and evidentiary standards, by using comparable methodologies to determine compliance, by testing both in writing and operational comparability and stringency in application, and by adjusting its rates for MH/SUD providers based on a measure of outcomes for specialty group demand and access to in-network care as it had done for certain outpatient M/S providers.

**EXAMPLE 3**

**Concurrent Review of Outpatient MH/SUD:** Compliant in the development and application of concurrent review NQTL.

**NQTL Type:** Concurrent utilization review (UR) process for outpatient mental health and substance use disorder (MH/SUD) services, which requires that all office visits after the 10th visit be reviewed for authorization prior to coverage of further care.

**Facts:** The plan's information and documentation for this NQTL consist of the following:
**Step 1.** The plan states that it applies the NQTL of concurrent review to both MH/SUD office visits and medical/surgical (M/S) office visits. The plan places these services in an outpatient office visit sub-classification of the outpatient benefit class.

**Step 2.** The plan states that the factor of “high cost growth” was used to develop and support the rationale for the appropriateness of applying this NQTL to both M/S and MH/SUD outpatient benefits.

**Step 3.** The plan defines the factor of “high cost growth” by the evidentiary standard of an increase of 10% or more in the cost of all MH/SUD or M/S outpatient services (PCPs) in the most recent fiscal year (as compared to the fiscal year immediately preceding the most recent fiscal year). The plan states that all MH/SUD and M/S services in the outpatient class that grew in cost by an average of 10% or more were subject to the same concurrent review process triggered after the 10th visit, including the same frequency of review. The plan further stated that no MH/SUD and no M/S services in this classification that grew in cost by 10% or more were exempt from this NQTL.

**Step 4.** The plan provided its analyses and the results obtained from those analyses that it used to develop and apply this factor and evidentiary standard. The plan disclosed that it conducted a review of its own claims data to develop the evidentiary standard used to define high cost growth. The plan also provided the type of analysis conducted to apply this factor and evidentiary standard to outpatient M/S and MH/SUD services. For example, the plan disclosed that it reviewed its outpatient-based claims in the office visits sub-classification of benefits for both M/S and MH/SUD, and that both increased by a minimum of 10% in the most recent plan fiscal year as compared to the fiscal year immediately preceding the most recent fiscal year. The plan stated that it applied concurrent review to all MH/SUD office visits and for all PCP office visits, as those groups of providers had met the same evidentiary standard of a 10% or more increase in costs. The plan further provided its written policies and procedures used to apply concurrent review, which demonstrated comparability and no more stringency, as written, between MH/SUD and M/S.

**Step 5.** The plan provided information that it routinely conducts audits to determine whether this NQTL is being applied in a comparable and no more stringent manner. Specifically, the plan provided the results of various tests that were conducted to determine that, in operation, these NQTLs were applied as designed and had inter-reviewer reliability. The plan conducted an audit of denial rates for outpatient office visits according to the definitions and methodologies set forth in the MDRF and analyzed the number of denials and percent of denials for MH/SUD services compared to M/S services as follows:

(A) **Denials for which no claim was submitted** (i.e. authorization for coverage of service was requested and denied; service was either not delivered or self-paid), shown as a percentage (%):

1. **Numerator:** Concurrent review denials based on *lack of medical necessity* for services requested in the particular setting noted.

   **Denominator:** All concurrent reviews conducted for the particular setting noted.

2. **Numerator:** Concurrent review denials based on *administrative reasons* for services requested in the particular setting noted.

   **Denominator:** All concurrent reviews conducted for the particular setting noted.

(B) **Claims denials** (i.e., authorization for coverage of service was requested and denied; service was delivered and claim was submitted), shown as a percentage (%) (Counted as one denial for each unique claim, not counting denials on resubmissions of the same claim):
(1) **Numerator**: Claims denied for *lack of medical necessity*, upon concurrent review in the particular setting noted.

**Denominator**: Total claims submitted for the particular setting noted.

(2) **Numerator**: Claims denied for *administrative reasons*, upon concurrent review in the particular setting noted.

**Denominator**: Total claims submitted for the particular setting noted.

The plan determined that MH/SUD concurrent reviews resulted in denials (of any type) 32% of the time and M/S concurrent reviews resulted in denials (of any type) 30% of the time, constituting a disparity in denial rates of less than 5 percentage points, which the plan deemed comparable. The plan also provided results of several random audits: a) testing to verify that the concurrent reviews were, in fact, conducted with similar frequency; and, b) testing to verify that the information requested and the administrative process to conduct the review was similar for both M/S and MH/SUD providers. The results from these audits revealed that: a) concurrent reviews were conducted for every visit after the 10th visit for both MH/SUD and M/S office visits; and, b) the utilization review process itself was the same, e.g., time taken to conduct reviews, documentation required for reviews, inter-rater reliability surveys, etc.

**Step 6.** The plan disclosed a detailed summary explanation of the analyses it had conducted and the results of its testing and audits, and how the plan concluded that the NQTL of concurrent review was developed and applied comparably and no more stringently.

**Conclusion:** The plan conducted and provided a compliant analysis with respect to its development of this NQTL in terms of how the plan comparably defined the factor and evidentiary standards for this NQTL for both MH/SUD and M/S; and, how it conducted outcomes measurements and documented the results of its denial rates and other comparisons to validate that the NQTL was being applied, in operation, in a comparable and no more stringent manner.

**EXAMPLE 4**

**Experimental vs. Non-Experimental Reviews for MH/SUD Treatment: Compliant in development and application of this NQTL.**

**NQTL Type:** Limiting or excluding benefits based on whether a treatment is deemed experimental / investigational.

**Facts:** The plan provided the following analyses, documentation and testing of this NQTL:

**Step 1.** The plan states that it requires any new treatment for both MH/SUD and medical/surgical (M/S) to be reviewed, in order to determine whether the intervention is deemed experimental or non-experimental for all benefit classifications.

**Step 2.** The plan identifies the key factor of “assuring safety and efficacy of new treatments” as the rationale for the development of this NQTL.

**Step 3.** The plan defined this factor by the specific evidentiary standard of a requirement that “new” M/S and “new” MH/SUD treatments must have at least two (2) Randomized Controlled Trials (RCTs) published in peer-reviewed journals that demonstrate safety and efficacy in a consistent manner. The plan defined “new” as any treatment that had not been submitted for reimbursement in the past, or had been reviewed in the past by the
experimental panel and rejected for reimbursement as experimental. The plan disclosed guidelines for when an RCT was not acceptable, e.g., if the size of the control and treatment groups were not large enough to enable statistically significant results.

**Step 4.** The plan stated that it used the same factor and evidentiary standards for both MH/SUD and M/S services and the same review process consisting of a panel of subject matter experts. The plan also has internal guidelines for how the panel is to conduct the review process for all benefit classifications, which the plan disclosed.

**Step 5.** The plan disclosed that it conducted a number of tests to determine the in operation comparability and stringency with which these reviews were being applied. For example, the plan required each review panel to report on any rejections of reimbursements from its reviews to determine experimental vs. non-experimental, along with the panel’s rationale. The plan conducted an audit of rejections of application/submission rates, as well as claim denial rates, based on “experimental” within the last 12 months. Adapted from the methodology set forth in the MDRF, the plan analyzed the number of (a) panel review rejections and (b) utilization review denials, both expressed as a percentage for MH/SUD treatment services compared to M/S treatment services as follows:

**A. Panel Review Rejections shown as a percentage (%):**

- **Numerator:** Panel review rejections of applications for coverage based on “experimental” for any treatment service.
- **Denominator:** All applications for coverage submitted for any treatment service as a “non-experimental” service.

**B. Utilization Review Denials on review shown as a percentage (%):**

- **Numerator:** UR denials of coverage based on “experimental” for any treatment service.
- **Denominator:** All UR denials of coverage, including both medical necessity and administrative denials, for any treatment service.

The plan determined that for MH/SUD, panel reviews resulted in rejections of applications/submissions based on experimental 35% of the time; and that for M/S, panel reviews resulted in rejections of applications/submissions based on experimental 33% of the time, constituting a disparity in rejection rates of less than 5 percentage points, which the plan deemed comparable. The plan also determined that for MH/SUD, utilization review resulted in denials of coverage based on experimental 10% of the time; and that for M/S, utilization review resulted in denials of coverage based on experimental 9% of the time, which likewise constituted a disparity in denial rates of less than 5 percentage points. The plan also monitored whether there were timely responses to requests for panel reviews and the wait times for the panel reviews to be conducted and determined these were comparable for both MH/SUD and M/S services. Importantly, the plan conducted testing for a sample of current M/S and MH/SUD treatments that were being reimbursed to determine what proportion met the two (2) RCTs test in order to ascertain whether MH/SUD services were being held to a higher standard than M/S, as many MH/SUD treatments had been rejected prior to the federal parity law interim final regulations.

**Step 6.** The plan disclosed a detailed summary explanation of the analyses it had conducted and the results of its testing and audits, and how the plan concluded that this NQTL was developed and applied comparably and no more stringently, both in writing and in operation.
Conclusion: The plan’s documentation, analysis and testing showed compliance with both the development of this NQTL, and its application in operation.

NOTE: These types of analyses and testing are essential for several reasons. For example, there have been many complaints regarding plans denying “new” treatments, even though these “new” treatments do have two (2) or more RCTs. Further, plans have stated that they do apply the 2 RCT criteria consistently to both medical and behavioral health services; however, plans do not provide standards based on which certain RCTs are accepted and others are not, which makes it impossible to confirm a compliant process. Further, many plans have “grandfathered” in M/S treatments pre-existing the federal parity law interim final regulations that do not meet the 2 RCT test, while NOT grandfathering many MH/SUD treatments pre-existing these parity regulations and requiring those treatments to meet the 2 RCT test.

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