

Network Notifications

New Hampshire



Date: March 27, 2026 Number: 122

To: All WellSense Providers

From: WellSense Health Plan

Subject: **Medical Policy updates**

Product: NH Medicaid NH Clarity plans NH Medicare Advantage

Medical policy updates

Reminder:

In our commitment to provide electronic criteria at the point of care, all practitioners can [access InterQual criteria via our website](#). Choose Access One Healthcare ID at the link above, enter your One Healthcare ID (or create one), and you will be directed to InterQual criteria.

Policy updates:

- Effective June 1, 2026, we will adopt InterQual criteria 2026 Criteria. A summary of the revisions is attached to this notice.
- Effective June 1, 2026, we have revised the policy Clinical Review Criteria, OCA 3.201. A copy is attached to this notice.
- Effective July 1, 2026, eviCore will update multiple criteria sets under its Laboratory Management program. eviCore will publish the clinical guidelines here. Once you're logged in on the [eviCore site](#), click on Laboratory Management and type in WellSense in the search bar and then select the Future tab.

Questions?

If you have any questions, please contact your dedicated Provider Relations Consultant or call:

- NH Medicaid: 877-957-1300, option 3
- NH Clarity plans: 855-833-8122, option 3

Network Notifications

New Hampshire



- NH Medicare Advantage: 866-808-3833

You can also send comments about our medical policies to medical.policy@wellsense.org. Please include the medical policy title and number with your comments

Adult & Geriatric Psychiatry

Global Updates

- Across the content, the term “detoxification” has been replaced with “withdrawal management” to align with ASAM 4th Edition terminology.
- Time-based requirements have been removed from the symptoms and findings criteria for Inpatient and Behavioral Health Observation. Documentation should now focus on the patient’s present condition. This change supports flexible, clinically relevant decision-making and ensures care is guided by the patient’s current risk and needs rather than the timing of past events:
 - Removal of “within last 24 hours” and “over last 24 hours”
 - “Substance use within last 24 hours” has been updated to “Recent Substance Use.”
 - “Attempt within last 48 hours” has been updated to “Attempt and high risk of reoccurrence.”
- Updates have been made to improve clarity in specific Inpatient criteria points:
 - “Paranoia or persecutory delusions directed at specific individual or group” has been updated to “Paranoia or persecutory delusions and directed at specific individual or group.”
 - “Obsessive or compulsive behavior interferes with participation in daily program” has been updated to “Obsessive or compulsive behavior and interferes with participation in daily program.”

Inpatient

Updates to:

- Eating disorder
- Severe and persistent mental illness or autism
- Suicide Ideation and risk of attempt

Intensive Outpatient Program

Removed “Assaultive or threatening within last 24 hours and able to prevent reoccurrence”

Outpatient

- Removed “Maximum possible progress attained and 1 or fewer visits per month planned for psychotherapy or medication management”
- Changed “1 or fewer visits per month planned for psychotherapy” and all sub criteria to “Psychotherapy”
- Changed “Maintenance psychotherapy 1 time per month or less” to “Maintenance psychotherapy”

Child & Adolescent Psychiatry

Global Updates

- Across the content, the term “detoxification” has been replaced with “withdrawal management” to align with ASAM 4th Edition terminology.
- Time-based requirements have been removed from the symptoms and findings criteria for Inpatient and Behavioral Health Observation. Documentation should now focus on the patient’s present condition. This change supports flexible, clinically relevant decision-making and ensures care is guided by the patient’s current risk and needs rather than the timing of past events:
 - Removal of “within last 24 hours” and “over last 24 hours”
 - “Substance use within last 24 hours” and “Active substance use” have been updated to “Recent Substance Use.”
 - “Attempt within last 48 hours” has been updated to “Attempt and high risk of reoccurrence.”
- Updates have been made to improve clarity in specific Inpatient criteria points:
 - “Paranoia or persecutory delusions directed at specific individual or group” has been updated to “Paranoia or persecutory delusions and directed at specific individual or group.”
 - “Paranoia or persecutory delusions focused at specific individual or group” has been updated to “Paranoia or persecutory delusions and focused at specific individual or group.”
 - “Obsessions or compulsive behavior interferes with participation in daily program” has been updated to “Obsessions or compulsive behavior and interferes with participation in daily program.”
- New headers have been added to Inpatient symptoms or findings criteria to reduce confusion and support more accurate reviews:
 - Episode Day 1: “Symptom or finding requiring urgent intervention.”
 - Episode Day 2–13 and 14–X: “Acute symptom and requires hospitalization for safety.”

Behavioral Health Services

Global Updates

- Added a new recommendation for scenarios where referral for secondary review is appropriate when an indication or test or medication is not included in the criteria. Indications or tests or medications not included in the InterQual criteria should be reviewed at secondary review.
- For usability, the criteria in the following subsets have been revised so the requested molecular test and the appropriate CPT code(s) are first selected and lead to test-specific criteria and recommendation(s). This change was made to enhance usability by identifying the code associated with the test at the start of the review and to represent the frequently utilized testing indications.
 - Multi-Gene Panels for Autism Spectrum Disorder (ASD)
 - Pharmacogenomic Testing for Psychotropic Medication Drug Response

Updates made to:

- Psychological Testing
- Transcranial Magnetic Stimulation (TMS): added adolescent pathway

Medical Codes

See the Behavioral Health Services Clinical Revisions document for specific code changes.

SUD

Global Updates

- Across the content, the term “detoxification” has been replaced with “withdrawal management” to align with ASAM 4th Edition terminology.
- Time-based requirements have been removed from the symptoms and findings criteria for Inpatient, Inpatient Withdrawal Management and Behavioral Health Observation. Documentation should now focus on the patient’s present condition. This change supports flexible, clinically relevant decision-making and ensures care is guided by the patient’s current risk and needs rather than the timing of past events:
 - Removal of “within last 24 hours” and “over last 24 hours”
 - “Substance use within last 24 hours” has been updated to “Recent Substance Use.”
 - “Attempt within last 48 hours” has been updated to “Attempt and high risk of reoccurrence.”
 - “Assaultive within last 24 hours and high risk of reoccurrence” has been updated to “Assaultive and high risk of reoccurrence.”
 - “Accidental overdose within last 48 hours” has been updated to “Accidental overdose”
- Updates have been made to improve clarity in specific Inpatient criteria points:
 - “Paranoia or persecutory delusions directed at specific individual or group” has been updated to “Paranoia or persecutory delusions and directed at specific individual or group.”
 - “Obsessive or compulsive behavior prevent attending daily substance use disorder treatment activities” has been updated to “Obsessive or compulsive behavior and prevents attending daily substance use disorder treatment activities.”
- The Review Process Document has been updated to support timeline changes in Inpatient and Behavioral Health Observation levels of care.
- New headers have been added to Inpatient and Inpatient Withdrawal Management symptoms or findings criteria to reduce confusion and support more accurate reviews:
 - Episode Day 1: “Symptom or finding requiring urgent intervention.”
 - Episode Day 2–13 and 14–X: “Acute symptom and requires hospitalization for safety.”
- A selectable rule was added in Inpatient

No significant revisions

- ASAM

LOC: Acute Adult

Global Updates

Global revisions improve clinical accuracy, clarity, and review efficiency for reviewers by streamlining criteria, standardizing terminology, and better aligning content with real-world practice and evidence-based guidelines. Key themes include removal of restrictive language (e.g., “sustained” vital signs, rigid frequency or timing requirements), consolidation of overlapping rules, and clarification of clinical intent to support consistent application across scenarios. Criteria were refined to rely on more readily available and clinically meaningful findings (e.g., updated AKI definitions aligned with KDIGO, clarified SIRS parameters), and allowance for appropriate formulation inclusivity (e.g., PO medications). Several diagnoses were simplified by removing redundant findings or treatment lists now addressed in explanatory notes, while responder criteria were modernized to reflect current care settings and workflows.

- “(includes PO)” has been added to the immunosuppressant criteria line to clarify the intent and be more inclusive of all formulations. Also, the word “therapy” has been removed for clarity.
- For various conditions in Responder criteria, the anti-infective criteria have been streamlined to clarify the intent and accurately reflect the patient appropriate for discharge.
- “TPN or PPN” criteria were introduced for clinical appropriateness as additional interventions for ileus as a primary condition that has not resolved on continued stay and when ileus is a complication secondary to other conditions such as *C. difficile* infection.
- Comorbid arrhythmia criteria were removed from the Intermediate and Critical levels of care as the review can be completed in the appropriate arrhythmia subset – see COPD, Hematology/Oncology: Complications, Hematology/Oncology: Treatments, Infection: Endocarditis, Withdrawal
- “surgically inserted device” was added to medical prosthetics or implants to broaden the definition of different medical devices that potentially pose a higher risk of serious skin infection if the area affected overlies a medical device

Acute Coronary Syndrome (ACS)

Updated to improve clarity, consistency, and usability by simplifying criteria and aligning them with real-world clinical workflows. Key enhancements include removal of 24-hour endpoint timing language, allowing criteria to be met on the current episode day when the intervention is completed, clearer intent language such as “plan of care includes” to support appropriate Observation determinations. New emphasis on guideline-directed medical therapy optimization recognizes short, clinically necessary stays post-ACS supporting more consistent, defensible medical necessity decisions.

Acute Kidney Injury

Updated to focus on improving clarity, eliminating ambiguity in timing and treatment requirements, and aligning clinical definitions with current AKI practice standards. On Episode Day 1, the term “Oliguria” replaces multiple urine-output descriptors to simplify review and ensure consistent interpretation for AKI in the hospitalized patient. Time-based endpoints were removed for clarity. A new criterion for medication adjustment or discontinuation (e.g., diuretics, nephrotoxic agents) was added in hospital acquired AKI to better reflect real-world management needs and ensure appropriate capture of patients requiring continued inpatient monitoring for renal-impacting medication changes.

Antepartum

Had minor updates to improve workflow and review process for the patient in preterm labor or having vaginal bleeding who requires transitioning from Observation to Acute level of care on Episode Day 2. Also, specific criterion for pre- or gestation Diabetes Mellitus has been clarified.

Arrhythmia, Atrial

Revised to improve clarity, broaden clinical applicability, addition of a new condition, and streamline decision-making for reviewers by aligning criteria with real-world presentations. The content was expanded by adding sinus node dysfunction and tachy-brady syndrome to better represent the spectrum of conduction abnormalities seen in hospitalized patients, creating more accurate pathways for patients with symptomatic bradyarrhythmia or alternating tachy- and brady-rhythms. Hemodynamic instability findings were strengthened by adding chest pain and heart failure with hypoxemia, ensuring the criteria capture clinically significant decompensation more precisely. Additional updates include adding a new inpatient-onset atrial fibrillation/flutter pathway in Intermediate level of care to reflect the common scenario of arrhythmia developing during hospitalization who requires antiarrhythmic medication with proarrhythmic risks.

Arrhythmia, Blocks

Had minor updates for clarification of intent and streamlining the review process and for consistency across the content.

Arrhythmia, Ventricular or Abnormal ECG Finding

Streamlined to improve clarity, consistency, and efficiency by focusing criteria on clinically meaningful arrhythmic risk and treatment intensity. Updates removed redundant or implicit requirements (e.g., imaging confirmation of heart failure, post-resuscitation language for cardiac arrest), broadened antiarrhythmic criteria to include oral agents, and simplified monitoring pathways. Intermediate-level criteria were refined by adding known EF <35% to better capture higher risk syncope in patients with established systolic heart failure.

Asthma

Updates focus on improving clinical accuracy, aligning severity thresholds with current guideline-based evidence, and ensuring clearer distinction between Observation and Critical levels of care. Key changes include modifications to time period after receiving initial treatment to perform a re-evaluation or reassessment and restructuring high risk for decompensation factors to be assessed after initial treatment has been completed to clarify and determine need for hospitalization. Thresholds for peak expiratory flow or forced expiratory volume in one second were revised based on most recent GINA guidelines. Respiratory rate was updated (e.g., >22/min) to match validated markers of increased work of breathing.

Bowel Obstruction

Revised primarily to clarify clinical intent and broaden applicability for the review of the patient who cannot tolerate or undergo nasogastric (NG) tube placement whether due to intolerance or anatomical limitations.

COPD

Revisions focused on improving clinical precision, aligning work-of-breathing descriptors with the correct level of care, and incorporating guideline-based risk factors to better identify higher-risk patients. Phrases such as "Talks in phrases due to respiratory effort" were replaced with "Inability to speak full sentences" to more accurately reflect a more severe respiratory effort that is appropriate for the Acute level of care. Additional objective findings such as respiratory rate > 24/min and use of accessory muscles were added to strengthen recognition of increased work of breathing in acute exacerbations. Several new clinical risk factors (including active lung cancer, BMI < 21 kg/m² or > 30 kg/m², and BAP-65 criteria) were incorporated to better identify patients at elevated risk for adverse events.

Cystic Fibrosis

Chest tube responder criteria has been broadened for inclusivity in the ambulatory setting by removing the prior restriction to Heimlich valve.

Dehydration

"Dehydration or Gastroenteritis" subset was renamed to "Dehydration" subset, as its gastroenteritis-related criteria have been removed and incorporated into the Infection: GI/GYN subset.

Eating Disorders

Removed from the General Medical subset and developed into its own condition specific subset. The length of stay was revised from 3-x to 12 days, with Episode Day 12 designated as Non-responder day based on the

geometric mean length of stay (GMLOS) benchmark data. Additionally, dehydration criteria were updated by eliminating BUN and creatinine thresholds to enhance clinical accuracy and emphasize orthostatic changes as more reliable physiologic markers of dehydration in this population.

Electrolyte or Mineral Imbalance

Had minor update for inclusivity of different formulation types of vasopressin receptor antagonist (vaptans) used in the treatment for hyponatremia.

Extended Stay

Revised to enhance clinical precision, review efficiency, and consistency by streamlining criteria, clarifying intent, and better aligning with real-world care delivery across acuity levels. Changes emphasize improved reviewability through consolidation or removal of overly granular subcriteria, and redistribution of content to condition-specific subsets to ensure patients are evaluated under the most clinically appropriate context. Comorbid arrhythmia criteria at the Intermediate level of care have been revised for completeness and clarity to now include better distinction between certain antiarrhythmic medications for their proarrhythmic and no proarrhythmic properties. Updates also refine thresholds, interventions, and terminology (e.g., VAD management, MDRO infection, and wound care) to better identify patients who truly require continued hospitalization at each level of care.

Gallbladder Disorders

The criteria for acute cholecystitis were streamlined by removing the “confirmed by imaging” requirement and its associated subcriteria, acknowledging that imaging confirmation is inherent in establishing the diagnosis and does not need to be restated within the criteria. Additionally, the analgesic requirements were revised to improve clinical accuracy, shifting from rigid thresholds such as “unresponsive to at least 2 doses” or “analgesic 3x/24h or continuous” to a more clinically accurate framework of analgesic use 2–3 times per 24 hours.

General Medical

In the **Cardiovascular** section, VAD criteria have been updated at the Intermediate and Critical levels of care on all Episode Days. At the Intermediate level of care, anticoagulation criteria were revised to “Device thrombosis and antithrombotic therapy” to clarify the intent of the criteria and streamline the review process. Additionally, infectious criteria were separated into suspected and confirmed VAD-specific infection or bacteremia criteria. At the Critical level of care, volume expander or blood product transfusion have been added to the hypotension/decreased flow criteria and respiratory interventions HFNC, NIPPV, and Oxygen \geq 40% have been added to the hypoxia criterion, to better identify the patient requiring this level of care.

The **Eating disorder** section and criteria have been removed, as the patient with these conditions can now be reviewed in the new Eating Disorders subset.

In the **Genitourinary** section at the Observation level of care on all Episode Days, the renal calculus without obstruction and urinary tract obstruction (includes hydronephrosis) criteria have been removed, and on Episode Day 1, the post obstructive diuresis criteria were also removed. At the Acute level of care on all Episode Days, the urinary tract obstruction (includes hydronephrosis) criteria have been removed, and on Episode Days 2 and 3, the post obstructive diuresis criteria have been removed, as the patient with these conditions can now be reviewed in the new Genitourinary Obstruction subset.

In the **Gastrointestinal or biliary** section hepatic disorders and the complications criteria have been removed, as the patient with these conditions can now be reviewed in the new Hepatic Disorders subset.

In the **Neurological** section at the Critical level of care, acute delirium has been added as a new and distinct condition to capture the patient where conservative management was unsuccessful, and the patient now requires Dexmedetomidine (Precedex) infusion for sedation given its known inherent risk profile to cause hypotension and/or bradycardia necessitating close hemodynamic monitoring.

In the **Respiratory** section at the Observation level of care, acute pulmonary edema has been added as a new condition to capture the end-stage renal disease patient who requires emergent dialysis due to progressive pulmonary edema or volume overload that occurred in between scheduled outpatient dialysis session. These patients require brief hospitalization to stabilize volume status and respiratory function.

Within the **Transplant** section, post transplant complication criteria have been updated to include hepatic arterial thrombosis, a common complication following liver transplantation. Endovascular intervention has been added at the Acute level of care, and thrombolysis has been added to the Critical level of care on all episode days as additional treatment options for arterial, hepatic, or portal vein thrombosis. Additionally, “Thrombectomy” has been removed at the Acute level of care, as the patient requiring an open thrombectomy should be reviewed in the General Surgical subset.

General Surgery

At the **Observation** level of care, the header was updated to clarify that the criteria apply to both expected and unexpected postoperative events or complication(s). On Operative Day, the delayed recovery from anesthesia criteria have been more clearly defined and now include respiratory impairment related to anesthesia. New criteria also address the post-PCI patient who may require 24 hours of observation, and vascular access site complication criteria were added for both Operative day and Post-Op Day 1. Arrhythmia criteria were removed from the Observation level of care; such patients should now be reviewed within the appropriate Arrhythmia subset or at the higher levels of care.

At the **Acute** level of care, cardiac clearance criteria were added on Pre-Op Day to address the patient requiring cardiac evaluation prior to an unplanned procedure. The “High risk for thromboembolism” criteria were revised to “Pre-operative anticoagulation management,” now including both bridging therapy and reversal for urgent procedures. On Operative Day, updates were made to the comorbid or high-risk medical history criteria for identifying the patient who may warrant inpatient admission following an ambulatory procedure. This included an expanded definition for liver disease, a more specific delineation of immunocompromised status (including individuals with disseminated cancer and/or those on immunosuppressants), and updated HbA1c threshold associated with the diabetes mellitus criterion based on guidelines. For Post-Op Days, terminology regarding “Short,” “Moderate,” and “Long” routine postoperative stays, as well as “Solid organ transplant,” was clarified to indicate the number of days that the criteria can be applied, counting the Operative Day as day 1. End points related to solid organ transplants were updated based on the most recent available geometric mean length of stay (GMLOS) benchmark data. Additional criteria were added for the patient necessitating continued hospitalization for anticoagulation bridge therapy, anti-infective treatment post-ambulatory procedure, and multiple modifications were made to the complication criteria, which are intended for use after exhausting the number of days allotted in routine postop stay criteria.

At the **Intermediate** level of care, major updates include the addition of HFNC and transplant criteria to capture the post-transplant patient who requires a higher level of care due to the intensity of postoperative services. Starting from Post-Op Day 1, new criteria were added to capture the patient transitioning down to the Intermediate level, such as those with a mediastinal chest tube, temporary pacing wires that are not in use but remain inserted, or a pericardial drain. The pre-existing VAD criteria were reorganized to capture the patient undergoing either an inpatient or ambulatory procedure. Wound care and COPD criteria were removed; these patients should now be reviewed at the Acute level of care.

At the **Critical** level of care, transplant-specific criteria were removed, and the post transplant patient should now be reviewed based on the intervention or clinical findings that necessitate this level of care. To ensure the post transplant patient requiring this level of care is captured, new criteria were added, including pancreas allograft assessment and expanded transplant-related complication criteria. Additional updates broadened the scope of neurological drainage criteria to include subdural drains, and the digit or limb reimplantation criteria were expanded to encompass all inpatient vascular surgeries requiring frequent neurovascular assessments. New criteria were also added to capture the postoperative patient requiring this level of care, such as post-thrombectomy management, inhaled pulmonary dilator therapy, HFNC support, and continuous diuretic infusion. VAD criteria were also added to Operative Day and Post-Op Days 1 and 2 to capture the postoperative pre-existing VAD patient who may necessitate this level of care.

General Trauma

Updated to improve clarity, clinical accuracy, and consistency in level-of-care determination by focusing reviews on injury-specific severity and required monitoring rather than mechanism alone. Changes streamlined criteria by removing compartment syndrome content reviewed more appropriately in the Rhabdomyolysis or Compartment Syndrome subset. Head trauma criteria were expanded across Observation and Acute levels to

incorporate evidence-based risk factors and imaging-confirmed findings that warrant close neurological monitoring despite minimal or no symptoms. Critical level of care criteria (e.g., cardiac arrest) was simplified recognizing post-resuscitation care as inherent and refining Intermediate level of care by removal of high-risk trauma mechanisms.

Genitourinary Obstruction

The genitourinary obstruction content was removed from the General Medical subset and developed into its own condition specific subset. The length of stay was changed from 3-x to 5 days, with Episode Day 5 being the Non-responder day based on the geometric mean length of stay (GMLOS) benchmark data.

Heart Failure

The global change replaces “CXR” with the broader term “imaging” to ensure all appropriate modalities used to diagnose acute heart failure are included. Across the Observation and Acute levels of care on continued stay, the threshold for bradycardia has been revised from a heart rate < 60/min to < 50/min, aligning with guideline definitions and ensuring consistent application across the content. The cardiac catheterization criterion was clarified by removing the phrase “scheduled or performed within 24 hours”, emphasizing that the criteria can be satisfied when the procedure is completed on that episode day, reducing ambiguity in application.

Hematology/Oncology: Complications or Disease Progression

Updated to focus on enhancing clarity, broadening inclusivity, and improving alignment with current clinical practice. Chest tube criteria in Responder section on continued stay were broadened to include chest tubes appropriate for the ambulatory setting rather than restricting to Heimlich valves. A new condition, malignant ascites has been added to the Observation level of care to capture symptomatic patients requiring therapeutic paracentesis or catheter placement (e.g., PleurX). Malignant pleural effusion thresholds were refined to emphasize symptoms supporting admission and expand hypoxemia criteria to O₂ saturation ≤ 91% for better clinical precision. Thrombocytopenia thresholds were updated to align with newer multi-societal guidelines, differentiating thresholds for platelet counts based on treatment type (chemotherapy vs. immunotherapy) that support hospitalization for further intervention(s). Cytokine release syndrome criteria were simplified by removing temperature and systolic blood pressure requirements.

Hematology/Oncology: Treatments

Updated to align with recent multi-societal guideline recommendations, refining platelet thresholds that warrant continued admission for further interventions (e.g., platelet transfusion).

Hematology/Oncology: Hemolytic Uremic Syndrome

Had minor updates to improve clinical accuracy as it relates to oxygenation.

Hepatic Disorders - NEW

The Hepatic Disorders subset has been created to centralize common liver-related conditions into a new dedicated subset (“Gastrointestinal or biliary” section was removed from the General Medical subset) and expand clinical criteria to better reflect current guideline-based diagnoses and management of ascites, hepatic encephalopathy (HE), acute alcoholic hepatitis, acute or acute-on-chronic liver failure, drug-induced liver injury (DILI), and hepatorenal syndrome (HRS).

One of the key changes includes adding Observation level of care criteria for new onset or symptomatic Grade 2 ascites including appropriate interventions. At the Acute level of care, new additions incorporate AKI and HRS-related findings, refining ascites severity descriptors, and introducing a full set of evidence-based treatments such as albumin, NAC, corticosteroids, TIPS, vasoconstrictors, and targeted fluid management. Mental status changes, infection markers, and liver function abnormalities were added across conditions to more accurately identify decompensation risk. Episode days were recalibrated to align with the updated geometric mean length of stay (GMLOS) benchmarks and appropriate level of care content were included for clinical accuracy.

Hospital in the Home

Underwent significant updating and restructuring. The subset was redesigned to be a screening tool and to help identify patients who may be appropriate candidates for inclusion in a hospital in the home (HITH)

program for any diagnosis. It is intended to be utilized after a medical necessity review has been completed in the appropriate subset at the Acute level of care for either admission or continued stay.

The HITH screening tool includes both clinical and social factors that influence a patient's appropriateness for a HITH program. The clinical factors include, but are not limited to clinical safety, comorbidity management, and the need for surgical intervention. The social considerations include, but are not limited to home environment safety, social barriers (e.g., patient is in police custody, resides in a skilled nursing facility), patient willingness, and caregiver support.

Hypertension

Further refined to improve clinical accuracy in identifying true end-organ involvement during hypertensive emergencies at the Critical level of care indicating glomerular injury or damage. The key change removes gross hematuria as an indicator of acute kidney injury–related end-organ damage. Retaining only microscopic hematuria and proteinuria ensures reviewers apply criteria that better reflect the underlying pathophysiology of hypertensive renal injury.

Infection: COVID-19

Updated to revise the oxygenation thresholds to align with current clinical guidelines that delineate patients with severe COVID-19 infection who require supplemental oxygen.

Infection: GI/GYN

Updated to more accurately distinguish Observation versus Acute levels of care for patients with acute diarrhea-related conditions. Key improvements include dedicated, new content for acute gastroenteritis at the Observation level and introduction of infectious diarrhea or infectious colitis content at the Acute level. Criteria were streamlined and standardized across episode days, also responder and partial-responder pathways were clarified to support safe discharge versus continued hospitalization.

Infection: Pneumonia

Updated with the removal of "Pneumonia confirmed by imaging" across all levels of care as imaging confirmation is already inherent in diagnosing acute pneumonia.

Infection: Pyelonephritis or Complex UTI

Updated to enhance clinical precision, improve risk stratification, and strengthen alignment with practice guidelines. The primary changes reorganize where creatinine-based organ-dysfunction thresholds appear in the criteria: the finding "creatinine > 1.5x baseline and < 2x baseline" was relocated and added to more accurately represent moderate organ dysfunction while still requiring 2 findings, while a new criterion "creatinine ≥ 2x baseline" was added to clearly define high-risk organ dysfunction consistent with sepsis-aligned scoring such as SOFA. These adjustments ensure reviewers can more accurately differentiate patients with mild-to-moderate deterioration from those with clinically significant kidney injury requiring Acute level of care. Additional modifications broadened lactic acid criteria (allowing SIRS and/or qSOFA as valid pathways) and refined temperature thresholds to match current practice guidelines.

Infection: Sepsis

Updated to broaden lactic acid criteria allowing SIRS and/or qSOFA as valid pathways

Intestinal Ischemia – NEW

Intestinal Ischemia is a new subset created based on evidentiary medicine for the review of the patient with intestinal ischemia. This subset encompasses both acute mesenteric ischemia and ischemic colitis.

Non-Traumatic Bleeding

updated to focus on improving clinical appropriateness, accuracy, and clarity while streamlining the review process. Routine clinical assessments, such as oximetry, were removed to reduce redundancy and better align criteria with meaningful indicators of medical necessity. Additionally, clarifications were made to treatment criteria for abnormal uterine or vaginal bleeding, including inclusion of oral hormonal therapy formulations, to better reflect current clinical management options.

Pancreatitis

Minor revisions have been made to the Pancreatitis subset where temperature and respiratory rate symbols have been updated to clarify the intent of the criteria.

Rhabdomyolysis or Compartment Syndrome

Rhabdomyolysis or Crush Syndrome was renamed to Rhabdomyolysis or Compartment Syndrome. Extensive restructuring has occurred within this subset to be more inclusive of patients with rhabdomyolysis from all etiologies, including traumatic, exertional, and nontraumatic causes. The diagnostic criteria now emphasize definitive laboratory values over physical findings. References to creatine phosphokinase (CPK) have been expanded to include creatine kinase (CK).

The subset now clearly outlines care considerations for patients with traumatic injuries leading to crush syndrome or acute compartment syndrome, including those requiring fasciotomy.

The number of episode days in this subset have been updated to reflect the multiple conditions. Based on the geometric mean length of stay (GMLOS) benchmarking data, patients with rhabdomyolysis and crush syndrome may be reviewed up to 5 days. For patients with compartment syndrome, this subset has been extended to 8 days.

Stroke

Had minor definitional clarification for the patient who presents with stroke with image findings for any intracranial hemorrhage that warrants Critical level of care admission.

Syncope

Updated and high-risk criteria were restructured to streamline the review process by separating clinical findings from interventions. New criteria have also been introduced to better account for non-cardiac causes of syncope, such as autonomic dysfunction and polypharmacy.

Withdrawal Syndrome

Updated to improve clinical accuracy, reduce redundancy, and streamline the review process. Key changes included removal of the dehydration criteria and associated laboratory thresholds across episode days, since these elements were duplicative of existing vital sign and symptom findings. Critical level of care criteria for hepatic encephalopathy were simplified by removing medication lists and coma, recognizing that the diagnosis of Grade IV hepatic encephalopathy alone appropriately supports Critical level of care.

Medical Codes

See the Acute Adult Clinical Revisions document for specific code changes.

LOC: Acute Pedi

Global Updates

The 2026 Global revisions improve clinical accuracy, clarity, and review efficiency for reviewers by streamlining criteria, standardizing terminology, and better aligning content with real-world practice and evidence-based guidelines. Key themes include removal of restrictive language (e.g., “sustained” vital signs, rigid frequency or timing requirements), consolidation of overlapping rules, and clarification of clinical intent to support consistent application across scenarios. Criteria were refined to rely on more readily available and clinically meaningful findings (e.g., updated AKI definitions aligned with KDIGO), and allowance for appropriate formulation inclusivity (e.g., PO medications). Several diagnoses were simplified by removing redundant findings or treatment lists now addressed in explanatory notes, while responder criteria were modernized to reflect current care settings and workflows.

- The word “sustained” has been removed from all vital sign thresholds in content to enhance clarity and clinical applicability. The revised criteria now can be satisfied by either a sustained abnormal value based on existing definition or a single, clinically meaningful value that prompts an urgent or emergent intervention. A new definitional note has been added to guide reviewers in the appropriate application of these criteria, ensuring consistent and accurate assessment across clinical scenarios.
- “(includes PO)” has been added to the immunosuppressant criteria line to clarify the intent and be more inclusive of all formulations. Also, the word “therapy” has been removed for clarity.
- “TPN or PPN” criteria were introduced for clinical appropriateness as additional interventions for ileus as a primary condition that has not resolved on continued stay.
- Comorbid arrhythmia criteria were removed from the Intermediate and Critical levels of care as the review can be completed in the appropriate arrhythmia subset—see Carbon Monoxide Poisoning, Failure to Thrive, Hematology/Oncology: Tumor Lysis Syndrome, Infection: COVID-19, Infection: Endocarditis, Withdrawal
- “surgically inserted device” was added to medical prosthetics or implants to broaden the definition of different medical devices that potentially pose a higher risk of serious skin infection if the area affected overlies a medical device
- Comorbid arrhythmia criteria at the Intermediate level of care have been revised for completeness and clarity to now include better distinction between certain antiarrhythmic medications for their proarrhythmic and no proarrhythmic properties to clarify the intent including those antiarrhythmics such as sotalol that require prolonged hospital monitoring due to their inherent risk to ensure clinical appropriateness. In addition, criterion has been defined better to capture the patient being converted from IV to PO antiarrhythmics with either proarrhythmic risk properties or non-proarrhythmic characteristics are ensured appropriate monitoring on the current episode day.

Acute Kidney Injury

Had minor revision to streamline the review process by adding “Oliguria” to replace multiple urine-output descriptors across all episode days.

Antepartum

minor updates to improve workflow and review process for the patient in preterm labor or having vaginal bleeding who requires transitioning from Observation to Acute level of care on Episode Day 2. Also, specific criterion for pre- or gestation Diabetes Mellitus has been clarified.

Asthma

Updated to improve clarity, consistency, and alignment with annual updates of pediatric guidelines. Overall, the changes streamline how clinical response, severity, and risk of decompensation are assessed early and across the hospitalization, supporting more timely and appropriate level of care determinations. Revisions emphasize earlier re-evaluation of treatment response, greater use of objective, age-appropriate indicators of exacerbation severity, and clearer separation of criteria supporting observation versus acute inpatient care.

Bowel Obstruction

Minor update has been made to the Bowel Obstruction subset to focus on standardizing Non-responder language at the Observation level of care for clinical accuracy.

Eating Disorders

The eating disorders content was removed from the General Medical subset and developed into its own condition specific subset. The length of stay was changed from 3-X to 12 days, with Episode Day 12 being the Non-responder day based upon the geometric mean length of stay (GMLOS) benchmark data.

Epilepsy

Revisions focus on improving clinical accuracy of ketogenic diet induction therapy for refractory epilepsy on continued stay based on risk profile during early fasting phase for hypoglycemia or acidosis.

Extended Stay

Updated to strengthen medical necessity review by improving clarity, consistency, and clinical alignment across all levels of care. Revisions refine responder and partial responder pathways to more accurately distinguish patients appropriate for discharge from those requiring continued hospitalization, while simplifying and standardizing criteria to reduce variability in interpretation. Content was reorganized to ensure patients are reviewed based on clinical appropriateness for continued stay. Time-based endpoints and overly granular requirements were removed or adjusted where they did not reflect real-world pediatric care, and new criteria were added to better capture prolonged, resource-intensive management (e.g., acute inflammatory bowel disease complications, herpes infections in high-risk patients, complex and post-fasciotomy wound care).

General Medical

Various updates focus on improving clinical clarity, strengthening alignment with current evidence, and ensuring that level of care determinations more accurately reflect real-world severity and treatment needs. Across the syncope criteria, **orthostatic hypotension** definitions were clarified and expanded, such as adding orthostatic heart-rate changes >40/min to better capture patients with conditions like POTS. Several cardiovascular conditions, including ARVC, CPVT, LQTS, and hypertrophic cardiomyopathy, were organized between Intermediate and Critical levels of care to ensure patients are categorized based on whether they require medication management or invasive device-based interventions (e.g., ICD placement). Lastly, medication-related language was broadened to include initiation, adjustment, and discontinuation, streamlining the review, and capturing the full spectrum of interventions that influence monitoring needs.

Thresholds for **thrombocytopenia** were updated to reflect current multi-societal guidelines, improving accuracy in identifying when platelet levels truly necessitate Acute-level care.

The **Eating disorder** section and criteria have been removed, as the patient with these conditions can now be reviewed in the new Eating Disorders subset.

Gastrointestinal updates include removal of IBD-related findings and hepatic-related conditions as the patient can now be reviewed in the new Inflammatory Bowel Disease and Hepatic Disorder subsets, respectively.

In the **Genitourinary** section on all episode days, the renal calculus without obstruction and urinary tract obstruction (includes hydronephrosis) criteria have been removed, as the patient with these conditions can now be reviewed in the Genitourinary Obstruction subset.

Arrhythmia in the hospitalized patient criteria have been included at the Intermediate level of care to capture the patient who acutely develops an arrhythmia who was being reviewed for another primary condition subset.

General Surgical

Updated to focus on improving clarity, strengthening clinical accuracy and relevance, and ensuring better alignment with real-world perioperative management. The arrhythmia criteria were updated to streamline antiarrhythmic management by distinguishing between antiarrhythmic initiation or adjustments (IV or oral) and higher-risk sotalol initiation, allowing clearer differentiation of in-hospital monitoring needs.

New Pre-op Day content was added at both Observation and Acute levels of care to capture trauma patients requiring urgent ambulatory or designated inpatient procedures, along with appropriate expectations for

analgesic use and IV hydration, ensuring reviewers correctly identify patients whose pre-operative stabilization necessitates hospitalization.

In Operative Day criteria, vomiting-related requirements were revised to clarify failure of PACU antiemetics, improving precision in determining which patients truly need Observation level care. For Post-op Day 1, vomiting criteria were refined to allow qualification through either antiemetics or IV fluids, reflecting real-world treatment patterns.

General Trauma – SUBSTANTIALLY REVISED

General Trauma subset underwent significant changes, including modifications to the workflow, criteria structure, and content.

The following workflow changes were made:

- Patients awaiting an ambulatory surgical procedure who require hospitalization prior to the procedure for severe pain management can now be redirected and reviewed at the Observation level of care in the General Surgical subset
- Similarly, patients awaiting a designated inpatient surgical procedure who require pain and/or fluid management may now be reviewed at the Acute level of care in the General Surgical subset
- Criteria have been incorporated in the General Trauma subset to address injuries that require staged operative procedures in addition to medical management (e.g., burns) or require an ambulatory procedure as part of their treatment plan (e.g., eye injuries)
- Compartment syndrome was removed from this subset and can now be reviewed in the Rhabdomyolysis or Compartment Syndrome subset
- “High risk trauma” criteria were removed from the Intermediate level of care as reviews should focus on identified injuries or concern for injuries, rather than solely on mechanism of injury. Mechanism of injury guidelines are best used for initial first responder/field triage and emergency department evaluation
- “Functional impairment” criteria were moved to the General section on Episode Day 2 at the Observation level of care and are included on Episode Day 3-X at the Acute level of care to account for the patient recovering from injuries who may need continued stay for therapies (e.g., physical therapy, occupational therapy, speech and swallow evaluation, cognitive evaluation)
- “Pain, uncontrolled” criteria were added to the General section on Episode Day 2 at the Observation level of care and are included on Episode Day 2 and 3-X at the Acute level of care to account for the patient who may require continued stay for ongoing pain management
- During each review within the General Trauma subset, the patient may now be evaluated under a different category (e.g., General, Respiratory, Neurological), injury, or intervention depending on their continued need for hospitalization. Despite a change in the reason for continued stay, the review should be conducted on the current episode day, rather than starting from Episode Day 1, since the injury originated from the initial trauma (i.e., not a new condition).
- If the patient sustains an injury while hospitalized (e.g., a fall from the bed), it would be appropriate to apply Episode Day 1 criteria, since this represents a brand-new condition

The structure of the criteria was updated to simplify the review process. Categories have been removed from the Intermediate and Critical levels of care. This change was made as interventions typically drive the need for a higher level of care and can be applied to multiple injuries/conditions.

The significant content changes are as follows:

General

- “Abuse or neglect” criteria were added to the Observation level of care to capture the patient with minor injuries from suspected or actual abuse or neglect which are not otherwise included in the General Trauma subset; however, they require admission to determine a safe discharge plan

- “Foreign body” criteria now include “Airway, esophageal, or stomach foreign body” and “Intestinal foreign body” at the Observation level of care to better define the patient who may need admission due to ingestion or aspiration of a foreign body
- “Snakebite” criteria at the Observation level of care were updated to include site assessments and neurovascular assessments to better account for the patient with a dry bite or concern for envenomation
- “Snakebite” criteria were added at the Critical level of care to capture the patient with envenomation requiring antivenom treatment or close neurovascular and/or neurological monitoring
- “Post antivenom” criteria were added to the Critical level of care on Episode Days 2 and 3-X to account for the patient requiring monitoring after antivenom treatment completion to ensure symptoms and coagulopathy have resolved
- “Bleeding, actual or suspected” criteria for heart rate thresholds were updated to align with the 2025 Pediatric Advanced Life Support (PALS) guidelines
- “Orthostatic hypotension” criteria were removed from the “Bleeding, actual or suspected” as heart rate and hematocrit/hemoglobin changes are more commonly used in trauma resuscitation for blood loss assessment
- “Button battery foreign body” criteria were added at the Critical level of care to capture the patient who has swallowed a button battery and requires monitoring for this serious injury
- “Button battery foreign body” criteria were added at the Acute level of care on Episode Day 3-X to capture the patient who may need serial imaging due to injury concerns proximal to the aorta or requires endoscopic reevaluation
- “Acute kidney injury (AKI)” criteria were removed from the Acute level of care on Episode Day 3-X, as ongoing AKI issues can be reviewed in the Acute Kidney Injury subset

Cardiovascular

- “Chest trauma” criteria for the patient with normal initial ECG and troponin were moved from Acute to Observation level of care, as these tests are sensitive for ruling out blunt cardiac injury. While the patient may require continuous cardiac monitoring, this is appropriate at the Observation level of care.
- “Extremity vascular injury” was added to the “Vascular compromise” criteria at both the Acute and Critical levels of care to include the patient with vascular injuries of the extremities
- “Chest trauma” criteria at the Intermediate level of care were updated to include abnormal ECG findings, accounting for the patient who may need a monitored setting due to an abnormal ECG and/or elevated troponin
- “Pericardial effusion” criteria were updated to include the patient at high risk for cardiac tamponade who may require interventions such as continuous cardiac monitoring and echocardiography
- “Chest trauma” criteria were removed from the Critical level of care, as the patient can be reviewed under other interventions at this level of care (e.g., Arrhythmia, Hemodynamic instability) or under Intermediate “Chest trauma” criteria
- “Thoracoabdominal vascular injury” criteria were added at the Critical level of care to capture the patient requiring nonoperative management of this injury
- “Vascular compromise” criteria at the Critical level of care were updated to better capture the patient with blunt cerebrovascular injuries, extremity vascular injuries, or limb ischemia who may require endovascular revascularization or close neurological/neurovascular monitoring
- “Post endovascular revascularization” criterion was added at the Critical level of care on continued stay to capture the patient who underwent endovascular revascularization within the last 24 hours and requires ongoing monitoring

- “Post permanent pacemaker or ICD placement” criterion was added at the Critical level of care on continued stay to account for the patient requiring this intervention for ongoing arrhythmias due to trauma

Eye

- “Alkali or acid burn of the eye” criterion was moved to the Observation level of care to account for the patient who may require ophthalmology consultation after irrigation of their eye injury
- “Eye injury” criteria at the Acute level of care were updated to better define the patient who requires admission for surgical intervention and those requiring pain control with analgesics and/or anti-infectives on continued stay

Gastrointestinal, Genitourinary, or Biliary

- “Organ injury, suspected” criteria were updated at the Observation level of care to account for the patient with possible abdominal injuries who may require further monitoring
- Definition of abdominal organ injury was broadened to include additional organs such as the kidneys, pancreas, intestines, ureter, and urethra. Interventions to address these injuries were added to the Acute level of care
- “Spleen and liver grade I injuries” criteria were removed from the Observation level of care and all low-grade injuries (e.g., AAST grade < III liver, pancreas, spleen, kidney) can now be reviewed at the Acute level of care due to concern for bleeding
- “Abdominal trauma and angioembolization” criterion was added to capture the patient with abdominal injuries (e.g., liver, spleen) who continues to have bleeding and hemodynamic instability requiring angioembolization
- “Post angioembolization ≤ 24h” criterion was added to capture the patient who underwent angioembolization of an abdominal organ injury within the last 24 hours and requires continued stay at the Critical level of care for up to 24 hours of monitoring
- “High grade organ injury” criteria were added at the Critical level of care to allow the patient with these injuries to have frequent monitoring due to the risk of non-operative management failure

Musculoskeletal

- “Musculoskeletal” criteria were added at the Observation level of care to capture the patient who may require a surgical consultation to be cleared for discharge or to determine if further treatment is warranted
- “Facial fracture” criteria were updated to include the patient at risk for airway compromise or cerebrospinal fluid (CSF) leak who may require frequent assessments and monitoring at the Acute level of care
- “Fracture, subluxation, or dislocation” criteria at the Acute level of care were updated to include interventions such as regional anesthesia and simplified traction subcriteria to better reflect the patient’s needs
- “Cervical skeletal traction” criterion was moved to the Critical level of care, as the patient requires frequent neurological and neurovascular checks and may need sedation depending on age
- “Pelvic fracture” criteria at the Critical level of care were added and includes interventions for hemodynamically unstable patients
- “Pelvic external fixator” criterion was added at the Acute level of care on Episode Day 3-x to provide a place for the patient to step-down from the Critical level of care

Neurological

- “Head trauma” criteria at the Observation level of care were revised to better define the patient who either did not receive head imaging but would benefit from overnight monitoring or the patient who has a negative head CT but remain symptomatic with concussive symptoms

- “Head trauma” criteria at the Acute level of care were updated to capture the patient with a basilar skull fracture, CSF leak, or positive findings on head imaging with a Glasgow Coma Score (GCS) of 15.
- “Head trauma” criteria were added at the Intermediate level of care to include the patient with a negative head CT with Glasgow Coma Score (GCS) of 9-12, or those with positive head imaging finding with a GCS of 13 or 14
- “Head trauma” criteria at the Critical level of care were updated to include the patient with a Glasgow Coma Score (GCS) of less than or equal to 8, depressed skull fracture, focal neurological deficits, or a positive head imaging with GCS less than or equal to 12
- “Neurogenic sodium imbalance” criteria were added at the Critical level of care to account for the patient with cerebral salt wasting, diabetes insipidus (DI), or syndrome of inappropriate antidiuretic hormone secretion (SIADH) resulting from head trauma
- “Paroxysmal sympathetic hyperactivity” (a.k.a., neuro storming) criterion was added at the Critical level of care to account for the patient who develops this condition following head trauma
- “Spinal cord injury” criterion was added at the Critical level of care to be more inclusive of the neurological injuries that may necessitate this level of care
- “External ventricular or lumbar drainage” criterion was moved from the Intermediate level of care to the Critical level of care, as the patient requires more frequent monitoring and may need sedation depending on age

Respiratory

- “Nonfatal drowning” criteria at the Observation level of care were updated to better define the patient who may require hospitalization for monitoring due to the risk of respiratory decompensation but presents with normal exam findings (i.e., clear breath sounds on auscultation)
- “Thoracic injury” criteria were added at the Observation level of care on Episode Day 1 for the patient requiring oximetry monitoring and repeat chest x-ray
- “Nonfatal drowning” criteria were added at the Acute level of care to capture the patient at risk for respiratory decompensation who shows concerning exam findings (i.e., rales on auscultation) and/or requires supplemental oxygen
- “Pulmonary contusion” criterion was added at the Acute level of care to account for the patient with this injury who requires supplemental oxygen
- “Thoracic injury” criteria at the Acute level of care were updated to account for the patient with a hemothorax or pneumothorax requiring chest tube placement
- “Emergent tracheostomy or cricothyrotomy” criterion was added at the Critical level of care to account for the patient requiring the above interventions due to airway trauma
- “Decompression sickness” criteria at the Intermediate level of care on continued stay were updated to include hyperbaric oxygen therapy for the patient who may require additional hyperbaric oxygen treatments

Skin

- Criteria for burns were added at the Observation level of care to capture the patient with second-degree burns who would typically be treated as outpatient but are unable to adhere to the outpatient treatment regimen or when outpatient services are unavailable
- “Low voltage electrical burn” criterion was added at the Observation level of care to account for the patient who may require additional cardiac monitoring and burn care
- “Wound management education” criterion was added at the Observation level of care to capture the patient with complex wounds who may need an overnight stay for education on wound care
- “Burn” criteria at the Acute level of care were updated based on American Burn Association guidelines to account for the patient requiring admission due to the extent of their burn injuries

- “Burn therapy” criteria interventions at the Acute level of care were updated with revised hydration and nutrition criteria, continuous analgesic administration, and neurovascular assessments to improve clinical accuracy
- “Complex wound and treatment” criteria were updated to be more comprehensive and moved to the Acute level of care to better capture the patient who requires admission for advanced wound care
- “Burn” criteria at the Critical level of care were updated to better capture the patient requiring higher-level interventions, including continuous analgesic or sedative administration (excluding PCA), urine output monitoring every 1-2 hours with fluid resuscitation, neurovascular assessments, and wound care requiring procedural sedation

Genitourinary Obstruction

The genitourinary obstruction content was removed from the General Medical subset and developed into its own condition specific subset. The length of stay was changed from 3-X to 5 days, with Episode Day 5 being the Non-responder day based upon the geometric mean length of stay (GMLOS) benchmark data.

Hematology/Oncology: Hemolytic Uremic Syndrome

Had minor updates to improve clinical accuracy as it relates to oxygenation.

Hepatic Disorders - NEW

The Hepatic Disorders subset has been created to centralize common liver-related conditions into a new dedicated subset (“Gastrointestinal or biliary” section was removed from the General Medical subset) and expand clinical criteria to better reflect current guideline-based diagnoses and management of ascites, hepatic encephalopathy (HE), hyperbilirubinemia, and hepatorenal syndrome (HRS).

An Observation level of care has been added to include the review of the patient presenting to the emergency department with undifferentiated hyperbilirubinemia who requires hospital-based imaging for further diagnostic workup. At the Acute level of care, new additions incorporate AKI and hyponatremia as early complications of ascites and associated endpoints were removed based on the geometric mean length of stay (GMLOS) benchmark data. HRS-related interventions have now been included starting on Episode Day 2 based on pathophysiology of the condition. A full set of evidence-based treatments such as albumin, corticosteroids, TIPS, vasoconstrictors, and targeted fluid management and/or fluid restriction measures have also been included. Episode days were recalibrated to align with the updated geometric mean length of stay (GMLOS) benchmarks and appropriate level of care content were included for clinical accuracy.

Infection: COVID-19

Updated to revise the oxygenation threshold to align with current clinical guidelines that delineate patients with severe COVID-19 infection who require supplemental oxygen and clarify the intent associated with COVID-19 targeted therapy.

Infection: Pneumonia

Updated to focus on improving clinical accuracy and aligning respiratory findings with current guideline-based age thresholds. The global change removes “Pneumonia confirmed by imaging” because imaging confirmation is already inherent in the diagnosing acute pneumonia.

Infection: Sepsis

At the **Observation** level of care, revisions focused on capturing well-appearing, low-risk infants with suspected infection. This included removing uncommon findings (e.g., inadequate oral intake) and interventions (e.g., IV fluid), broadening discharge barriers, and updating risk stratification based on the latest American Academy of Pediatric guidelines.

At the **Acute** level of care, updates emphasized identification of well-appearing infants at higher risk for invasive bacterial infection, which included updating risk factors. The systemic infection (excludes viral) content was expanded by removing the age restriction (> 3 months) and eliminating the requirement for a high-risk factor. The “sign or symptom” criteria were refined to reflect typical clinical presentation of a patient with a systemic infection. The structure now requires at least 1 newly added infection-related finding and 2 signs/symptoms of systemic infection, or 1 sign/symptom if the patient is high risk.

At the **Intermediate** level of care, the SIRS criteria have been removed because they are no longer recommended for defining sepsis. These were replaced with findings confirming infection and indicators of host response. “IV fluid resuscitation \geq 2 boluses” has been added to identify the patient who needs closer monitoring despite receiving initial resuscitation. Additionally, chronic ventilator criteria have been added to capture the patient who necessitates the Intermediate level of care based on setting changes.

At the **Critical** level of Care, the SIRS criteria have been removed, and organ dysfunction criteria have been updated to align with the Phoenix Sepsis Score described in recent guidelines. Cardiac dysfunction criteria have been revised to better define the patient who requires the Critical level of care. Several interventions (e.g., mechanical ventilation, invasive hemodynamic monitoring) were made standalone criteria on Episode Day 1, as they independently justify the Critical level of care. Similarly, chronic ventilation criteria were also added at this level to capture the patient who requires acute changes in ventilatory settings.

Infection: Skin

Revised to improve clarity, clinical accuracy, and alignment with current IDSA guidelines while streamlining the review process across all levels of care. Systemic findings such as temperature and WBC thresholds were moved to the Acute level of care to better distinguish moderate to severe skin and soft tissue infections.

New pathways were added, including bullous or widespread impetigo, eczema herpeticum, herpes ophthalmicus, and expanded surgical site infection criteria to ensure comprehensive coverage of pediatric skin infections. Content including Episode Day 2 and beyond was streamlined by focusing on infection improvement status, anti-infective duration, and clinical stability. Intermediate and Critical levels of care were added for consistency across pediatric subsets and to clearly define when advanced respiratory or hemodynamic support is required.

Inflammatory Bowel Disease

The inflammatory bowel disease (IBD) content has been removed from the General Medical subset and developed into its own dedicated condition-specific subset. The length of stay was revised from 3-X to 5 days, with Episode Day 5 being the Non-responder day based upon the geometric mean length of stay (GMLOS) benchmark data. IBD content has been updated to include criteria for the patient with an acute flare (e.g., acute exacerbation) of Crohn’s disease at the Observation level of care. Findings were also refined to more clearly distinguish the patient who requires Observation versus the Acute level of care due to an acute IBD flare based on severity of illness. Length of stay end points for inflammatory bowel disease and ileus have been removed as they are now represented within the episode day structure. Complications of inflammatory bowel disease (i.e., fistula, megacolon, small bowel obstruction) criteria were added to review the patient who requires medical management at the Acute level of care on Episode Day 1 and on continued stay.

Nursery

Updated to streamline review, clarify clinical intent, and ensure more accurate capture of neonates requiring continued Special Care Level II services. The apnea or bradycardia criteria were revised by relocating the clinically significant event definitions into a hover-over note, simplifying reviewer workflow while preserving appropriate intervention requirements. The addition of PPN initiation reflects real-world neonatal practice and ensures infants started on peripheral parenteral nutrition are appropriately identified for this level of care. On Episode Days 2-X, similar refinements were made to apnea or bradycardia criteria and a new criterion for ongoing PPN was added to recognize neonates who continue to require parenteral nutritional support during continued stay.

Rhabdomyolysis or Compartment Syndrome

Rhabdomyolysis or Crash Syndrome was renamed to Rhabdomyolysis or Compartment Syndrome. Extensive restructuring has occurred within this subset to be more inclusive of patients with rhabdomyolysis from all etiologies, including traumatic, exertional, and nontraumatic causes. The diagnostic criteria now emphasize definitive laboratory values over physical findings. References to creatine phosphokinase (CPK) have been expanded to include creatine kinase (CK).

The subset now clearly outlines care considerations for patients with traumatic injuries leading to crush syndrome or acute compartment syndrome, including those requiring fasciotomy.

The number of episode days in this subset have been updated to reflect the multiple conditions. Based on the geometric mean length of stay (GMLOS) benchmark data, patients with rhabdomyolysis and crush syndrome may be reviewed up to 4 days. For patients with compartment syndrome, this subset has been extended to 8 days.

Withdrawal Syndrome

Refined to improve clinical accuracy, reduce redundancy, and streamline the review process. Key changes included removal of the dehydration criteria and associated laboratory thresholds across episode days, since these elements were duplicative of existing vital sign and symptom findings. Critical level of care criteria for hepatic encephalopathy were simplified by removing medication lists and coma, recognizing that the diagnosis of Grade IV hepatic encephalopathy alone appropriately supports Critical level of care.

LOC: Inpatient Rehab

Global revisions

The word “sustained” has been removed from all vital sign thresholds in content to enhance clarity and clinical applicability. A new definitional note has been added to guide reviewers in the appropriate application of these criteria.

Burns

Restructured from a Severity of Illness (SI) and Intensity of Service (IS) model to a week model (i.e., Preadmission, Admission, Week 1, Week 2-3, Week 4) to more accurately differentiate patients who require admission to an inpatient rehabilitation facility, those who require continued stay, and those who are appropriate for discharge to a lower level of care. The week model is based on the geometric mean length of stay (GMLOS) benchmark data and is in alignment with the average length of stay for patients with conditions within this subset.

Within Preadmission and Admission, Week 1, “Skin condition” (e.g., Graft-versus-host-disease, Stevens-Johnson syndrome, wounds requiring complex wound care) has been added to account for conditions that may necessitate and benefit from inpatient rehabilitation.

In Week 2-3, “Speech, language, or swallowing” has been added as an appropriate burn-related impairment that potentially may require therapy intervention to reach established goals.

Non-responder criteria have been added to account for patients who are not clinically appropriate for discharge and exceed episode weeks for this subset.

CNS / TBI

Restructured from a Severity of Illness (SI) and Intensity of Service (IS) model to a week model (i.e., Preadmission, Admission, Week 1, Week 2, Week 3, Week 4) to more accurately differentiate patients who require admission to an inpatient rehabilitation facility, those who require continued stay, and those who are appropriate for discharge to a lower level of care. The week model is based on the geometric mean length of stay (GMLOS) benchmark data and is in alignment with the average length of stay for patients with conditions within this subset.

Within Preadmission and Admission, Week 1, the “Brain injury” subcriteria specific to the Ranchos Los Amigos Scale have been removed to allow for broader clinical judgment and appropriateness, recognizing that various severity classification tools commonly used in practice may be used to assess patients experiencing traumatic brain injury and appropriate for acute inpatient rehabilitation services. “Hemorrhage (intracranial, subarachnoid, or subdural)” has been removed to reduce redundancy, as clinical scenarios represented by this criterion are already encompassed within existing categories such as “Stroke” and “Brain injury.” “Language, speech, or swallowing impairment” has been removed as a qualifying impairment as admission is supported by the patient’s need for and ability to engage in physical and/or occupational therapies.

Non-responder criteria have been added to account for patients who are not clinically appropriate for discharge and exceed episode weeks for this subset.

Medically Intensive Rehabilitation

Restructured from a Severity of Illness (SI) and Intensity of Service (IS) model to a week model (i.e., Preadmission, Admission, Week 1, Week 2, Week 3) to more accurately differentiate patients who require admission to an inpatient rehabilitation facility, those who require continued stay, and those who are appropriate for discharge to a lower level of care. The week model is based on the geometric mean length of stay (GMLOS) benchmark data and is in alignment with the average length of stay for patients with conditions within this subset.

In Preadmission and Admission, Week 1, “Hospital-acquired deconditioning or debility” has been added to clarify the intent and better capture the patient who has acquired generalized deconditioning not attributable to other covered conditions and is appropriate for acute inpatient rehabilitation services. “Myopathy” has been removed as a condition, as a patient experiencing myopathy can be reviewed under “Neuromuscular disorder.” The descriptors “Progressive or degenerative” have been removed from “Neuromuscular disorder” to capture

the patient with a non-progressive neuromuscular disorder who would be appropriate for acute inpatient rehabilitation admission due to a new functional activity limitation. “Brain” and “Spine” are now excluded from “Neoplasm, benign or malignant,” as these conditions can now be reviewed under Inpatient Rehabilitation: CNS / TBI or Inpatient Rehabilitation: Spinal Cord Injury, respectively. “Language, speech, or swallowing impairment” has been removed as a qualifying impairment as admission is supported by the patient’s need for and ability to engage in physical and/or occupational therapies.

In Week 2, “Speech, language, or swallowing” has been added as an appropriate impairment that potentially may require therapy intervention to reach established goals.

Non-responder criteria were added to account for patients who are not clinically appropriate for discharge and exceed episode weeks for this subset.

Orthopedic / Amputation

Restructured from a Severity of Illness (SI) and Intensity of Service (IS) model to a week model (i.e., Preadmission, Admission, Week 1, Week 2, Week 3) in order to more accurately differentiate patients who require admission to an inpatient rehabilitation facility, those who require continued stay, and those who are appropriate for discharge to a lower level of care. The week model is based on the geometric mean length of stay (GMLOS) benchmark data and is in alignment with the average length of stay for patients with conditions within this subset.

On Week 2, “Pain decreased or controlled with increased tolerance of functional activity” has been added as a component related to orthopedic conditions and amputations in which measurable progress may be demonstrated to warrant continued inpatient rehabilitation stay.

Non-responder criteria have been added to account for patients who are not clinically appropriate for discharge and exceed episode weeks for this subset.

Pediatric Rehabilitation

Restructured from a Severity of Illness (SI) and Intensity of Service (IS) model to a week model (i.e., Preadmission, Admission, Week 1, Week 2, Week 3, Week 4) in order to more accurately differentiate patients who require admission to an inpatient rehabilitation facility, those who require continued stay, and those who are appropriate for discharge to a lower level of care. The week model is based on feedback from InterQual® external peer reviewers regarding the average length of stay for pediatric patients with conditions within this subset.

In Preadmission and Admission, Week 1, there were several additions and changes made to conditions listed as appropriate for inpatient rehabilitation facility admission.

Throughout the subset, the intensity of therapies has been revised from “≥ 3h/d of skilled therapy ≥ 5d/wk” to “≥ 15h/wk” to allow for greater flexibility in scheduling therapy sessions and accounting for situations in which a patient may be medically unable to participate in 3 hours of therapy on certain days but can still meet the weekly therapy threshold.

On Week 2 and Week 3, “Measurable progress documented toward pre-established goals with gains sustained” has been updated from “≥ Two” to “≥ One” as the requirement for intervention by at least two therapy disciplines is captured within the “Daily skilled therapy” criteria. Discipline-specific references (i.e., PT, OT, ST) have been removed to eliminate which therapy services may be appropriate for a given criterion to reinforce that therapists will operate within their individual scope of practice and according to the patient’s individualized plan of care, rather than being limited by predefined discipline assignments. Findings under “Medical instability (new onset) and decreased participation in therapy for ≤ 3d” were updated to better reflect conditions that may limit a patient’s ability to fully participate in skilled therapies.

On Week 3, “Burn”, “Brain injury”, “Guillain-Barré syndrome”, “Spinal cord injury or spinal cord stroke”, and “Stroke” have been added as appropriate conditions that may require an additional week of inpatient rehabilitation, which is supported by InterQual® external peer reviewers.

Non-responder criteria have been added to account for patients who are not clinically appropriate for discharge and exceed episode weeks for this subset.

Spinal Cord Injury

Restructured from a Severity of Illness (SI) and Intensity of Service (IS) model to a week model (i.e., Preadmission, Admission, Week 1, Week 2, Week 3, Week 4) in order to more accurately differentiate patients who require admission to an inpatient rehabilitation facility, those who require continued stay, and those who are appropriate for discharge to a lower level of care. The week model is based on the geometric mean length of stay (GMLOS) benchmark data and is in alignment with the average length of stay for patients with conditions within this subset.

Within Preadmission and Admission, Week 1, the criterion “Spinal cord injury” has been revised to “Spinal cord injury or dysfunction” to include other conditions (e.g., cauda equina, myelopathies, spinal stenosis) which may appropriately warrant inpatient rehabilitation services but are not directly captured under “Spinal cord injury” alone.

Non-responder criteria were added to account for patients who are not clinically appropriate for discharge and exceed episode weeks for this subset.

LOC: Outpatient Rehab

Habilitation

Underwent terminology updates to align with the broader Outpatient Rehabilitation & Chiropractic product, improve overall usability, and clarify clinical intent.

Throughout the subset, the phrase “patient and/or caregiver” has been standardized to more accurately represent scenarios in which either or both parties may participate in the maintenance program.

In the adult and pediatric physical, occupational, and speech therapy pathways, the description and application of objective measurements have been updated. This revision ensures inclusivity of patients whose assessment outcomes should be compared to their prior level of function, as they previously may not have demonstrated normal values.

In the “Additional treatment beyond initial treatment authorization or treatment visits” pathways, “Weeks of occupational therapy (OT) / physical therapy (PT) / speech therapy (ST) previously authorized for this episode of care” has been revised to “Previously authorized weeks or treatment visits attended of occupational/physical/speech therapy for this episode of care” to clarify that the required response reflects the number of visits or weeks previously authorized, not the amount currently being requested.

Maintenance

Underwent terminology updates to align with the broader Outpatient Rehabilitation & Chiropractic product, improve overall usability, and clarify clinical intent.

“Diagnosed with a chronic progressive condition or persistent functional impairment” has been revised to “Persistent functional impairment present or chronic progressive condition” to emphasize that a diagnosis of a progressive condition is not required for the patient to qualify for or benefit from outpatient maintenance services.

On the “Authorization of treatment following initial evaluation (prior to treatment)” and “Additional treatment beyond initial treatment authorization or treatment visits” pathways, new indications have been added to occupational therapy and physical therapy to better specify when maintenance services may be appropriate to preserve current functional status or to prevent or slow further deterioration.

On the “Authorization of treatment following initial evaluation (prior to treatment)” and “Additional treatment beyond initial treatment authorization or treatment visits” pathways under the “Documented plan of care requiring skilled intervention” and “Update plan of care” questions respectively, “Patient and/or caregiver training and education in home treatment program (unskilled/unsupervised) designed to maintain level of function or slow functional decline” has been removed because an unskilled or unsupervised home program, while beneficial and valuable, is not an essential component when the maintenance program is being managed and delivered by a skilled therapist.

Within the “Additional treatment beyond initial treatment authorization or treatment visits” pathways, the language has been refined to distinguish between maintenance programs in which a therapist conducts a follow-up visit to evaluate program effectiveness and those in which the maintenance program is actively delivered by a skilled therapist.

In addition, throughout the subset, the phrase “patient and/or caregiver” has been standardized to more accurately represent scenarios in which either or both parties may participate in the maintenance program.

Rehab

Underwent terminology updates to align with the broader Outpatient Rehabilitation & Chiropractic content, improve overall usability, and clarify clinical intent.

Throughout the subset, the phrase “patient and/or caregiver” has been standardized to more accurately represent scenarios in which either or both parties may participate in the maintenance program.

In the adult and pediatric “Outpatient therapy (OT, PT, ST)” pathways under the “Authorization of treatment following initial evaluation (prior to treatment)” and “Additional treatment beyond initial treatment authorization or treatment visits”, indications were expanded and refined under “Musculoskeletal”, “Neurological (disorder)”,

“Pain syndromes”, “General deconditioning”, “Pelvic floor dysfunction”, “Communication, cognition, or voice disorder”, “Swallowing or feeding dysfunction”, “Congenital disorder”, “Developmental delay”, and “Neurodevelopmental disorder”, as appropriate impairments that may require skilled therapy intervention. In the “Lymphedema” pathways, percentage comparisons have been removed to align with common clinical documentation and the International Society of Lymphology (ISL) classifications, which utilize staging versus percentage comparison to the contralateral limb. The description of objective measurements has been revised to ensure inclusivity of patients whose assessment outcomes should be compared to their prior level of function, as they may not have previously demonstrated normal values.

Within the adult and pediatric “Outpatient therapy (OT, PT, ST)” pathways under the “Additional treatment beyond initial treatment authorization or treatment visits” pathways, “Weeks of occupational therapy previously authorized or treatment visits attended for this episode of care” and “Weeks of physical therapy/speech therapy previously authorized or treatment visits attended” were revised to “Previously authorized weeks or treatment visits attended of occupational therapy/physical therapy/speech therapy for this episode of care” to clarify that the response should reflect the number of visits or weeks previously authorized, not the amount currently being requested.

In the adult “Comprehensive pulmonary rehabilitation program” and “Comprehensive cardiac rehabilitation program” pathways, “nonphysician practitioner” has been added as an appropriate medical professional authorized to order pulmonary and cardiac rehabilitation, aligning with Centers for Medicare & Medicaid Services policy.

Under the adult “Comprehensive pulmonary rehabilitation program” pathway, “Confirmed or suspected COVID-19” has been added as an appropriate condition that may benefit from a pulmonary rehabilitation program, which is in alignment with updated guidelines.

On the adult “Comprehensive cardiac rehabilitation program” pathway, the heart failure specific pathway (questions and indications) have been removed as it is now nested under “Stable, chronic heart failure” and follow-up questions can be found in attached notes.

Procedures

Note that procedures reviewed by eviCore are excluded from the info below.

Cardiology

Exercise Treadmill Testing (ETT): updated criteria throughout the subset to improve usability

Neurosurgery

Changed “nerve root compression” to “nerve or nerve root compression” for all indications within Decompression +/- Fusion, Lumbar subset.

Obstetrics & Gynecology

- For individuals aged 45 or older with abnormal uterine bleeding, criteria were added for endometrial evaluation to rule out endometrial cancer or other causes of bleeding before any interventions are performed.
- The definition of infertility was clarified and updated to align with current guidelines.
- Criteria for simple hysterectomy were added for individuals with cervical cancer stage IA2 or IB1 when specific tumor characteristics (e.g., histology, size, conization findings, depth of invasion) are present.
- Throughout the updated subsets listed below, removed criteria referring to continued symptoms or findings after treatment to streamline criteria, since pathways are often structured to review symptoms and findings first, then review the prior treatments, and the continued nature of symptoms or findings is implied.

Oro-Maxillo-Facial, Dental & Otolaryngology

Arthroplasty, Temporomandibular Joint (TMJ): revised the required therapies that should be tried prior to arthroplasty, and expanded the indications with additional subtypes of intra-articular temporomandibular disorder.

Orthognathic Surgery: Requirement for dental model assessments were removed to streamline criteria as there are variations in practice in how these models are completed, utilized, and documented in the medical record.

Specialized Procedures

Electromyography (EMG) and Nerve Conduction Studies (NCS): Defined severity of symptoms for carpal tunnel syndrome (CTS) as defined by guidelines. Differentiated the appropriate pathways for patients who have mild or moderate carpal tunnel syndrome (CTS). Included the CTS-6 scoring criteria in patients who have mild CTS and whether conservative treatment would be required prior to electrodiagnostic studies. Clarified that nerve conduction studies (NCS) with or without electromyography (EMG) is appropriate to diagnosis a patient who have carpal tunnel syndrome (CTS). Added corticosteroid injection as a conservative treatment for patients with carpal tunnel syndrome (CTS).

Retired Subsets

- Aortic Valvuloplasty, Percutaneous Balloon
- Biopsy, Adrenal Mass, Needle
- Cholangiogram, Intraoperative (Pediatric)
- Cystolithotomy (Pediatric)
- Dental Implant, Osseointegrated
- Discectomy, Temporomandibular Joint (TMJ)
- Facial Nerve Repair
- Hearing Device, Middle Ear
- Hydrocelectomy (Pediatric)

- Hyperbaric Oxygen Therapy (Pediatric)
- Laparoscopy, Diagnostic (Abdomen) (Pediatric)
- Laparotomy or Exploratory Laparotomy (Pediatric)
- Lithotripsy, Extracorporeal Shock Wave (ESWL) (Pediatric)
- Lung Volume Reduction Surgery (LVRS)
- Mitral Valvuloplasty, Percutaneous Balloon
- Nerve Graft, Hand or Digit
- Orbitotomy
- Photocoagulation, Grid Laser
- Plantar Fasciitis, Extracorporeal Shock Wave Therapy (ESWT)
- Pneumonectomy
- Proton Beam Radiotherapy (PBRT) (Pediatric)
- Pyloromyotomy (Pediatric)
- Reconstruction, Temporomandibular Joint (TMJ)
- Salpingostomy
- Sympathectomy
- Thrombolysis, Deep Vein Thrombosis (DVT)
- Thyroidectomy, Partial or Total (Pediatric)
- Tibial Nerve Decompression
- Ureteroscopy (Pediatric)
- Urethral Sling, Male

Medical Codes

See the Procedures Clinical Revisions document for specific code changes.

No significant revisions

- LOC: Home Care
- LOC: LTAC
- LOC: SAC/SNF

Clinical Review Criteria

Policy Number: OCA UMC 3.201

Version Number: 45

Version Effective Date: 06/01/26

Impacted Products

- All Products**
- NH Clarity plans
- NH Medicaid
- NH Medicare Advantage
- MA MassHealth ACO
- MA MassHealth MCO
- MA Clarity plans/Employer Choice Direct

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The WellSense Health Plan Utilization Management Committee (UMC) determines which non-urgent/non-emergent medical/surgical and behavioral health services are subject to prior authorization when managed by the Plan or its delegated clinical suppliers. At least annually, the UMC reviews and approves all Plan-adopted medical necessity criteria and any revisions to criteria used to assess the medical necessity of covered services, including those developed by delegated clinical suppliers. Approval of Plan-adopted criteria constitutes authorization for their use in managing covered services.

In determining whether non-urgent/non-emergent services require prior authorization, the UMC evaluates six factors using quantitative and non-quantitative benchmarks, threshold, and measures: clinical efficacy, comparable efficacy, patient safety, cost, utilization patterns, and susceptibility to fraud, waste, and abuse. These six factors are evaluated holistically, weighted equally, and may be applied in any order during the annual comprehensive assessment. As a steward of public funds, the Plan monitors utilization, cost, and encounter data to identify services that are high cost, overutilized, or at increased risk for fraud, waste, and abuse. Clinical considerations guide the identification of services appropriate for prior authorization, including those lacking sufficient evidence of efficacy or safety, not recognized as standard of care for the indication, or where alternative treatments may offer greater clinical benefit. Prior authorization is applied when advance verification of medical necessity is

reasonably expected to improve clinical outcomes and ensure services are delivered in a medically appropriate, safe, and cost-effective manner.

This policy defines the Plan's process for making utilization review decisions using written clinical review criteria based on sound, current clinical evidence. The Plan conducts all utilization review activities, including prior authorization, in accordance with applicable policies and procedures and the Plan's Utilization Management (UM) Program. The Plan complies with all applicable state and federally-mandated benefit coverage guidelines for medically necessary services. In addition, the Plan's guidelines (including but not limited to appeals and/or clinical reconsiderations) comply with all applicable Plan contract terms with providers, employers, governmental agencies, and other contracting entities.

Plan authorizations, as well as authorizations by each of the Plan's partner clinical suppliers delegated for utilization management, are conducted by appropriately qualified staff. Medical necessity determinations are based on consistently applied clinical review criteria and a comprehensive, individualized needs assessment that addresses all member needs, including but not limited to social determinants of health and a subsequent person-centered planning process to integrate healthcare for continuity, coordination, and collaboration of services. Plan prior authorization requirements (and those of each of the Plan's delegated clinical suppliers) are not more stringent nor applied more stringently for behavioral health services (i.e., interventions and support services used for mental health and substance use disorders) than for medical/surgical services and therefore comply with parity in coverage and medical necessity guidelines for mental health and substance use disorders. The Plan and the Plan's delegated clinical suppliers conducting utilization management do NOT discriminate, arbitrarily deny, or impose stricter requirements by reducing the amount, duration, or scope of required and medically necessary services for any Plan member based on the member's diagnosis, type of illness, health status or condition, disability, age, race, color, ethnicity, national origin, religion, sex, gender identity/gender incongruence, and/or sexual orientation.

All Plan-adopted written clinical review criteria are developed, reviewed at least annually, and updated as appropriate based on credible clinical findings and evidence-based standards of care in accordance with contractual requirements, state and federal regulations, and guidelines from accrediting organizations, including the National Committee for Quality Assurance (NCQA). Review the Plan's *Prior Authorization/Notification Requirements Matrix*, *Code Look-up Tool*, medical policies for medical, surgical, and behavioral health services, medical drug policies, pharmacy policies, and the Plan's pharmacy formulary (available via the drug search tool or the formulary guidebook) to determine if prior authorization is required. For the Plan's MassHealth members, the Plan follows the guidelines and clinical review criteria documented in the MassHealth Drug List, including but not limited to treatments specified on the MassHealth Acute Hospitals Carve-Out Drugs List, available at:

<https://mhdl.pharmacy.services.conduent.com/MHDL/>

Review the member's product-specific handbook on the Plan's website for benefit coverage guidelines, benefit limitations, and a summary of member rights and responsibilities, as well as the Plan's process for receiving and promptly resolving inquires, grievances, or appeals from a member (or an authorized representative acting on behalf of the member). Member appeals may be related to

issues that include but are not limited to benefit coverage, the evaluation of clinical technology (including new technology and a new indication for an established technology), and/or the application of the Plan's clinical review criteria for the member's requested indication for treatment.

Policy Statement

Plan-adopted written clinical review criteria are used to determine the medical necessity of services that require utilization review, including medical services, surgical treatment, pharmacotherapy and pharmacy services, medical drug management, behavioral health services, radiological services, dental services, and durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). In addition, clinical review criteria are used to determine the most clinically appropriate level of care and intensity of services to ensure the provision of medically necessary services. Plan-adopted written clinical review criteria include the Plan's internally developed medical policies for medical, surgical, and behavior health services, medical drug policies, pharmacy policies, InterQual® criteria utilized by the Plan, state-mandated policies, and clinical guidelines established by delegated management partners (for related services provided to Plan members for applicable Plan products). When the Plan conducts utilization review (UR), appropriately qualified professional Plan staff consistently apply current, Plan-adopted written clinical review criteria.

Plan staff (including but not limited to representatives from the Plan's Accreditation, Utilization Management, Pharmacy, and Supplier Management Departments) routinely collect and review documentation to verify that quality standards are met by clinical suppliers who are delegated to conduct utilization management on behalf of Plan members, including but not limited to contractual obligations and the guidelines specified in the Delegated Management section of this policy. When national clinical guidelines (e.g., InterQual® criteria) are not available or not adopted by the Plan, Plan-specific criteria may be established and documented in internally developed medical policies for medical, surgical, and behavioral health services, medical drug policies, and pharmacy policies. The development of Plan-adopted clinical criteria utilized to make utilization management decisions for services (including but not limited to new and established treatments, applications, and technologies) requires a thorough review of published and generally accepted, scientifically-based standards of care before Plan-adopted clinical criteria are utilized to make medical necessity determinations.

The development and review of the Plan's internal clinical criteria include input from participating practitioners and consultant specialists in the related specialties that may include but are not limited to licensed pharmacists, community-based providers, behavioral health clinicians, and physician specialists in psychiatry, neonatology, pediatrics, family medicine, internal medicine, medical/pediatric/surgical subspecialties, and geriatrics. Practitioners with professional expertise and relevant credentials in the clinical area being reviewed have the opportunity to advise or comment on the development, adoption, and implementation of all UM criteria utilized by the Plan; this includes feedback from qualified practitioners on staff at the Plan or delegated clinical suppliers, outside physician consultants, provider reviewers, and practicing providers in the local community. All participating providers in the Plan's network, and practitioners treating Plan members may submit recommendations and comments on Plan-adopted clinical criteria. The Plan-adopted written clinical review criteria (i.e., the Plan's internal medical policies, medical drug policies, pharmacy policies,

InterQual® criteria utilized by the Plan, state-mandated policies, and clinical guidelines implemented by the Plan's delegated management partners for related services provided Plan members by Plan product type) are objective, scientifically derived, and evidence-based for the requested service(s) and indication(s) for treatment and are compliant with applicable legal obligations, regulatory requirements, and national accreditation organization standards.

The Plan's clinical coverage criteria and UM decision tools are applied equitably across the Plan's membership. All Plan-adopted written clinical review criteria are clinically reviewed at least annually to verify that these clinical guidelines are consistent with generally accepted standards of medical/clinical practice which are based on objective, current, and credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying on controlled clinical trials. On at least an annual basis, Plan staff confirm that all clinical review criteria utilized by the Plan (including all of the Plan's internal medical policies for medical, surgical, and behavioral health services, medical drug policies, pharmacy policies, InterQual® criteria adopted by the Plan, state-mandated policies, and clinical guidelines implemented by the Plan's delegated management partners for related services) have had an annual clinical review and the procedures for applying those clinical review criteria are documented.

Updates to clinical review criteria are implemented as new treatments, applications, and technologies are adopted and become components of generally accepted professional practice for behavioral health, medical/surgical services, dental services, and/or pharmacotherapy. The Plan's UM staff applies the clinical review criteria consistently; however, UM staff also takes into account the member's individual needs and circumstances. When clinical review criteria are not met for a requested treatment such that medical necessity cannot be established for the member's condition or indication for treatment, UM staff engages in discussions with licensed Plan Clinical Pharmacists, UM clinicians, and/or Plan Medical Directors to determine if the clinical review criteria are appropriate for the member's circumstances or local delivery system (utilizing qualified Plan clinicians applicable for the member's condition and requested treatment). If the clinical review criteria are not appropriate, UM staff may make the utilization determination based on the member's condition and other unique circumstances. The Plan's Medical Directors and/or licensed Plan Clinical Pharmacists also consider member-specific factors when applying clinical criteria to a request for services. The Delegated Management section of this policy includes delegated management guidelines applicable for the Plan's partner clinical suppliers, including Plan oversight and the development, review, and application of clinical suppliers' clinical review criteria.

Optum staff analyze over 3,000 medical literature sources daily to review and update current InterQual® clinical review criteria and to develop criteria for new technologies and new application(s) of existing technologies. InterQual® criteria are developed and implemented in accordance with generally accepted standards of medical/clinical practice which are based on objective, current, and credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying on controlled clinical trials. In addition, InterQual® criteria are evaluated by an independent clinical review panel drawn from more than 900 experts for authoritative peer review, utilizing providers with expertise and appropriate credentials in the applicable clinical area under consideration. Inter-rater reliability testing is conducted annually by the Plan using the Plan-

adopted InterQual® criteria sets. InterQual® criteria are revised, as necessary, throughout the year (at least annually but may occur quarterly).

Delegated Management

The Plan's delegated clinical suppliers conduct utilization management for behavioral health services (until December 1, 2025 for the Plan's NH Medicaid product and until January 1, 2026 for the other Plan products, as noted below), genetic testing, musculoskeletal services (i.e., joint surgeries, spine surgeries, and interventional pain management treatments), radiology services, medical drug management services, pharmacy services, dental and vision services, and durable medical equipment, prosthetics, orthotics and supplies on behalf of Plan members when applicable for specific services and/or the Plan product. Practitioners with clinical expertise in the area being reviewed have the opportunity to advise or comment on the development, adoption, and implementation of utilization management criteria established by the Plan's delegated management partners; this includes feedback from qualified practitioners on staff at the Plan or delegated clinical suppliers, outside physician consultants, provider reviewers, participating providers in the Plan's network, and practitioners treating Plan members.

All Plan-adopted written clinical review criteria, including clinical guidelines implemented by delegated clinical suppliers, are reviewed at least annually (or more frequently when policy revisions require more immediate implementation). Clinical review criteria utilized by each of the Plan's delegated clinical suppliers are adopted with oversight by the clinical supplier's Medical Director who is an actively practicing physician responsible for the oversight of the clinical supplier's utilization management program. Proposed new and revised clinical guidelines are evaluated by the clinical supplier's expert panel, all of whom are practicing clinicians and acknowledged experts in the relevant fields and pertinent specialties. All clinical review criteria are developed in accordance with applicable state and federal requirements and guidelines from applicable national accreditation organizations. When the Plan has not implemented treatment-specific medical necessity criteria for the requested service, the Plan may use applicable clinical review criteria implemented by a Plan delegated clinical supplier (and adopted by the Plan) for prior authorization requests managed directly by the Plan, requests that require Plan Medical Director review, and/or to make medical necessity determinations related to appeals or grievances.

The clinical review criteria and UM decision tools from each of the Plan's delegated clinical suppliers are applied equitably across the Plan's membership. However, delegated clinical suppliers' professional staff (when the management of services is delegated to clinical suppliers) will take into account the member's individual needs, circumstances, and healthcare services requested and/or currently provided to the member to integrate healthcare for continuity, coordination, and collaboration of services, as well as assessing the local healthcare delivery system's ability to meet the member's healthcare needs, when determining the medical necessity of services. Inter-rater reliability testing is utilized by the Plan's delegated clinical suppliers to assess the consistency and adherence to clinical review criteria. At least quarterly, the consistency with which the healthcare professionals involved in prior authorization apply criteria in decision making is evaluated by delegated clinical suppliers using a variety of mechanisms. The application of medical necessity criteria by Medical

Directors and non-physician reviewers is assessed to ensure consistency and accuracy. Results are reported to the Plan.

Below are delegated management guidelines applicable for the Plan's partner clinical suppliers, including Plan oversight and the development, review, and application of clinical suppliers' clinical review criteria.

1. Plan's Delegated Services and Partner Clinical Suppliers:

When applicable for the Plan product, the following services are managed by a delegated clinical supplier for a Plan member, as stated in items a through e:

a. Dental Services:

The Plan's dental suppliers include:

(1) Delta Dental of Massachusetts:

Delta Dental of Massachusetts establishes policies for communicating criteria to providers, and this supplier has its own clinical criteria and procedures which have been approved as part of the Plan's delegation oversight using appropriately qualified, licensed dentists for utilization management. As of November 23, 2016, the Plan has delegated the utilization management of dental services to Delta Dental of Massachusetts for Massachusetts Clarity plans/Employer Choice Direct pediatric members aged 19 or younger.

(2) Northeast Delta Dental:

Northeast Delta Dental administers the dental benefits for the Plan's New Hampshire Medicare Advantage HMO members (as of October 1, 2023) and New Hampshire Medicare Advantage PPO members (effective January 1, 2025), but the Plan has NOT delegated utilization management to this dental supplier. Northeast Delta Dental will provide dental consultants to WellSense during a medical necessity review, when necessary; these dental consultants are appropriately qualified, licensed dentists on staff at Northeast Delta Dental.

b. Durable Medical Equipment, Prosthetics, Orthotics and Supplies - Northwood, Inc.:

Effective April 1, 2011, the Plan delegated the utilization management of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) to an NCQA-accredited DMEPOS clinical supplier, Northwood, Inc. The Plan has retained the management of medical necessity denial decisions and notifications. This clinical supplier has its own clinical criteria policy and procedure which has been approved as part of delegation oversight. The Plan may use

Northwood medical necessity criteria for DME requests managed by the Plan when DME-specific criteria have not been established by the Plan.

c. Genetic Testing, Musculoskeletal Services, and Radiology Services – eviCore healthcare:

Effective March 15, 2010, the Plan delegated the utilization management of radiology services to an NCQA-accredited managed care clinical supplier, eviCore healthcare MSI, LLC (d/b/a eviCore healthcare). As of March 1, 2023, the Plan has delegated to eviCore the utilization management of genetic testing and musculoskeletal services (i.e., joint surgeries, spine surgeries, and interventional pain management treatments), as well as the ongoing utilization management of radiology services (e.g., MRI, MRA, CT, CTA, PET scan, nuclear cardiology studies) for Plan members. eviCore develops and utilizes criteria to make utilization management decisions for requested services, establishes policies for communicating those criteria to providers and members, and evaluates consistency in the application of those criteria through inter-rater reliability testing when determining medical necessity for these delegated services.

d. Pharmacy Benefits Manager – Express Scripts:

Effective January 1, 2021, Express Scripts is the Plan’s pharmacy benefits manager for the Plan’s products. Express Scripts adopts the guidelines included in this Plan’s Clinical Review Criteria administrative policy and adheres to the Plan’s administrative UM policies and clinical policy criteria, unless specifically delegated such as the Plan’s Medicare product lines. Policies delegated to Express Scripts have been approved as part of delegation oversight. Effective December 1, 2019, the Plan’s pharmacy mail order company for all the Plan’s Massachusetts and New Hampshire products is Cornerstone Health Solutions.

e. Medical Drug Management – Care Continuum:

Effective January 1, 2025, the Plan delegated utilization management of medical drug services to Care Continuum for select Plan products. Care Continuum is an NCQA-accredited managed care clinical supplier with expertise in the management of medical drug services. CCUM adopts the guidelines included in the Plan’s Clinical Review Criteria administrative policy and adheres to the Plan’s administrative UM policies and clinical policy criteria, unless specifically delegated.

2. Clinical Supplier Clinical Review:

a. Review and Application of Clinical Supplier Established Clinical Review Criteria:

The Plan’s Utilization Management Committee reviews at least annually and adopts the clinical review criteria established by partner clinical suppliers for genetic testing, musculoskeletal services, radiology services, and durable medical equipment, prosthetics, orthotics and supplies after confirmation that these medical necessity guidelines are based on sound, current clinical evidence. The Plan’s Oversight Committee conducts an annual review of each clinical supplier

that conducts delegated management for Plan members to ensure that all of the following guidelines are met: each clinical supplier conducts an annual review of its clinical criteria, approving and implementing criteria that are objective, scientifically-derived, and evidence-based for the requested service(s) and indication(s) for treatment and compliant with applicable legal obligations; each clinical supplier completes an annual review and approval of policies and procedures developed to ensure that the clinical supplier's clinical criteria are consistently applied to Plan members for a requested service. The service may include a treatment, procedure, supply, device, biologic, or drug that will be used to prevent, diagnose, stabilize, or treat a disease, condition, or disorder that results in health impairment or disability, or the service allows the member to attain, maintain, or regain functional capacity. The clinical suppliers will also consider member-specific factors impacting the member's individual healthcare needs when applying clinical review criteria to determine if the service is medically necessary for the requested indication in consultation with a Plan Medical Director, when appropriate. Timely individual consideration of requests and determinations of case-by-case exceptions for medically necessary services include a comprehensive assessment of all member needs and member-specific factors impacting care, including but not limited to social determinants of health and subsequent person-centered planning, with evaluation of one or more of the following factors:

- (1) Member's condition, including diagnoses and functional status;
- (2) Member's comorbidities;
- (3) Member's age, including the assessment of the member's age-appropriate growth, development, and competencies, as well as evaluation of age-related and condition-specific healthcare needs and associated issues (and determine if requested service meets EPSDT guidelines for a Medicaid member aged 20 or younger);
- (4) Relevant past medical/surgical/behavioral health/dental/pharmacotherapy history;
- (5) Complications;
- (6) Progression of the member's condition, illness, or injury;
- (7) Diagnostic test results;
- (8) Treatment outcomes;
- (9) Treatment options;
- (10) Treating provider's recommendations and clinical notes;
- (11) Psychosocial circumstances;

- (12) Home and environmental factors impacting member's clinical condition (e.g., homelessness, employment status, poverty, neighborhood);
- (13) Other healthcare services requested and/or provided to the member to integrate healthcare for continuity, coordination, and collaboration of services;
- (14) Local healthcare delivery system's ability to meet the healthcare needs of the member's specific condition;
- (15) Availability of an in-network provider to meet the healthcare needs of the member's specific condition;
- (16) Member's reasonable accessibility to a qualified provider with appropriate credentials, licensure, clinical expertise, clinical and linguistic capabilities, and/or resources in the applicable clinical area necessary to adequately manage the member's condition (including but not limited to pharmacotherapy, behavioral health services, dental services, radiology services, and/or durable medical equipment, prosthetics, orthotics and supplies);
- (17) Other factors related to the member's plan of care or health outcomes; AND/OR
- (18) If applicable, verification that the requested device, therapeutic, biologic, or drug is being prescribed/requested and will be utilized according to its FDA-approved or compendia indication and guideline information, including intended use for the member's age and medical condition.

b. Clinical Supplier Review of Requested Service Without Written Clinical Review Criteria:

If written clinical review criteria have not been established for the requested service (for the specified indication) by the Plan's delegated management clinical suppliers, these clinical suppliers will use published and applicable generally accepted, scientifically-based standards of care and objective current, and credible scientific evidence published in peer-reviewed medical/clinical literature, and/or reviewing observational studies for a request for services for a Plan member to make medical necessity determination. If scientifically-based standards of care are not available, observational studies from more than one (1) institution that suggest a causal relationship between the service or treatment and health outcomes may be used by the delegated utilization management clinical suppliers to make medical necessity determinations if these observational studies are clinically appropriate with respect to the member's clinical presentation.

The Plan's delegated management clinical suppliers will also consider member-specific factors impacting the member's individual healthcare needs to determine if a covered service is medically necessary for the requested indication. Covered services and benefit limitations are noted in the member's product-specific benefit documents. The covered service may include a

treatment, procedure, supply, device, biologic, or drug and will be used to prevent, diagnose, stabilize, and/or treat a disease, condition, and/or disorder that results in health impairment and/or disability, and/or the service allows the member to attain, maintain, or regain functional capacity. Timely individual consideration of requests and determination of case-by-case exceptions for medically necessary services include a comprehensive assessment of all member needs and member-specific factors impacting care, including but not limited to social determinants of health and subsequent person-centered planning, with evaluation of one or more of the following factors and in consultation with a Plan Medical Director, when appropriate:

- (1) Member's condition, including diagnoses and functional status;
- (2) Member's comorbidities, including the assessment of ongoing and/or chronic conditions with services authorized in a manner that reflects the member's continuing need for such services and supports for stabilization of one or more ongoing and/or chronic conditions;
- (3) Member's age, including the assessment of the member's age-appropriate growth, development, and competencies, as well as evaluation of age-related and condition-specific healthcare needs and associated issues;
- (4) Relevant past medical/surgical/behavioral health/dental/pharmacotherapy history;
- (5) Complications;
- (6) Progression of the member's condition, illness, or injury;
- (7) Diagnostic test results;
- (8) Treatment outcomes;
- (9) Treatment options;
- (10) Treating provider's recommendations and clinical notes;
- (11) Psychosocial circumstances;
- (12) Home and environmental factors impacting member's clinical condition (e.g., homelessness, employment status, poverty, neighborhood);
- (13) Other healthcare services requested and/or provided to the member to integrate healthcare for continuity, coordination, and collaboration of services;
- (14) Local healthcare delivery system's ability to meet the healthcare needs of the member's specific condition;

- (15) Availability of an in-network provider to meet the healthcare needs of the member's specific condition;
- (16) Member's reasonable accessibility to a qualified provider with appropriate credentials, licensure, clinical expertise, clinical and linguistic capabilities, or resources in the applicable clinical area necessary to adequately manage the member's condition, including but not limited to pharmacotherapy, behavioral health services, dental services, radiology services, or durable medical equipment (prosthetics, orthotics and supplies);
- (17) Other factors related to the member's plan of care or health outcomes;
- (18) If applicable, verification that the requested device, system, biologic, or drug is being prescribed/requested and will be utilized according to its FDA-approved or compendia indication and guideline information, including intended use for the member's age and medical condition.

c. Clinical Supplier Evaluation of New Technology:

The Plan's partner clinical suppliers evaluate new technology and new application(s) of an established technology to develop new clinical review criteria or revise established clinical review criteria when clinically appropriate. The Plan's partner clinical suppliers will use published and applicable generally accepted, scientifically-based standards of care; objective, current, and credible scientific evidence published in peer-reviewed medical/clinical literature; and/or reviewed observational studies for the new technology or new application(s) of an existing technology in order to establish written clinical review criteria that will be used to make medical necessity determinations (in addition to individual consideration of the member's status and healthcare needs). When a requested covered service does not have established, applicable clinical review criteria, the medical necessity of the service is determined on a case-by-case basis for timely individual consideration indication, as specified above in the Clinical Supplier Review of Requested Service Without Written Clinical Review Criteria section. Covered services and benefit limitations are noted in the member's product-specific benefit documents.

d. Out-of-Network Providers:

The clinical suppliers will authorize a member's care for a covered behavioral health service and/or physical health service from an out-of-network provider when, as determined by the clinical suppliers, the care and necessary resources are needed by the member are not available or are not reasonably accessible to the member in compliance with product-specific guidelines outlined in the member's benefit documents and the Plan's *Out-of-Network Services* medical policy, OCA 3.18.

e. Input from Practicing Practitioners:

Actively practicing practitioners with appropriate credentials and clinical expertise in the applicable clinical area have the opportunity to submit comments on clinical review criteria utilized by clinical suppliers who are delegated to conduct utilization management on behalf of Plan members (with feedback related to the development, ongoing management, and/or application of those criteria). Practitioners may submit feedback through the Plan's Provider Information Mailbox available at Provider.Info@wellsense.org.

If the practitioner would like to provide input on a clinical supplier clinical review criteria and have those comments considered during the criteria's next annual review, supporting documentation must be provided that includes position statements developed or endorsed by nationally recognized professional associations, consensus reports or guidelines from specialty societies, and/or standards adopted by governmental agencies (e.g., National Institutes of Health, Agency for Healthcare Research and Quality, Center for Medicare & Medicaid Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Bureau of Substance Addiction Services (BSAS), Massachusetts Executive Office of Health and Human Services, or New Hampshire Department of Health and Human Services). Published scientific evidence from additional reputable sources may also be submitted for consideration.

Issues related to clinical review criteria that must be addressed before each clinical supplier's annual review will be evaluated immediately during a prior authorization request for services; clinical suppliers conducting delegated utilization will engage in individual case discussions with qualified clinicians applicable for the member's condition and requested treatment to determine if the clinical review criteria are appropriate for the member's circumstances or care provided by a local delivery system according to the guidelines specified below in the Application of the Plan's Clinical Review Criteria section of this policy.

f. Access to Clinical Review Criteria:

The current versions of clinical review criteria are available to all providers, members, regulators, and the general public on the Plan's extranet site. In addition, the Plan makes all its clinical review criteria available to practitioners and members upon verbal or written request. Providers and members may call or fax the Plan with a request for a copy of the specific criteria, as stated in writing in the provider manual on the Plan's website. This access to clinical review criteria includes applicable copyrighted commercial criteria used by the Plan's partner delegated clinical suppliers. Participating providers are notified at least 60 calendar days before the implementation of substantive revisions to applicable coding (excluding industry-wide code updates) and/or material changes clinical review criteria (i.e., implementation of new medical necessity guidelines and/or revised clinical review criteria) used by the Plan's partner delegated clinical suppliers.

3. Plan Oversight:

Plan staff (including but not limited to representatives from the Plan's Accreditation, Utilization Management, Pharmacy, and Supplier Management Departments) routinely collect and review

documentation to verify that quality standards are met by clinical suppliers who are delegated to conduct utilization management on behalf of Plan members. In addition, an annual review of each clinical supplier is completed by the Plan's Oversight Committee to ensure that each clinical supplier complies with delegated utilization management requirements, including but not limited to contractual obligations and the guidelines specified in this section of this policy related to the development, review, and application of objective, scientifically-derived, and evidence-based clinical review criteria, with timely individual consideration of the member's status (when appropriate). If established quality standards are not met, the delegated utilization management clinical supplier develops and implements a targeted and measurable corrective action plan that is monitored by the Plan.

For services managed by clinical suppliers with whom the Plan has delegated utilization management, the Plan evaluates member access to treating facilities and availability of qualified providers (including care from an out-of-network provider when clinically appropriate and in compliance with the guidelines outlined in the Plan's *Out-of-Network Services* medical policy, OCA 3.18), member satisfaction, provider satisfaction, member and provider timely access to applicable clinical review criteria, and the suppliers process for evaluating recommended revisions to clinical review criteria submitted by actively practicing practitioners with appropriate credentials and clinical expertise.

Procedure

The Plan-adopted clinical review criteria are developed, implemented, reviewed at least annually, and updated in accordance with generally accepted standards of medical/clinical practice which are based on objective, current, and credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying on controlled clinical trials. Practitioners with clinical expertise in the area being reviewed have the opportunity to advise or comment on the development, adoption, and implementation of all UM criteria utilized by the Plan; this includes feedback from qualified practitioners on staff at the Plan or delegated clinical suppliers, outside physician consultants, provider reviewers, participating providers in the Plan's network, and practitioners treating Plan members.

See the Policy Summary and the Delegated Management sections of this policy for guidelines related to applicable clinical review criteria and services managed by partner clinical suppliers with whom the Plan has delegated utilization management (by Plan product), including radiology services, pharmacy benefits administration, and durable medical equipment, prosthetics, orthotics and supplies. Review the *Clinical Technology Evaluation* administrative policy, policy number OCA UMC 3.13, for a description of the Plan's process for evaluating new technology and the new application of existing technology.

1. Development and Review of the Plan's Internal Clinical Review Criteria:

The Plan's internal clinical review criteria are specified in the Plan's medical policies, medical drug policies, or pharmacy policies. Internal clinical review criteria are developed for a treatment that

may provide clinical benefits for a member's care and are highly likely to outweigh any clinical harms, including from delayed or decreased access to the clinical service, treatment, technology, or item. Where required by regulatory agencies, the Plan adopts the policy and clinical review criteria developed by the regulatory agency, as is the case for Massachusetts Medicaid and EOHHS for the Unified Pharmacy Product List (UPPL). Internal clinical review criteria are developed, reviewed at least annually, and updated as necessary, utilizing the following resources (as applicable) to evaluate the clinical services, treatments, and technologies for the specified indications and the application of medical necessity criteria, as stated below in items a through f:

- a. In consultation with the Plan's Medical Director(s) and other Plan staff, as appropriate; AND
- b. With input from actively practicing specialists and/or professionals or serving as consultants who have expertise and appropriate credentials in the applicable clinical area under consideration, as appropriate; e.g., criteria review by board-certified physician experts in the Plan's service area, feedback from participants of the local network-based Provider Advisory Committee, and/or independent medical criteria review from board-certified physician consultants from Advanced Medical Reviews (AMR) or local, appropriately qualified physician consultants. Consultants may include but are not limited to pharmacists, community-based providers, behavioral health clinicians, dentists, and/or board-certified physicians actively practicing in specialties that include psychiatry, neonatology, pediatrics, family medicine, internal medicine, medical/surgical subspecialties, and/or geriatrics; AND
- c. In accordance with the Plan's definition of medical necessity (as specified in the *Medically Necessary* medical policy, policy number OCA 3.14), the Plan's definition of experimental and investigational services (as stated in the *Experimental and Investigational Treatment* medical policy, policy number OCA 3.12), and the Plan's definition of cosmetic and reconstructive or restorative services (as documented in the *Cosmetic, Reconstructive, and Restorative Services* medical policy, policy number OCA 3.69); AND
- d. Review of unbiased, evidence-based assessments of health technologies, clinical programs, and/or healthcare services to determine the impact of intervention(s) on patient safety and clinical outcomes; AND
- e. Review of current and widely used position papers and guidelines established or endorsed by relevant, nationally recognized medical associations, specialty societies, dental organizations, or governmental agencies, including but not limited to practice guidelines adopted by the Plan (e.g., American Society of Addiction Medicine/ASAM clinical guidelines); AND
- f. Clinical studies published in peer-reviewed scientific literature evaluating the use of the clinical service as an alternative treatment strategy to established interventions considered the standard of care for the specified indication (considering the patient's medical condition, age, comorbidities, and other factors applicable to the health outcomes of the clinical technology) to determine if the service improves the net health outcome, is cost-effective compared to the

standard of care, and if the clinical outcomes outweigh any harmful effects, including from delayed or decreased access to the clinical service, treatment, technology, or item; AND

- g. The documented, favorable health outcomes are reasonably expected to be attainable outside of the investigational settings (i.e., in a standard clinical setting) to a degree comparable in the published, scientifically derived and evidence-based investigations; AND
- h. When applicable, the clinical technology, including drugs, biologics, devices, or other products requiring final approval to market, has final approval for the specified indication from the appropriate governmental body(ies) with the authority to regulate the clinical technology (e.g., the U.S. Food and Drug Administration); AND
- i. Policies, position statements, consensus reports, and standards adopted by governmental agencies which may include but are not limited to the National Institutes of Health (NIH), Agency for Healthcare Research and Quality (AHRQ), U.S. Center for Disease Control and Prevention (CDC), Center for Medicare & Medicaid Services (CMS), Substance Abuse and Mental Health Services Administration (SAMHSA), Bureau of Substance Addiction Services (BSAS), Massachusetts Executive Office of Health and Human Services, or New Hampshire Department of Health and Human Services (e.g., U.S. Preventive Services Task Force, AAP Bright Futures); AND
- j. Published scientific evidence from additional reputable sources concerning the safety and effectiveness of the clinical treatment on health outcomes (i.e., proven benefit, unproven benefit, insufficient evidence to determine effect, or documented harm) such as industry-standard, evidence-based guidelines and recommendations (such as those established by InterQual®, National Institute for Health and Care Excellences, National Comprehensive Cancer Network); AND
- k. Other sources deemed necessary to evaluate the clinical technology for the specified clinical indication and to develop the Plan's clinical coverage criteria; AND
- l. With input from actively practicing practitioners with appropriate credentials and clinical expertise in the applicable clinical area who have the opportunity to submit comments on clinical review criteria utilized for Plan members (with feedback related to the development, ongoing management, and/or application of those criteria). Practitioners may submit feedback at any time through the Plan's Provider Information Mailbox available at Provider.Info@wellsense.org. The Plan will thoroughly research recommendations and comments submitted from providers.

On at least an annual basis, Plan staff review all clinical review criteria utilized by the Plan and the procedures for applying those clinical review criteria; the Plan will evaluate provider feedback submitted by practicing practitioners when evaluating applicable clinical review criteria. If the practitioner would like to provide input on clinical review criteria that will be considered during the internal policy's next annual review, it is recommended that comments

and supporting references be submitted to the Plan a few months before the applicable policy's scheduled annual review date (as specified in the Next Review Date section at the end of each internal policy). Supporting documentation must include position statements developed or endorsed by nationally recognized professional associations, consensus reports or guidelines from specialty societies, or standards adopted by governmental agencies (e.g., National Institutes of Health, Agency for Healthcare Research and Quality, Center for Medicare & Medicaid Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Bureau of Substance Addiction Services (BSAS), Massachusetts Executive Office of Health and Human Services, or New Hampshire Department of Health and Human Services). Published scientific evidence from additional reputable sources may also be submitted for consideration.

Issues related to clinical review criteria that must be addressed before the policy's annual review date will be evaluated immediately during a prior authorization request for services; UM staff will engage in individual case discussions with licensed Plan Clinical Pharmacists, UM clinicians, and/or Plan Medical Directors (utilizing qualified Plan clinicians applicable for the member's condition and requested treatment) to determine if the clinical review criteria are appropriate for the member's circumstances or care provided by a local delivery system according to the guidelines specified below in the Application of the Plan's Clinical Review Criteria section of this policy. Providers are encouraged to submit feedback on Plan-adopted clinical review criteria using the medical policy mailbox and pharmacy mailbox, as noted below.

2. Application of Plan's Internal Clinical Review Criteria and Plan-Adopted InterQual® Criteria:

WellSense will automatically adopt the annual InterQual® guidelines effective on the official release date of the new-year edition. Any subsequent updates to the InterQual® guidelines published by Change Healthcare (Optum) shall also be automatically adopted and effective upon publication. Providers shall always comply with the then-current InterQual® guidelines in effect. Application of the Plan's clinical review criteria (including internal clinical review criteria and InterQual® criteria utilized by the Plan) follows the procedure specified below in items a through g:

- a. The Plan's UM staff, licensed Plan Clinical Pharmacists, and Plan Medical Directors who apply applicable Plan clinical review criteria consistently when determining the medical necessity of healthcare services. The Plan's UM staff includes both the Pharmacy UM staff and UM staff. Reporting to the Senior Director of Pharmacy, the Pharmacy UM staff reviews requests for pharmacotherapy or directs requests to a partner clinical supplier for delegated utilization management. Reporting to the Directors of Utilization Management, UM staff reviews medical/surgical/behavioral health requests for service or directs requests to a partner clinical supplier for delegated utilization management according to guidelines in both item (1) and item (2):
 - (1) The Plan's UM staff applies clinical review criteria consistently for all Plan members according to the standards specified in this policy (e.g., requests for transplant services), as well as complying with the Plan's out-of-network guidelines and product-specific

requirements outlined in the *Out-of-Network Services* medical policy, policy number OCA 3.18. When standard clinical criteria are not met, qualified UM staff also considers member-specific factors impacting the member's individual healthcare needs to determine if the service is medically necessary for the requested indication. The service may include a treatment, procedure, supply, device, biologic, or drug and will be used to prevent, diagnose, stabilize, and/or treat a physical health or behavioral health disease, condition, and/or disorder that results in health impairment and/or disability, and/or the service allows the member to attain, maintain, or regain functional capacity. Timely individual consideration of requests and determination of case-by-case exceptions for medically necessary services by a Plan Medical Director or Clinical Pharmacist (when clinically appropriate) include a comprehensive assessment of all the member's physical health and behavioral health needs and member-specific factors impacting care, including but not limited to social determinants of health and subsequent person-centered planning, with evaluation of one or more of the following factors:

- (a) Member's condition, including diagnoses and functional status;
- (b) Member's comorbidities, including the assessment of ongoing and/or chronic conditions with services authorized in a manner that reflects the member's continuing need for such services and supports for stabilization of one or more ongoing and/or chronic conditions;
- (c) Member's age, including the assessment of the member's age-appropriate growth, development, and competencies, as well as evaluation of age-related and condition-specific healthcare needs and associated issues (and determine if requested service meets EPSDT guidelines for a Medicaid member aged 20 or younger);
- (d) Relevant past medical/surgical/behavioral health/dental/pharmacotherapy history;
- (e) Complications;
- (f) Progression of the member's condition, illness, or injury;
- (g) Diagnostic test results;
- (h) Treatment outcomes;
- (i) Treatment options;
- (j) Treating provider's recommendations and clinical notes;
- (k) Psychosocial circumstances;

- (l) Home and environmental factors impacting member's clinical condition (e.g., homelessness, employment status, poverty, neighborhood);
 - (m) Other healthcare services requested and/or provided to the member to integrate healthcare for continuity, coordination, and collaboration of services;
 - (n) Local healthcare delivery system's ability to meet the healthcare needs of the member's specific condition;
 - (o) Availability of an in-network provider to meet the healthcare needs of the member's specific condition;
 - (p) Member's reasonable accessibility to a qualified provider with appropriate credentials, licensure, clinical expertise or resources in the applicable clinical area necessary to adequately manage the member's condition, including but not limited to pharmacotherapy, behavioral health services, dental services, radiology services, or durable medical equipment (prosthetics, orthotics and supplies);
 - (q) Other factors related to the member's plan of care or health outcomes;
 - (r) If applicable, verification that the requested device, system, biologic, or drug is being prescribed/requested and will be utilized according to its FDA-approved or compendia indication and guideline information, including intended use for the member's age and medical condition; AND
- (2) When clinical review criteria are NOT met for a specified service such that medical necessity cannot be established, UM staff will engage in individual case discussions with licensed Plan Clinical Pharmacists, UM clinicians, behavioral health clinicians (e.g., psychiatrists) and/or Plan Medical Directors (utilizing qualified Plan clinicians applicable for the member's condition and requested treatment) to determine if the clinical review criteria are appropriate for the member's circumstances or care provided by a local delivery system. If the clinical review criteria are not appropriate, UM staff may make the utilization determination based on the member's condition and other unique circumstances; AND
- b. UM staff considers the following characteristics of the healthcare delivery system listed in items (1) through (4) to assess the local healthcare delivery system's ability to meet the member's healthcare needs when applying clinical review criteria to each request:
- (1) Availability and member access to acute and subacute care facilities, including but not limited to acute care inpatient hospitals (with access to inpatient and outpatient specialty hospital services such as major burn care, transplantation, specialty pediatric care, specialty outpatient centers for HIV/AIDS, sickle cell disease, hemophilia, craniofacial and congenital anomalies), surgicenters, rehabilitation facilities, transitional care facilities,

skilled nursing facilities (SNF), home health agencies, hospice programs, and behavioral health treatment programs, as applicable for the member's clinical needs; AND

- (2) Member's reasonable accessibility to a qualified provider with appropriate credentials and clinical expertise in the applicable clinical area necessary to adequately treat the member's condition; AND

Note: The Plan will authorize a member's care from an out-of-network provider when, as determined by the Plan, the care needed by the member is not available or is not reasonably accessible to the member, as outlined in the Plan's *Out-of-Network Services* medical policy, OCA 3.18.

- (3) Covered benefits for acute and subacute care facilities, including but not limited to acute care inpatient hospitals, surgicenters, rehabilitation facilities, transitional care facilities, SNF, or home health agencies, as applicable for the member's clinical needs; AND
 - (4) The ability of acute and subacute care facilities, including but not limited to acute care inpatient hospitals, surgicenters, rehabilitation facilities, transitional care facilities, SNF, or home health agencies, to provide the following services, as specified below in BOTH items (a) and (b):
 - (a) Provide the recommended medically necessary services to the member within the estimated amount, frequency, and duration of treatment (including the estimated length of stay, when applicable); medically necessary services required by the member and provided by the facility/treating provider may include routine medical/surgical services, highly specialized healthcare services (such as transplant services or cancer care), rehabilitative care, habilitative services, and/or support services after hospital discharge; AND
 - (b) Provide the medically necessary clinical support to the Plan member after the member's hospital discharge and/or transition to a less intense clinical setting or to home, as applicable for the member's treatment plan; AND
- c. When a UM staff member is unable to authorize care by establishing medical necessity, the UM staff will forward the request and documentation to the appropriate Medical Director or licensed Plan Clinical Pharmacist for a determination (utilizing qualified Plan clinicians applicable for the member's condition and requested treatment); AND
 - d. When medical necessity cannot be determined with existing clinical review criteria, the Plan's Medical Directors (including psychiatrists reviewing requests for behavioral health services and appropriate level of care) and/or licensed Plan Clinical Pharmacists (when clinically appropriate) consider alternate methods of determining medical necessity for a covered service. If Plan-adopted written clinical review criteria have not been established for the requested covered service for the specified indication, the Plan's Medical Directors and/or

licensed Plan Clinical Pharmacists will use published and applicable generally accepted, scientifically-based standards of care to determine medical necessity using the product-specific definition of medically necessary services stated in the *Medically Necessary* medical policy, policy number OCA 3.14. If scientifically-based standards of care are not available, observational studies from more than one (1) institution that suggest a causal relationship between the service or treatment and health outcomes may be used by the Plan's Medical Directors and/or licensed Plan Clinical Pharmacists to make medical necessity determinations if these observational studies are clinically appropriate with respect to the member's clinical presentation. The Plan's Medical Directors and/or licensed Plan Clinical Pharmacists also consider member-specific factors when applying clinical criteria, evaluating standards of care and credible scientific evidence published in peer-reviewed medical/clinical literature, and/or reviewing observational studies for a request for services for a Plan member to make medical necessity determinations for covered services. Covered services and benefit limitations are noted in the member's product-specific benefit documents; AND

- e. The Pharmacy and Therapeutics (P&T) Committee, Utilization Management Committee (UMC), and other applicable committees meet annually or more frequently as needed to review and/or authorize all clinical review criteria used by the Plan along with the policies and procedures for application; AND
- f. UM staff training and inter-rater reliability testing are conducted at least annually (with biweekly case review by the Plan Medical Directors) to review the application of internal clinical review criteria (including criteria in the Plan's internal medical policies, medical drug policies, and internal pharmacy policies) and Plan-adopted InterQual® criteria to ensure the consistency of medical necessity determinations among the UM staff, licensed Plan Clinical Pharmacists, and Plan Medical Directors (according to the definitions of inter-rater reliability and UM staff in the Definitions section of this policy); AND
- g. The Plan makes all its clinical review criteria available to practitioners, members, regulatory agencies, and accreditation organizations, upon verbal or written request. The current version of clinical review criteria included in the Plan's internal medical policies, medical drug policies, and internal pharmacy policies are available to all providers, members, and the general public on the Plan's extranet site, with the exception of MassHealth policies which are managed and published by EOHHS as required under the Unified Pharmacy Product List (UPPL). Providers and members may call or fax the Plan with a request for a copy of the specific criteria, as stated in writing in the Plan's provider manual on the Plan's website. This access to clinical review criteria includes applicable copyrighted commercial criteria such as those used by the Plan's partner delegated clinical suppliers and Plan-adopted InterQual® criteria.

Plan-adopted medical necessity criteria from delegated clinical suppliers conducting utilization management (eviCore and Northwood), internal medical policies, behavioral health (BH) performance specifications applicable for BH services requested for WellSense MassHealth members, pharmacy policies, medical drug policies, and payment policies are available through the WellSense website by selecting the "Providers" tab on the landing page, choosing the

applicable state, scrolling down and selecting "Policies," and then accessing the appropriate category.

The Plan provides access to InterQual® criteria from the landing page of the WellSense website. The link can be found on the bottom of the page under the Helpful links section by clicking on the "Transparency in coverage" option. Providers should then select "Coverage criteria transparency" and choose "Access One Healthcare ID." After entering their One Healthcare ID, they will be directed to InterQual® criteria. If the provider does not have a One Healthcare ID, the provider may select "Create One Healthcare ID," enter the required fields, and create a password to gain access to InterQual® criteria at the point of care.

Participating providers receive network notifications via email at least 60 calendar days before material changes are made to Plan-adopted clinical review criteria and/or substantive revisions are made to applicable coding (excluding industry-wide code updates and administrative changes). Material changes may include the adoption of an updated version of InterQual® criteria sets, the implementation of new Plan-adopted clinical review criteria (e.g., evidence-based medical necessity criteria are developed for new technologies), or material revisions are made to established clinical review criteria and/or associated coding. Plan-adopted criteria review criteria and associated coding include guidelines specified in internal medical policies, medical drug policies, pharmacy policies, and guidelines utilized by partner clinical suppliers delegated to conduct utilization management for Plan members. The provider notifications include access to the specific material changes; e.g., copies of updated internal medical policies are attached to the notices, notices include written instructions on how to access online versions of revised guidelines from the Plan's partner clinical suppliers, and updated version numbers/dates of InterQual® criteria sets utilized by the Plan are specified. Provider notifications are also posted on the Plan's website for public viewing when the notices are sent and are available to providers, members, regulators, and the general public at least 60 calendar days before the effective date through the Provider tab on the Documents and Forms page of the Plan's website. Copies of provider notifications communicating material updates to Plan-adopted medical necessity criteria and prior authorization guidelines (including applicable coding) are posted on the WellSense Health Plan website. Select the "Provider" tab on the landing page, choose the applicable state, scroll down and select "News and Updates." These provider network notifications will reference "medical policy updates" in the title. Providers may email feedback on the Plan's internal medical policies to the Medical Policy Mailbox at medicalpolicy@wellsense.org. It is important to include the medical policy title and policy number with the comments so Plan staff can thoroughly research the issue. An integral component of the Plan's annual medical policy review process is to evaluate and thoroughly research provider comments and recommendations.

The Plan will submit material revisions to its medical necessity guidelines (i.e., material changes to clinical review criteria and/or applicable coding) and related utilization management protocols to the Massachusetts Office of Patient Protection, Massachusetts Executive Office of Health and Human Services (EOHHS), New Hampshire Department of Health and Human Services (DHHS), and the Centers for Medicare & Medicaid Services (CMS) at least 60

calendar days before the effective date of these material revisions (or another timeframe specified by the organization) when these changes may impact services provided to the organization's enrollees. A designated contact person must be provided in writing to the Utilization Management Committee (UMC) by the organization or its designee.

Internal medical drug and pharmacy policy revisions are communicated to providers 60 calendar days before the effective date of the revisions. Pharmacy policies for the Plan's NH Medicaid product are submitted to DHHS for review and approval prior to implementation. Once approved, pharmacy policies are available on the Plan's website 30 calendar days before the effective date. For Medicaid and commercial lines of business, providers may email feedback on the Plan's medical drug and pharmacy policies at pharmacy@wellsense.org, or provide feedback as part of the UM process during Peer to Peer discussions with the Plan's clinical staff. During the annual medical drug and pharmacy policy review process, the Plan evaluates provider feedback and recommendations. Medical drug and pharmacy policies for Medicaid and commercial products are approved by the Plan's P&T Committee. For the NH Medicare Advantage products, the pharmacy policies are approved by CMS. Pharmacy utilization management functions and the P&T Committee responsibilities are delegated to the Pharmacy Benefit Manager for NH Medicare Advantage products.

Responsibility and Accountability

See the Policy Summary and Delegated Management sections of this policy for guidelines related to clinical review criteria and services managed by clinical suppliers with whom the Plan has delegated utilization management (by Plan product). Responsibility and accountability related to the development, implementation, and monitoring of the Plan's internal clinical review criteria (included in the Plan's medical policies for medical/surgical treatment and behavioral health services, medical drug policies, and internal pharmacy policies) are specified below in items 1 through 4:

1. The Utilization Management Committee (UMC), chaired by the Senior Medical Director for Utilization Management, Appeals and Grievances and Medical Policy, oversees and is accountable for the monitoring of member outcomes and utilization data, as well as implementing strategies that ensure members receive high-quality, clinically appropriate and cost-effective care. Generally, the Plan adopts nationally developed and accepted clinical review criteria (e.g., InterQual®) to manage care through the prior authorization process. When national criteria are not available or not utilized by the Plan, Plan-specific medical necessity criteria may be developed and used for Plan prior authorization; these internal criteria are objective, scientifically derived, and evidence-based, with input from participating practitioners and consistent with applicable legal, regulatory, and national accreditation organization standards.
2. The UMC is responsible for developing and approving medical policies for medical/surgical treatments and behavioral health services, and the Pharmacy and Therapeutics (P&T) Committee is responsible for developing and approving pharmaceutical coverage policies.
3. The Directors of Utilization Management, Directors of Pharmacy, Director of Behavioral Health

Clinical Programs, Chief Medical Officer, Senior Medical Directors and Plan Medical Directors, licensed Plan Clinical Pharmacists, and other UM staff use the Plan's clinical review criteria in accordance with applicable Plan policies and procedures.

4. The Directors of Utilization Management, Directors of Pharmacy, and the Director of Behavioral Health Clinical Programs or their designee(s) are responsible for ensuring UM staff training, evaluating, and monitoring. The Chief Medical Officer or designee is responsible for ensuring Medical Director training, evaluation, and monitoring to ensure consistent application of clinical review criteria and medical necessity determinations.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for the Plan's New Hampshire Medicare Advantage members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals, rather than Plan-adopted clinical review criteria. CMS coverage criteria are not fully established when: (1) additional, unspecified criteria are needed to interpret or supplement general provisions in order to determine medical necessity consistently; (2) NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD; or (3) there is an absence of any applicable Medicare statutes, regulations, NCDs or LCDs setting forth coverage criteria. Plan UM staff, Plan licensed Clinical Pharmacists, Plan Medical Directors, and clinical partner suppliers utilize CMS guidelines in effect on the date of the prior authorization request to make medical necessity and coverage determinations for requested services. It is recommended that providers review CMS guidelines for the requested service and indication for treatment on the date of the prior authorization request. Plan-adopted clinical review criteria will be used to determine medical necessity only when there is no guidance from CMS and/or coverage criteria are not fully established by CMS for the requested service. This guideline applies to all Plan-adopted clinical review criteria.

Definitions

Clinical Review Criteria – Definition for MassHealth Product: Criteria used to determine the most clinically appropriate and necessary level of care and intensity of services to ensure the provision of medically necessary services. Medical necessity guidelines established by the Plan will be no more restrictive than the applicable contractual MassHealth ACO and MCO definition of Medically Necessary or Medical Necessity and the same services furnished to members under MassHealth fee-for-service, as specified in the Plan's *Medically Necessary* medical policy, policy number OCA 3.14. Any new or amended pre-authorization requirement or restriction shall NOT be implemented unless the Plan's and/or partner clinical supplier's respective website has been updated to clearly reflect the new or amended requirement or restriction.

Clinical Review Criteria – Definition for Massachusetts Clarity Plans/Employer Choice Direct Products: In accordance with 958 CMR 3.020, clinical review criteria are the written screening procedures, decisions, abstracts, clinical protocols and/or practice guidelines used by the Plan to determine the medical necessity and appropriateness of health care services. Utilization review criteria

shall be up to date and applied consistently by the Plan or the Plan's partner clinical suppliers and made easily accessible to members, providers, and the general public on the Plan's website; or, in the alternative, on the Plan's partner clinical supplier's website so long as the Plan provides a link on its website to the supplier's website; provided, however, that the Plan shall not be required to disclose licensed, proprietary criteria purchased by the Plan or partner clinical suppliers on its website, but must disclose such criteria to a provider or subscriber upon request. Review the Plan's *Medically Necessary* medical policy, policy number OCA 3.14, for the product-specific definition of medically necessary treatment. Any new or amended pre-authorization requirement or restriction shall NOT be implemented unless the Plan's and/or partner clinical supplier's respective website has been updated to clearly reflect the new or amended requirement or restriction.

Clinical Review Criteria - Definition for New Hampshire Clarity Product: According to RSA 420-J:3 (amended with Chapter 172.1 in 2024), clinical review criteria are the written policies, screening procedures, decision abstracts, clinical protocols, practice guidelines, medical protocols, and any other written decision-making standards used by a health carrier or utilization review entity to determine the medical necessity and appropriateness of health care services. The Plan's clinical review criteria include internally developed criteria specified in the Plan's internal medical policies, medical drug policies, pharmacy policies, InterQual® criteria utilized by the Plan, state-mandated policies, and/or clinical guidelines established by delegated management partners. The Plan's Medically Necessary medical policy, policy number OCA 3.14, for the definition of medically necessary services; the medical necessity guidelines established by the Plan for WellSense Health Plan members will not be more restrictive than the product-specific definition of "medically necessary" according to the Plan's contract guidelines for the New Hampshire Clarity product.

Clinical Review Criteria - Definition for New Hampshire Medicaid Product: A set of medical decision standards employed in the utilization review process in order to ensure members receive appropriate care, at an appropriate time, in an appropriate setting by an appropriate provider and at an appropriate level of care. Criteria are consistent with an efficient and effective utilization of resources available to recipients. Medical necessity guidelines established by the Plan will be no more restrictive than the contractual definition of Medically Necessary for the New Hampshire Department of Health and Human Services (DHHS) and the same services furnished in the New Hampshire DHHS fee-for-service Medicaid program, as specified in the Plan's *Medically Necessary* medical policy, policy number OCA 3.14. Any new or amended pre-authorization requirement or restriction shall NOT be implemented unless the Plan's and/or partner clinical supplier's respective website has been updated to clearly reflect the new or amended requirement or restriction.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): EPSDT benefits provide comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services. States are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines. EPSDT services include screening, diagnostic, and/or treatment services. Screening services include comprehensive health and developmental history, comprehensive unclothed physical exam,

appropriate immunizations (according to the Advisory Committee on Immunization Practices), laboratory tests (including lead toxicity screening), and health education (including but not limited to child development, healthy lifestyles, accident prevention, and disease prevention). Additional EPSDT services include vision services (including but not limited to the diagnosis and treatment for defects in vision such as eyeglasses), dental services (including relief of infections and pain, restoration, maintenance, and emergency services), hearing services (including the diagnosis and treatment for defects in hearing, including hearing aids), and other medically necessary health care services required to treat, correct, and/or reduce illnesses and health conditions. Diagnostic EPSDT services are utilized to conduct a complete evaluation of the member's health condition and assure that comprehensive care is provided. Medically necessary health care services must be provided to treat physical and mental health illnesses or conditions identified by screening or diagnostic procedures. (Source: Medicaid.gov)

Inter-Rater Reliability (IRR): A performance measurement tool used to compare and evaluate the level of consistency in healthcare determinations between two (2) or more medical and behavioral health utilization management (UM) clinicians. The tool is used to minimize variation in the application of clinical review criteria and identify potentially avoidable utilization target areas that need improvement and evaluate the ability to identify quality of care issues.

Utilization Management (UM) Staff: The Plan's UM staff include Pharmacy UM staff, UM staff reviewing medical/surgical treatments, and UM staff reviewing behavioral health services. Reporting to the Director of Pharmacy, the Pharmacy UM staff reviews requests for pharmacotherapy or directs requests to a partner clinical suppliers for delegated utilization management. Reporting to the Directors of Utilization Management or the Director of Behavioral Health Clinical Programs, appropriately qualified UM staff reviews medical, surgical, behavioral health, and/or dental requests for service or directs requests to a partner clinical supplier for delegated utilization management. The Directors of Utilization Management, Director of Behavioral Health Clinical Programs, and the Director of Pharmacy, or their designees are responsible for ensuring UM staff training, evaluating, and monitoring. The Plan's UM staff, licensed Plan Clinical Pharmacists, and Plan Medical Directors consistently use applicable Plan clinical review criteria when determining the medical necessity of healthcare services. The Chief Medical Officer or designee is responsible for ensuring Medical Director training, evaluation, and monitoring to ensure consistent application of clinical review criteria and medical necessity determinations.

Plan-Adopted Clinical Review Criteria: Written clinical review criteria used to determine medical necessity, including internally developed criteria specified in Plan medical policies, medical drug policies, pharmacy policies, InterQual[®] criteria utilized by the Plan, state-mandated policies, and clinical guidelines established by delegated management partners (for related services provided Plan members for applicable Plan products).

Practitioner - Definition for Massachusetts Clarity Plans/Employer Choice Direct Products: A professional who provides healthcare services. Practitioners are usually required to be licensed as defined by law.

Prior Authorization - Definition for New Hampshire Clarity Product: According to RSA 420-J:3 (amended with Chapter 172.1 in 2024), prior authorization means the approval from a health carrier or utilization review entity that may be required before a particular health care service, item, or prescription drug is received by the covered person in order for that service, item, or prescription drug to be covered under the covered person's plan.

Prior Authorization Determination - Definition for New Hampshire Clarity Product: According to RSA 420-J:3 (amended with Chapter 172.1 in 2024), prior authorization determination means a determination by a health carrier or a utilization review entity that a health care service, item, or prescription drug has been reviewed pursuant to a request for prior authorization and, based on the information provided, satisfies or does not satisfy the health carrier's or the utilization review entity's requirements for coverage.

Utilization Review (UR): A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, healthcare services, procedures, or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, and/or retrospective review.

References

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Next Review Date

06/01/26

Authorizing Entity

UMC

Appendix

Appendix: Policy History

Reference to Applicable Laws and Regulations

42 CFR 405.1060. Code of Federal Regulations. Public Health. Centers for Medicare & Medicaid Services, Department of Health and Human Services. Medicare Program. Applicability of National Coverage Determinations.

42 CFR 422.101. Code of Federal Regulations. Public Health. Centers for Medicare & Medicaid Services, Department of Health and Human Services. Medicare Program. Medicare Advantage Program. Requirements Related to Basic Benefits.

42 CFR 422.205. Code of Federal Regulations. Public Health. Centers for Medicare & Medicaid Services, Department of Health and Human Services. Medicare Program. Medicare Advantage Program. Provider Antidiscrimination Rules.

42 CFR 422.562. Code of Federal Regulations. Public Health. Centers for Medicare & Medicaid Services, Department of Health and Human Services. Medicare Program. Medicare Advantage Program. General Provisions.

42 CFR 438.100. Code of Federal Regulations. Public Health. Centers for Medicare & Medicaid Services, Department of Health and Human Services. Medical Assistance Programs. Managed Care. Enrollee Rights and Protections. Enroll Rights.

42 CFR 438.210. Code of Federal Regulations. Public Health. Centers for Medicare & Medicaid Services, Department of Health and Human Services. Medical Assistance Programs. Managed Care. Coverage and Authorization of Services.

42 CFR Parts 438, 440, 456, and 457. Code of Federal Register. Vol. 81. No. 61. Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans. Centers for Medicare & Medicaid Services (CMS). 2016 Mar 30.

42 CFR 440.210. Code of Federal Regulations. Public Health. Centers for Medicare & Medicaid Services, Department of Health and Human Services. Medical Assistance Programs. Services: General Provisions. Required Services for the Categorically Needy.

42 CFR 441.56. Code of Federal Regulations. Public Health. Centers for Medicare & Medicaid Services, Department of Health and Human Services. Medical Assistance Programs. Services: Requirements and Limits Applicable to Specific Services. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals under Age 21. Required Activities.

42 USC 18001. United States Code. Patient Protection and Affordable Care Act. 2010.

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114.3 CMR 17.00. Code of Massachusetts Regulations. Division of Health Care Finance and Policy. Medicine.

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130 CMR 415.000. Code of Massachusetts Regulations. Division of Medical Assistance. Acute Inpatient Hospital Services.

130 CMR 433.00. Code of Massachusetts Regulations. Division of Medical Assistance. Physician Services.

130 CMR 440.00. Division of Medical Assistance. Code of Massachusetts Regulations. Early Intervention Program Services.

130 CMR 450.000. Code of Massachusetts Regulations. Division of Medical Assistance. Administrative and Billing Regulations.

130 CMR 450.117(J). Code of Massachusetts Regulations. Division of Medical Assistance. Administrative and Billing Regulations. Managed Care Participation. Compliance with Mental Health Parity Law.

130 CMR 450.204. Code of Massachusetts Regulations. Division of Medical Assistance. Administrative and Billing Regulations. Medically Necessary.

211 CMR 52.00. Code of Massachusetts Regulations. Division of Insurance. Managed Care Consumer Protections and Accreditation of Carriers.

211 CMR 52.02. Code of Massachusetts Regulations. Division of Insurance. Managed Care Consumer Protections and Accreditation of Carriers. Definitions. Clinical Review Criteria.

211 CMR 52.02. Code of Massachusetts Regulations. Division of Insurance. Managed Care Consumer Protections and Accreditation of Carriers. Definitions. Medical Necessity or Medically Necessary.

211 CMR 52.02. Code of Massachusetts Regulations. Division of Insurance. Managed Care Consumer Protections and Accreditation of Carriers. Definitions. Utilization Review.

958 CMR 3.020. Code of Massachusetts Regulations. Health Insurance Consumer Protection. Definitions. Clinical Review Criteria.

958 CMR 3.020. Code of Massachusetts Regulations. Health Insurance Consumer Protection. Definitions. Utilization Review.

958 CMR 3.020. Code of Massachusetts Regulations. Health Insurance Consumer Protection. Definitions. Medical Necessity or Medically Necessary.

958 CMR 3.020. Code of Massachusetts Regulations. Health Insurance Consumer Protection. Definitions. Utilization Review.

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He-W 530.05(b)(4). New Hampshire Code of Administrative Rules. Medical Assistance. Non-Covered Services. Experimental or Investigational Procedures.

He-W 531. New Hampshire Code of Administrative Rules. Medical Assistance. Physician Services.

He-W 531.01(a). New Hampshire Code of Administrative Rules. Medical Assistance. Physician Services. Cosmetic Purpose.

He-W 543. New Hampshire Code of Administrative Rules. Medical Assistance. Hospital Services.

He-W 546. New Hampshire Code of Administrative Rules. Medical Assistance. Early and Periodic Screening, Diagnosis and Treatment Service.

MGL c 233. Massachusetts General Laws. An Act Relative to HIV-Associated Lipodystrophy Syndrome Treatment.

MGL c 1760. Massachusetts General Laws. Health Insurance Consumer Protections.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The Center for Consumer Information & Insurance Oversight. Centers for Medicare and Medicaid Services (CMS).

Newborns' and Mothers Health Protection Act of 1996 (NMHPA). The Center for Consumer Information & Insurance Oversight. Centers for Medicare and Medicaid Services (CMS).

NH RSA 417-D:2-b. New Hampshire Department of Health and Human Services (DHHS). Certified Administrative Rules. New Hampshire Revised Statutes Annotated. Women's Health Care. Reconstructive Surgery.

NH RSA 420-E. New Hampshire Revised Statutes. Insurance. Chapter 420-E. Licensure of Medical Utilization Review Entities.

NH RSA 420-J. New Hampshire Revised Statutes. Title XXXVII – Insurance. Chapter 420-J. Managed Care Law.

NH RSA 420-J:30. New Hampshire Revised Statutes. Title XXXVII – Insurance. Chapter 420-J. Managed Care Law. Section 420-J:3. Definitions. Clinical Review Criteria and Medical Necessity.

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Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: 08/01/08 MH Review: 02/19/10 Internal Approval: 07/24/07 and 08/13/07	08/13/07 Version 1	Senior Vice President/Associate Chief Medical Officer as Chair of Utilization Management Committee (UMC)	UMC

*Effective date for MassHealth: 08/13/07

*Effective date for MA Clarity plans (formerly known as QHP product)/Employer Choice Direct: 01/01/12

*Effective date for NH Medicaid: 01/01/13

*Effective date for MA Senior Care Options: 01/01/16 to 12/31/25

*Effective date for NH Medicare Advantage HMO: 01/01/22

*Effective date for NH Medicare Advantage PPO: 01/01/25

*Effective date for NH Clarity plans: 01/01/25

Note: Policy title was *Clinical Criteria* until 07/31/17. Policy title changed to *Clinical Review Criteria* as of 08/01/17.

Policy Revisions History			
Review Date	Summary of Revisions	Revision Effective Date and Version Number	Approved by
04/22/08	Typos and formatting corrected. Removed bullet stating Chief Medical Officer conducts review on all criteria annually.	Version 2	04/22/08: UMC
05/07/08	Added authority for plan pharmacists to render pharmacy denials.	Version 3	05/20/08: UMC 06/19/08: Quality Improvement Committee (QIC)
08/20/09	Changed titles within Health Services, minor typos and formatting, updated references, changed definition for clinical criteria.	Version 4	09/22/09: UMC 09/23/09: QIC
07/21/10	Updated names, departments and references, extra definition for medically necessary was removed.	Version 5	07/21/10: MPCTAC 08/25/10: QIC
07/01/11	Added medically necessary definition and language for Commercial product.	Version 6	07/22/11: MPCTAC 08/24/11: QIC
07/01/12	References updated, moved Purpose section of policy to the beginning of the document and added reference for the Plan's Prior Authorization/ Notification Requirements	Version 7	07/18/12: MPCTAC 08/15/12: MPCTAC

	matrix. Referenced the Plan's Medically Necessary policy for a definition of medically necessary for each member type and deleted medically necessary definitions from this policy. Added language regarding delegated management in Policy Statement section. Added reference to Physician Reviewers in policy. Changed definition title from "Clinical Criteria" to "Clinical Review Criteria."		
08/15/12	Off cycle review for New Hampshire Medicaid product. Revised the Purpose, Definitions, Policy Statement, reformatted Procedure, updated references for all Plan products.	Version 8	08/17/12: MPCTAC 09/13/12: QIC
9/01/12	Added language to clarify the Plan's UR process that includes the evaluation of member's circumstances and local delivery system, when clinically appropriate.	Version 9	09/19/12: MPCTAC 09/26/12: QIC
06/01/13	Review for effective date 07/18/13. Revised title of chair for the Utilization Management Committee.	07/18/13 Version 10	06/19/13: MPCTAC 07/18/13: QIC
06/01/14	Review for effective date 10/01/14. Updated Purpose, Policy Statement, Delegated Management, Procedure, Responsibility and Accountability, Definitions, and References sections.	10/01/14 Version 11	06/09/14: MPCTAC 07/09/14: QIC
06/01/15	Review for effective date 07/08/15. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available. Administrative changes made to Purpose, Policy Statement, Delegated Management, and Procedure sections.	07/08/15 Version 12	06/17/15: MPCTAC 07/08/15: QIC
09/01/15	Review for effective date 10/14/15. Added reference to eviCore healthcare in the Delegated Management section. Updated list of applicable products, including the removal of Common-wealth Care, Commonwealth Choice, and Employer Choice because the products are no longer available.	10/14/15 Version 13	09/16/15: MPCTAC 10/14/15: QIC
06/01/16	Review for effective date 07/13/16. Updated with administrative changes to the Delegated Management, References, and References to Applicable Laws and Regulations sections.	07/13/16 Version 14	06/15/16: MPCTAC 07/13/16: QIC
05/01/17	Review for effective date 06/01/17. Administrative changes made to the policy title and the Purpose, Policy Statement, Responsibility and Accountability, Definitions,	06/01/17 Version 15	05/17/17: MPCTAC

	References, and Reference to Applicable Laws and Regulations sections to clarify the Plan's clinical criteria review process and the use of these clinical criteria in utilization review activities.		
08/31/17	Updated the definition of Clinical Review Criteria (for Massachusetts products) to include requirements for the medical necessity guidelines applicable for the Accountable Care Organization (ACO). Updated Product Applicability and Reference sections to incorporate ACO.	08/31/17 Version 16	08/31/17: MPCTAC (electronic vote)
06/01/18	Review for effective date 07/01/18. Administrative changes made to the Policy Statement, Procedure, Responsibility and Accountability, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections.	07/01/18 Version 17	06/20/18: MPCTAC
09/01/18	Review for effective date 12/01/18. Administrative changes made to the Purpose and Policy Summary sections. Updated criteria in the Procedure section (clarifying the existing process).	12/01/18 Version 18	09/19/18: MPCTAC
11/01/18	Review for effective date 12/01/18. Administrative changes made to the Policy Statement, Delegated Management, and Procedure sections to clarify the existing process available for practitioners to submit comments related to clinical review criteria.	12/01/18 Version 19	11/21/18: MPCTAC
06/01/19	Review for effective date 07/01/19. Administrative changes made to the Policy Summary (formerly Purpose section), Policy Statement, Delegated Management, Procedure, Definitions, Responsibility and Accountability, References, and Reference to Applicable Laws and Regulations sections to clarify the existing process.	07/01/19 Version 20	06/19/19: MPCTAC
12/01/19	Review for effective date 01/01/20. Administrative changes made to the Delegated Management and Procedure sections.	01/01/20 Version 21	12/18/19: MPCTAC
06/01/20	Review for effective date 07/01/20. Administrative changes made to the Policy Summary, Procedure, References, and Reference to Applicable Laws and Regulations sections.	07/01/20 Version 22	06/17/20: MPCTAC
12/01/20	Review for effective date 01/01/21. Administrative changes made to the	01/01/21 Version 23	12/16/20: MPCTAC

	Delegated Management, Responsibility and Accountability, and Definitions sections.		
12/22/20	Review for effective date 01/01/21 (replacing version 23). Updated documentation related to the Plan's Pharmacy Manager, Express Scripts, in the Delegated Management section.	01/01/21 Version 24	12/23/20: MPCTAC (electronic vote)
06/01/21	Review for effective date 07/01/21. Clarified current guidelines with administrative changes made to the Policy Summary, Policy Statement, Delegated Management, and Procedure sections to clarify existing guidelines. Updated References section.	07/01/21 Version 25	06/16/21: MPCTAC
08/01/21	Review for effective date 09/01/21. Administrative changes made to the Policy Summary, Policy Statement, Definitions, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections to clarify current guidelines.	09/01/21 Version 26	08/13/21: MPCTAC (electronic vote)
11/01/21	Review for effective date 12/01/21. Added NH Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary and Policy Statement sections. Added the Variations section.	12/01/21 Version 27	11/17/21: MPCTAC
07/01/22	Review for effective date 08/01/22. Administrative changes made to the Policy Summary, Policy Statement, Delegated Management, Procedure, Responsibility and Accountability, Definitions, and Other Applicable Policies sections.	08/01/22 Version 28	07/25/22: MPCTAC (electronic vote)
08/01/22	Review for effective date 11/01/22. Revised the list of the Plan's delegated services and partner clinical vendors in the Delegated Management section.	11/01/22 Version 29 Version 29 NOT implemented	08/26/22: MPCTAC (electronic vote)
09/01/22	Review for effective date 11/01/22. Revised the Delegated Management section. Policy added to the Other Applicable Policies section.	11/01/22 Version 30 Version 30 NOT implemented	09/23/22: MPCTAC (electronic vote)
10/24/22	Review for effective date 11/01/22. Revisions made to version 29 and version 30 will not be implemented. Policy guidelines in effect in version 28 will remain in effect. Policy added to the Other Applicable Policies section.	11/01/22 Version 31	10/24/22: MPCTAC (electronic vote)

12/01/22	Review for effective date 01/01/23. Administrative change made to the Policy Summary section.	01/01/23 Version 32	12/21/22: MPCTAC
01/01/23	Review for effective date 03/01/23. Revised the Delegated Management section.	03/01/23 Version 33	01/05/23: MPCTAC
02/01/23	Review for effective date 03/01/23. Revised the Delegated Management section to reference the Plan's current behavioral health clinical partner vendor, Carelon Behavioral Health (formerly known as Beacon Health Strategies). Updated list of products with dental services administered by DentaQuest in the Delegated Management section.	03/01/23 Version 34	02/15/23: MPCTAC
06/01/23	Review for effective date 07/01/23. Administrative changes made to the Policy Summary, Policy Statement, Delegated Management, Procedure, Definitions, and Responsibility and Accountability sections.	07/01/23 Version 35	06/21/23: MPCTAC
07/01/23	Review for effective date 09/01/23. Updated language in the Delegated Management section for dental services managed by the Plan's partner clinical suppliers.	09/01/23 Version 36	07/19/23: MPCTAC
09/01/23	Review for effective date 10/01/23. Administrative changes made to the Policy Summary, Policy Statement, Delegated Management, Procedure, and Variations sections to clarify current guidelines.	10/01/23 Version 37	09/20/23: MPCTAC
12/01/23	Review for effective date 01/01/24. Administrative changes made to the Procedure, Responsibility and Accountability, Authorizing Authority, and Appendix: Policy History sections.	01/01/24 Version 38	12/20/23: MPCTAC
02/01/24	Review for effective date 03/01/24. Administrative changes made to the Policy Summary, Policy Statement, Delegated Management, Procedure, Responsibility and Accountability, Variations, and Definitions sections to clarify existing Plan guidelines.	03/01/24 Version 39	02/21/24: UMC
06/01/24	Review for effective date 07/01/24. Non-material changes made to the Delegated Management, Procedure, and Other Applicable Policies sections to clarify existing guidelines.	07/01/24 Version 40	06/19/24: UMC
09/01/24	Review for effective date 01/01/25. Added NH Clarity as an applicable product and updated the Definitions section. Administrative changes made to the Variations and Reference to Applicable Laws	01/01/25 Version 41	09/16/24: UMC (electronic vote)

	and Regulations sections. Material changes made to the Delegated Management section.		
05/01/25	Review for effective date 12/01/25. Administrative changes made to the Policy Summary, Policy Statement, Responsibility and Accountability, Variations, Definitions, and References sections. Deleted the Other Applicable Policies section. Updated Delegated Management and Procedure sections to document changes to the management of behavioral health services and medical drug services.	12/01/25 Version 42	05/21/25: UMC
12/01/25	Review for effective date 01/01/26. Removed MA Senior Care Options as an applicable product as of 01/01/26. Administrative changes to the Policy Statement, Delegated Management, Procedure, Definitions, Delegated Management, Procedure, Variations, and References sections.	01/01/26 Version 43	12/17/25: UMC
02/01/26	Review for effective date 03/01/26. Administrative changes to the Policy Summary and Procedure sections to clarify current Plan processes.	03/01/26 Version 44	02/18/26: UMC
03/01/26	Review for effective date 06/01/26. Material change to the Procedure section stating the Plan will adopt all future InterQual® criteria updates on the official release date. Other administrative changes to the Procedure section.	06/01/26 Version 45	03/18/26: UMC