Blue Cross & Blue Shield of Rhode Island (BCBSRI) Mental Health Parity and Addiction Equity Act - NQTL Comparative Analysis

The Consolidated Appropriations Act, 2021 ("CAA") requires group health plans and health insurance issuers to make available to the applicable State authority or the Secretaries of the Departments of Health and Human Services, Labor, and the Treasury (the "Secretaries"), upon request, the comparative analysis and information outlined below (the "NQTL Comparative Analysis").

The Mental Health Parity and Addiction Equity Act ("MHPAEA") Final Rules outline the elements that an NQTL Comparative Analysis must include for each NQTL. Specifically, they must include:

1. A description of the non-quantitative treatment limitation ("NQTLs");
2. Identification and definition of the factors used to design or apply the NQTL;
3. A description of how factors are used in the design and application of the NQTL;
4. A demonstration of comparability and stringency, as written;
5. A demonstration of comparability and stringency, in operation; and
6. Findings and conclusions.

BCBSRI (the "Plan")] [or Issuer Name] has completed the NQTL Comparative Analysis below, based on the content elements required under the MHPAEA Final Rules.

Restrictions on Provider Billing Codes and Restrictions Based on Geographic Location, Facility Type, Provider Specialty and Other Criteria That Limit the Scope or Duration of Benefits

The following analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply this NQTL for mental health or substance use disorder ("behavioral health") benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used for medical surgical ("M/S") benefits.

		Medical/Surgical				Mental Health/Substance Use Disorder			
Step		**Inpatient, In-Network**	**Inpatient, Out-of-Network**	**Outpatient, In-Network**	**Outpatient, Out-of-Network**	**Inpatient, In-Network**	**Inpatient, Out-of-Network**	**Outpatient, In-Network**	**Outpatient, Out-of-Network**
1	A description of the non-quantitative treatment limitation ("NQTLs");	Healthcare services are only covered if those services are provided within the scope of the *provider's* license. As a result, there may be coding and/or payment restriction edits for certain medical/surgical (M/S) and/or mental health /substance use disorder (MH/SUD) services/benefits. Medical/Payment Policies may restrict certain covered health services/ benefit categories based on related diagnosis. Blue Cross Blue Shield Association (BCBSA) guidelines restrict contracting with healthcare providers based on geographic location (BCBSRI contracts only with providers located within RI and select zip codes within contiguous counties). This NQTL is not applicable to ER services for medical/surgical or mental health /substance use disorder (MH/SUD).						
1.b.	Policies, Guidelines, and/or Other Documents Describing the NQTL	CN 5.01 Medical and Payment Policy Development and Implementation Medical and Payment Policy Review Committee Charter 2025 Blue Cross and Blue Shield Association Guidelines (Chapter 4, Chapter 5) CI 3.03.01 Authorization Review Program (Non-BlueCHiP for Medicare plans) CI 3.03.12 Investigational/Experimental Treatment							
2	Identification and Definition of the Factors and	**Provider licensure** and/or in some cases scope of practice rules are utilized to determine a provider's scope and what codes/services they are recognized to provide/allowed to be reimbursed for. • Professional practice standards (including but not limited to: National Association of Social Workers Code of Ethics, American College of Surgeons Statement on Scope of Practice, American Physical Therapy Association Standards of Practice for Physical Therapy) • Licensure boards (including but not limited to: Rhode Island Department of Health)							

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	Evidentiary Standards Used to Design or Apply the NQTL	• State rules and regulations (including but not limited to: RI Code of Regulations for Psychologists, RI Code of Regulations for Licensure and Discipline of Physicians) **Diagnosis and billing restrictions** are based on concepts of "correct coding" and generally accepted medical principals, national standards or industry recognized guidelines including but not limited to: • National Correct Coding Rules and guidelines and Correct Coding Initiative (CCI) Edits; • American Medical Association (AMA)'s Current Procedural Terminology (CPT) coding classifications; • International Classification of Diseases 10th Revision (ICD-10); • Healthcare Common Procedure Coding System (HCPCS); • Utilization derived medical unlikely edit standards ("MUE's") are derived from CMS and other national utilization data sources. • BCBSA Evidence Positioning System • Centers for Medicare & Medicaid Services • Food and Drug Administration • Centers for Disease Control • Policy Reporter/other industry standards/information • Professional Society Position Statements • Local Participating providers with expertise in the area of policy topic • and where appropriate, any limitations in state scope of practice statutes and regulations, etc. **Geographic Location** restrictions are based on Blue Cross Blue Shield Association licensing rules. • Geographic location contracting is in accordance with Blue Cross Blue Shield Association rules							
3	Description of How the Factors are Used in the Design and Application of the NQTL	For both M/S and MH/SUD services: Criteria may limit services that can be provided based on the **scope of license** for a particular provider type (for example: a Chiropractor may not perform surgical services and may be limited to codes/services allowed for manual manipulation of the spine and limited evaluation and management services, and a Licensed Independent Social Worker cannot bill codes for surgical codes/services and are limited to list of therapy codes/services). Medical and/or Payment Policies may restrict certain benefit categories based on **related diagnosis** and coding (for example: only patients with diabetes are eligible for diabetic pumps and supplies, and a patient must have an Autism diagnosis to receive Applied Behavioral Analysis (ABA) benefits/services.) Restrictions relating to scope of license and related diagnosis are components of medical and/or payment policies. The Payment and Medical Policy Review Committee (PMPRC) is the review and approval body for all presented BCBSRI policies. The purpose of the PMPRC is to review all Blue Cross & Blue Shield of Rhode Island (BCSBRI) policies, whether new or existing, and ensure consistency in the application of industry-standard medical necessity guidelines. These policies are developed utilizing the most current information available from a variety of sources including, but not limited to, Centers for Medicare and Medicaid Services (CMS) and Blue Cross & Blue Shield Association (BCA). These policies can be found externally on the Blue Cross & Blue Shield of Rhode Island website. The committee also reviews policies/content contained in the online authorization tool, using InterQual criteria. These policies are developed using industry standard evidence. BCBSRI keeps an online library that contains the supporting evidence and standards used to create each policy. Representatives from departments that attend PMPRC review policies presented and provide any necessary feedback. The Committee is composed of representatives from various the following departments, including but not limited to: • Medical Director • Medical Policy Team members • Payment Policy Team members • Utilization Management • Behavioral Health • Provider Relations							

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		• Contracting/Network Management • Grievances and Appeals Unit • Government Programs • Product Marketing • Special Investigations Unit • Audit and Recovery/Payment Integrity • Legal • Customer & Provider Services • Payment Controls • Claims Operations • Clinical Program Operations (MHK)							

Title	Qualifications
Utilization Management Medical Director	MD
Manager of Utilization Management	RN
Manager of Medical Policy	SME
Medical Policy Analysts	RN
Manager of Payment Policy	SME
Payment Policy Analysts	SME
Director of Contracting	SME
Grievances and Appeals Unit Nurse Reviewer	RN
Fraud Investigator	SME
Claims Ops Analyst	SME
Manager of Behavioral Health	SME
Director of Provider Relations	SME
Clinical Program Ops Analyst	SME

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	- -							

The decision-making process to develop a policy is outlined below and can be found in more detail in internal policy CN 5.01, Medical and Payment Policy Development and Implementation:

1. Policy Initiation Phase
    a. A policy request is made by an internal or external (i.e. provider) stakeholder. Requests may be initiated for a number of reasons, including but not limited to request for new service, identified lack of clarity in existing policy, changes in benefits, new literature to support modifying criteria, etc.
    b. Policy request is assigned to an analyst, who reviews request with a Medical Director
2. Policy Research and Development Phase
    a. Research is conducted using a variety of resources including:
        i. BCBSA Evidence Positioning System
        ii. Centers for Medicare & Medicaid Services
        iii. Food and Drug Administration
        iv. Centers for Disease Control
        v. Policy Reporter/other industry standards/information
        vi. Professional Society Position Statements
        vii. Local Participating providers with expertise in the area of policy topic
    b. Decision Making Process—the following decision processes are used in making determinations:
        i. Decisions about experimental or investigational services-- Decisions about experimental or investigational services that include any medical or behavioral health treatment, procedure, facility, equipment, drug, device, or supply, are made using Blue Cross & Blue Shield of Rhode Island's policies on Investigational/Experimental Treatment (CI 3.03.12) and Utilization Management (CI 3.03.01) Authorization Review Program (Non-BlueCHiP for Medicare Plans.
        ii. "Medically Necessary" is defined as health care services that are provided to treat an illness or injury, upon review by Blue Cross & Blue Shield of Rhode Island which are:
            1. appropriate and effective for the diagnosis, treatment, or care of the condition, disease, ailment or injury for which it is prescribed or performed;
            2. appropriate with regard to generally accepted standards of medical practice within the medical community;
            3. not primarily for the convenience of the member, the member's family or provider of such member; AND
            4. the most appropriate supplies or level of service which can safely be provided to the member, i.e. no less expensive professionally acceptable alternative is available.
        iii. Prior Authorization is the process of determining whether a covered healthcare service is medically necessary before the service is received or performed. Any medical and/or behavioral health service that requires prior authorization will require a medical necessity determination by BCBSRI's Utilization Management Department/BCBSRI Medical Directors or a BCBSRI vendor(s) to ensure that the service meets the "Medically Necessary" guidelines established for the service. **(noting Utilization Management, including Prior Authorization, is not conducted on Behavioral Health services)**
        iv. Policy determinations made based on benefits, coverage, and medical necessity guidelines and individuals are not excluded from participation in, denied the benefits of, or otherwise subject to discrimination on the basis of race, color, national origin, sex, age or disability. BCBSRI provides equal access to benefits without regard to race, color, national origin, sex, age or disability.
    c. Policy Development Document is utilized to document the policy development process. Information that is captured as part of this process includes:
        i. Status of current policy
        ii. Scope of proposed policy
            1. Policy classification
            2. UM systems/edits that should be implemented (noting Utilization Management is not conducted on Behavioral Health services)
            3. Benefit changes
            4. Products the policy applies to

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	iii. Financial impact iv. Coverage guidelines as well as industry information (includes Medicare NCD/LCD) v. Provider Comments vi. System implementation edits d. Annual and new policy review 3. Policy Final Review and Decision Phase a. Payment and Medical Policy Review Committee—policy is brought to committee for review/approval on an annual basis 4. Implementation Phase a. During the implementation phase, the systems configuration is completed to properly adjudicate the policy updates in the claims payment system b. This phase also allows for a 60-day notification period to providers of the policy change 5. Finalization of Policy—upon completion of all elements above, policy is considered final BCBSA guidelines restrict contracting based on **geographic location** (BCBSRI's contracts only with providers located within RI and select zip codes within contiguous counties). NOTE: Members may have access to providers in other states through the Blue Cross Association Blue Card Program which establishes a national network and plan's providers who provide care solely via telemedicine. BCBSRI does not otherwise limit services based on geography.							
4 Demonstration of Comparability and Stringency as Written	The Committee evaluates and makes recommendations regarding plan administration of the proposed and/or revised policy. The Committee's bi-weekly meetings (24 times annually) provide an open forum for the presentation of newly proposed and/or revised policies as well as annual reviews of policies with no updates to all affected departments. The Committee drafts new medical policies at any of these meetings. Reviews of existing policies, in accordance with the health care accreditation body "National Committee for Quality Assurance" (NCQA) standards, are conducted at least annually for each medical policy, and payment policies are reviewed once every three years. The policy development process applies equally to both M/S and MH/SUD services. The Committee is comprised of experts in M/S and MH/SUD benefits, policy and coding and include several members who are Certified Coders. The Committee meets regularly to review any new developments or emerging evidence. The Committee relies on evidence-based guidelines. The Committee uses the same process to determine to include or exclude a service or impose other rules. The resulting correct coding operational implementation review and configuration process includes the following teams/departments: Provider Payment Integrity, Medical Policy, Provider Relations, Contracting, Claims, and Behavioral Health. BCBSRI applies a claim editing process, for both medical and behavioral health claims, to review for appropriate billing by applying certain payment rules, including : (1) CMS's publicly available "medically unlikely edits" (MUEs) based on utilization, (2) "unlikely unit" edits determined by a review of national utilization of services, and (3) place of service edits which restrict locations from which a provider can bill (such as from a school). These payment rules may reduce provider reimbursement but do not result in increased member liability. Contracting within the applicable geographic area is conducted in accordance with BCBSA guidelines, credentialing criteria, NCQA, OHIC and other business criteria and applies all the factors equally to medical/surgical and MH/SUD providers. (i.e.: BCBSRI contracts only with providers located within RI and select zip codes within contiguous counties). NOTE: Members may have access to providers in other states through the Blue Cross Association Blue Card Program which establishes a national network. Additionally, BCBSRI contracts with telemedicine providers without regard to geographic restrictions. BCBSRI does not otherwise limit services based on geography. Where a variation in coding exists between what the provider bills in terms of coding locally (the location out of state which the provider resides) and what BCBSRI uses, BCBSRI works with the provider to align the coding from its geographic region with that more regularly used by BCBSRI; this occurs equally in M/S and MH/SUD and behavioral health. BCBSRI makes allowances for operational reasons when receiving and processing billing codes that are recognized by local Blue Cross Blue Shield Plans and/or by non-participating provides in their local geographic area that are generally not recognized by BCBSRI. BCBSRI contracts with providers and facilities in select zip codes within contiguous counties in the same manner as providers living within Rhode Island.							

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		A unique variation regarding geographic restrictions for early intervention services is a function of Rhode Island state law, as these are mandated by state law to be offered to RI residents obtaining care in Rhode Island.							
5	A demonstration of comparability and stringency, in operation	Medical and payment policies for MH/SUD services are developed in the same manner, and approved by the same governing body, as policies for M/S. BCBSRI subject matter expert staff are engaged in the community and are not aware of any unresolved scope of license requests or complaints. BCBSRI Provider Relations has not received any complaints regarding scope of license. BCBSRI Grievance and Appeals Unit (GAU), in 2025, presented on 2024 data with only one complaint relating to access to services for Behavioral Health. BCBSRI applies consistent considerations related to the application of Geographic Location, Facility Type, Provider Specialty, and other criteria that limit the scope or duration of benefits and is more favorable to behavioral health with respect to provider coding edits. BCBSRI applies a claim editing process, for both medical and behavioral health claims, to review for appropriate billing by applying certain payment rules, including : (1) CMS's publicly available "medically unlikely edits" (MUEs) based on utilization, (2) "unlikely unit" edits determined by a review of national utilization of services, and (3) place of service edits which restrict locations from which a provider can bill (such as from a school). These payment rules may reduce provider reimbursement but do not result in increased member liability.							
6	Findings and conclusions.	The above analysis demonstrates that: (1) the processes, strategies, evidentiary standards, and other factors used to design and apply out-of-network reimbursement rates to MH/SUD benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply out-of-network reimbursement rates to M/S benefits; and (2) the [Plan or Issuer] complies with the relevant data requirements under the MHPAEA Final Rules.							

Analysis Reviewed/Approved by BCBSRI's Mental Health Parity Governance Committee (PGC)	**09/29/2025**	**Implementation Date: 1/1/2026**
Analysis Performed By:	**Karen Labbe** **Director, Utilization Review** Signed by: Karen Labbe 3AA168C91C94431... **Sarah Fleury** **Director, Behavioral Health** Signed by: Sarah Fleury 144A4B16B483... **Tim Willis** **Mgr., Prov. Payment Integration & Network Contracting** DocuSigned by: Tim Willis	**Andrea Camera** **Mgr., Medical Payment Operations** Signed by: Andrea Camara 2D5544DC86AD4BE... **Mark Bevelander** **Director Network Contracting** DocuSigned by: Mark Bevelander 374D4... **Mary Ellen Moskal** **Mng. Director, Provider Services** DocuSigned by: Mary Ellen Moskal AE27958F2DBD4DA...
I certify that this analysis was reviewed/approved by BCBSRI's Mental Health Parity Governance Committee on the above-mentioned date.	**X** Signed by: Sonia Worrell Asare 0062B9B1A3B44E5... **Sonia Worrell Asare** **Managing Director, Compliance & Ethics** **Corporate Compliance Officer**	**DATE: 9/29/2025**