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SECTION I: INTRODUCTION AND OVERVIEW

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A. WELCOME TO ALLIANCE HEALTH

Welcome to the Alliance Provider Network. As a member of our Network you join a select, progressive group of providers who are dedicated to providing quality care for the Individuals of publicly-funded mental health (MH), intellectual and developmental disabilities (IDD) and substance use (SU) services in Cumberland, Durham, Johnston and Wake counties. As a provider, you represent the Network to the people we serve, and join us in our mission to help people with disabilities and special needs improve the quality of their lives.

As a contracted provider with Alliance Health (Alliance), it is your responsibility to be familiar and comply with all federal and state laws, rules and regulations governing the provision of MH/IDD/SA services and the processes outlined in this Manual. Failure to comply with this Manual may constitute a material breach of your Contract with Alliance and could result in sanction or administrative action by Alliance, up to and including termination from the Network. This Manual documents information about Alliance including our purpose, mission, vision, and core values and describes our processes related to participating in the Provider Network including obtaining referrals and authorizations, submitting claims and resolving many issues or problems. We have also included a glossary of frequently used terms for your reference and links to necessary forms. Your compliance with the requirements of this Manual will assist Alliance in providing you with timely service authorizations and claims reimbursement.

Please note that this Manual will change over time in response to changes in Alliance practices, federal and state law, rules, regulations and Department of Health and Human Services (DHHS) directives. In order to ensure high quality care, Alliance reserves the right to adopt more restrictive processes, policies and procedures than are required by state and federal rules and regulations. Alliance will strive to provide thirty days’ advance notice of any material changes to this Manual. Nothing in this Manual is intended, or should be construed, to create any enforceable rights, expectations or cause of action against Alliance for any provider or individual.

All timelines in this document refer to calendar days unless otherwise specified. A business or working day refers to a day on which Alliance is officially open for business.
We thank you for your participation in our Network, and look forward to a long and rewarding partnership as we work together to provide quality treatment to the individuals we all serve.

B. MESSAGE FROM THE ALLIANCE CHIEF EXECUTIVE OFFICER

Dear Providers,

Since the inception of the North Carolina State Mental Health Plan of 2001, Alliance Health (Alliance) has evolved from a treatment provider to a Local Management Entity/Managed Care Organization (LME/MCO). We employ a System of Care framework focusing on best-practice service delivery through a multi-county Provider Network.

Contracts between Alliance and MH/IDD/SA providers create reciprocal partnerships designed to ensure an integrated system of quality services and supports is available to Cumberland, Durham, Johnston and Wake County residents. All contracts between Alliance and providers contain requirements that promote person and family-centered treatment, sound clinical and business practices, and delivery of high quality services within Alliance’s System of Care.

It is Alliance’s goal to manage a comprehensive Provider Network that is integrated and responsive. We seek to maintain an environment in which providers can be successful both clinically and financially.

Alliance Network Providers must be mission-driven, willing to work cooperatively on behalf of individuals and their family members, and be active participants within Alliance’s System of Care. Medicaid is the payor of last resort, and Alliance Network Providers are expected to maximize other sources of funding and to extend public funding as far as possible.

Alliance recognizes that a comprehensive, community-wide System of Care requires multiple providers working together in collaborative relationships to serve individuals in the most effective and efficient manner possible. While these relationships sometimes prove challenging, they are the foundation on which we create and maintain the System of Care the individuals we serve and our community deserve. Alliance is interested in your perception of our operations as well. To evaluate performance, we will measure the satisfaction of your experience with Alliance as well as your experiences with other providers. We believe this information is important and will lead to continuous improvement in both quality and efficiency.
As the system evolves, Alliance will use performance indicators, outcome measures and other factors to determine selection and retention of providers in our closed Network, but individuals’ access to care will remain the primary determining factor. Alliance will always strive to maintain an appropriate balance between individual choice and our responsibility to effectively and efficiently manage publicly-funded MH/IDD/SA services.

We welcome you as our partner in Alliance’s System of Care, providing services that use evidence-based practices to achieve meaningful life outcomes for the citizens we work together every day to serve.

Sincerely,

Rob Robinson
Chief Executive Officer
Alliance Health

C. WHO WE ARE

Alliance Health (Alliance) is a multi-county area authority/Local Management Entity (LME) established and operating in accordance with Chapter 122C of the North Carolina General Statutes. We are a political subdivision of the State of North Carolina and an agency of local government. Additionally, Alliance operates as a regional Prepaid Inpatient Health Plan (PIHP) on a capitated risk basis for behavioral health services. A PIHP is a type of Managed Care Organization (MCO) as described in 42 CFR Part 438. Capitation means that Alliance receives funding on a per-member-per-month (PMPM) basis, which covers both treatment services and administrative costs, for the entire Medicaid Network population in the four Alliance counties. Capitation supports the type of creative flexibility necessary in an individual-driven system of care. Alliance also receives a limited allocation from the North Carolina Department of Health and Human Services for State-funded MH/IDD/SA services, and some competitive grant funding.

As an LME/MCO, Alliance is responsible for authorizing, managing, coordinating, facilitating and monitoring the provision of State, Federal and Medicaid-funded MH/IDD/SA services in Cumberland, Durham, Johnston and Wake counties. The LME/MCO model developed by the State utilizes a funding strategy that includes single management of all public funding resources through a local public system manager. Under this model, Alliance receives funding from multiple Federal, State and County sources. The financing provides for coordination and blending of funding resources, collaboration with out-of-system resources, appropriate and accountable distribution of resources, and allocation of the most resources to the people with the greatest disabilities. Re-engineering the system away from unnecessary high-cost and institutional use to a community-based system requires that a single entity has the authority to manage the full continuum of care.
D. ALLIANCE MISSION, VISION AND VALUES

Our Mission
To improve the health and well-being of the people we serve by ensuring highly-effective, community-based support and care.

Our Vision
To be a leader in transforming the delivery of whole person care in the public sector.

Our Values
Accountability and Integrity: We keep the commitments we make to our stakeholders and to each other. We ensure high-quality services at a sustainable cost.

Collaboration: We actively seek meaningful and diverse partnerships to improve services and systems for the people we serve. We value communication and cooperation between team members and departments to ensure that people receive needed services and supports.

Compassion: Our work is driven by dedication to the people we serve and an understanding of the importance of community in each of our lives.

Dignity and Respect: We value differences and seek diverse input. We strive to be inclusive and honor the culture and history of our communities and the people we serve.

Innovation: We challenge the way it’s always been done. We learn from experience to shape a better future.

E. THE ALLIANCE CLINICAL MODEL, TREATMENT PHILOSOPHY AND COMMUNITY STANDARDS OF PRACTICE

The Alliance clinical model is designed to ensure that individuals receive timely access to an array of high-quality behavioral health services at the level and intensity required to meet their needs. Delivery of services is based on best and evidence-based practices and clearly documented clinical practice parameters. Individuals can access services through multiple points allowing for a no wrong door approach. Alliance is responsible for developing, monitoring and maintaining a complete service continuum through a network of skilled private service providers. The service continuum ranges from community prevention to intensive crisis services as well as inpatient services. Alliance’s clinical model relies on a System of Care approach that blends professional paid resources with natural supports and other community partners to address the holistic needs of individuals served through Alliance.

Assessment, person centered planning, active care management and care coordination are essential elements of the clinical model. Comprehensive assessment of individual needs beyond behavioral healthcare is an essential first step for positive treatment outcomes. Assessment examines an individual’s need for behavioral health services, physical health, housing, education and or vocational needs, barriers and general support needs to enhance symptom reduction, recovery and the ability for one to live as independently as possible.
Person-driven and individualized service plans are developed to address the needs highlighted through the comprehensive assessment. Alliance Care Managers play an active role to ensure that the needs identified through the assessment and person-centered planning processes are being actively addressed by the treating providers. Care management includes review of requests for service, follow-up contact with providers and individuals, review of services provided, identification of both individual and systemic service over- and under-utilization and provider consultation and technical assistance.

Care coordination (performed by Alliance staff), case management (performed by providers in accordance with NC Medicaid Clinical Coverage Policies 8A, 8A-1, and 8A-2), and collaboration between treating providers are essential components of effective treatment, especially for individuals with more critical treatment needs and those at risk for crisis. High quality treatment and support that is coordinated between providers can minimize crises and decrease the need for inpatient treatment.

As part of the Alliance clinical model, individuals may be linked to a behavioral health home. The philosophy behind the use of the term “behavioral health home” is based on the need for each individual to have one provider that has overall responsibility for that person’s treatment and service coordination. This shall include coordination of any support services that the individual may need in addition to formal treatment services.

A provider of one of the enhanced benefit services listed below assumes the behavioral health home function for individuals immediately upon admission to these services:

- Intensive In-Home (IIH)
- Multi-systemic Therapy (MST)
- Community Support Team (CST)
- Assertive Community Treatment Team (ACTT)
- Substance Abuse Intensive Outpatient Program (SAIOP)
- Substance Abuse Comprehensive Outpatient (SACOT)

Outpatient therapists assume behavioral health home functions in the event that outpatient services are being delivered and none of the above services are a part of the individual’s Person-Centered Plan (PCP). Other behavioral health home providers may include:

- Day Treatment
- Psychosocial Rehabilitation
- Twenty-four (24) hour residential and treatment providers

The behavioral health home provider is the cornerstone of the individual’s treatment and fulfills key roles. These include:

- Conduct a Comprehensive Clinical Assessment.
- Develop the Person-Centered Plan (PCP), treatment plan, and/or individual service plan (ISP) as well as a crisis plan that address the individual as a whole person.
- Coordinate service provision for the individual, including monitoring of those services which includes managing and taking responsibility for a team approach to treatment and service provision.
• Make revisions to the PCP/treatment plan when the individual’s needs indicate a change of service or provider.

• Submit the necessary registration and authorization request paperwork to Alliance.

• Crisis response services as required by the applicable service definition.

• Convene a Child and Family Team meeting, or other team meeting, at least every 30 days (1) to review strengths, needs, and goals and (2) to revise the Person-Centered Plan (PCP), treatment plan, Individual Service Plan (ISP), and/or crisis plan as needed. Team meetings should demonstrate fidelity to System of Care principles and values.

• Ensure seamless transition between services and providers.

• Upon discharge from a behavioral health home provider and no other service provider remains in place, the behavioral health home provider will retain crisis response duties for 60 days post discharge.

The linkage with a behavioral health home is initiated based on the level of service each individual requires. Individuals who require a higher level of care will be linked to an appropriate service provider.

Outpatient therapy providers shall provide, or have a written agreement with another entity to provide, for access to 24-hour coverage for behavioral health crises. Outpatient providers may access Mobile Crisis Services for the individual if telephone contact cannot mitigate the crisis.

Alliance has adopted the following Recovery and Self-Determination Guiding Principles that incorporate and reflect best practices in a recovery and self-determination oriented System of Care and should be used as a guide in the way all services are provided. We would encourage all providers to adopt these or similar principles as we work together to provide appropriate supports and services to those in need.

**Principle I: Partnership**
*(Alliance Value – Collaboration)*

People direct their own recovery process. Therefore, their input is essential and validated throughout the process without fear. A Recovery-Oriented System of Care serves as a foundation within all Alliance Communities to ensure:

• A spirit of partnership and collaboration is supported throughout the person directed planning process.

• A team approach will be utilized to support each person to make educated decisions on their own behalf.

• All interactions will be supported through equality and mutual respect.

• Community partners will work together, communicate and collaborate with one another, Alliance, and people and families served.
Principle II: Empowerment, Choice and Personal Responsibility
(Alliance Values – Accountability and Integrity, Dignity and Respect)

With support and education, people are independent and free to accept responsibility for their own recovery:

- People know themselves best and are encouraged to guide their own recovery.
- Diversity and cultural differences are valued at all times.
- People are provided with options and supported to make decisions based on what they identify and prioritize as their own goals, wants and needs.
- People are provided options and choices, not final answers.
- People are free to voice their concerns and make their own decisions regarding programs, activities and treatment without being labeled.
- Having people, stakeholders, and systems honor their commitments and be accountable is essential.

Principle III: Respect, Dignity and Compassion
(Alliance Values – Dignity and Respect, Compassion)

A person’s unique strengths, attributes, and challenges all define them. Symptoms and diagnoses are only one part of a person’s experience:

- Individuality is appreciated and validated.
- Everyone’s beliefs, spirituality, culture and religion are honored.
- Sensitivity to each person’s challenges and circumstances guide the support they are offered.
- A sense of community and connection is a vital aspect of each person’s life.

Principle IV: Hope and Optimism
(Alliance Values – Innovation, Dignity and Respect, Compassion)

Recovery is an ongoing process in achieving wellness. Relapse can be a natural part of the recovery process that all people can relate to and learn from:

- People will be reminded that there are no limits to recovery and reassured that mental wellness is possible.
- People are encouraged to reflect and make informed decisions.
- Hope is essential. Even during relapse, it lays the groundwork for healing to begin.
- We challenge the way it’s always been done. We learn from experience to shape a better future.
- Recovery is not a service or system…it’s a life-long process of personal growth.

Principle V: Self-Acceptance, Personal Growth and Healing
(Alliance Values – Dignity and Respect, Innovation)

Mental wellness is possible through learning from past experiences, having self-awareness, and accepting oneself. Personal forgiveness, self-confidence and self-esteem foster the healing process:
• People have opportunities to learn about themselves, not as defined by their illness or by the way others view them, but based on insight and self-exploration.
• Through education about recovery, available resources and treatment options, people can change, grow and heal.
• Every person is supported to live a full, meaningful and productive life as defined by themselves.
• All successes, no matter how small, are recognized and celebrated.
• People deserve to feel valued in their community, as defined by them.

Principle VI: Support
(Alliance Values – Collaboration, Compassion, Dignity and Respect, Innovation)
No person goes through life alone. We all rely on someone to talk to and having people who care. Supportive teams will collaborate to create a “safety net.”
• Recovery from mental illness is most effective when a holistic approach with the person is utilized.
• Family and friend involvement may enhance the recovery process. Each person defines their own family unit and support team.
• Peer to peer support is one of the most powerful and helpful tools for recovery.
• Creativity is key; support persons will collaborate to offer creative solutions and options to meet a person’s needs.
• All efforts will be made to keep people in their community, utilizing natural supports during wellness and crisis.
• Support provided will be sensitive and aware of the role of trauma in mental health, will foster the healing process and ensure that services are trauma informed.

F. MEDICAID WAIVERS: WHAT IS THE NC MH/DD/SAS HEALTH PLAN?
The North Carolina MH/DD/SAS Health Plan (the Health Plan) is a prepaid inpatient health plan (PIHP) funded by Medicaid and approved by the Centers for Medicare and Medicaid (CMS). The Health Plan combines two types of waivers: a 1915(b) waiver generally known as a Managed Care/Freedom of Choice Waiver, and a 1915(c) waiver generally known as a Home and Community Based Waiver. The primary goals of the Health Plan is to improve access to services, improve the quality of care, ensure services are managed and delivered within a quality management framework, to empower individuals and families to shape the system through their choices of services and providers, and to empower LME/MCOs to build partnerships with individuals, providers and community stakeholders to create a more responsive system of community care.

Through the 1915(b) and 1915(c) sections of the Social Security Act, states are permitted to submit a request to waive some Medicaid requirements in order to provide alternatives to the traditional fee for service system of care and institutional care. This type of waiver system creates an opportunity to work closely with individuals and providers to better coordinate and manage services, resulting in better outcomes for individuals and more efficient use of resources. Alliance manages the resources using tools such as care
coordination, utilization management, flexible rate setting, and the careful selection of Network providers. Because the Health Plan waives Section 1902(a)(23) of Title XIX of the Social Security Act, which is often referred to as the any willing provider or free choice of provider provision, Alliance has the authority to limit provider participation in the Network and operate a closed Network of providers.

All Medicaid individuals in specified eligibility groups are eligible and automatically enrolled into the Health Plan for their mental health, intellectual/developmental disability, and substance abuse (MH/IDD/SU) service needs. Available services include current NC State Mental Health Plan Medicaid services, including inpatient psychiatric care and Intermediate Care Facilities for the Developmentally Disabled (ICF/DD). Under the approved Health Plan, Alliance has partnered with the State to create additional services and supports, referred to as (b)(3) services, that have been identified as best practices in care. These services are designed to use evidence-based practices which support achievement of positive outcomes for people with MH/IDD/SU needs. These (b)(3) services provide additional tools needed to reduce reliance on high cost institutional and facility care and offer a greater range of community services. These services are not covered in the NC State Medicaid Plan and are not available to individuals with Medicaid originating from outside the four Alliance counties.

G. ABOUT THE NC INNOVATIONS WAIVER and TBI Waiver

The NC Innovations Waiver is a 1915(c) Home and Community Based Services (HCBS) Waiver (formerly the Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities). This is a waiver of institutional care. Funds that are typically used to serve a person with intellectual and/or developmental disabilities in an Intermediate Care Facility (ICF) through this waiver may be used to support the participant outside of the ICF setting.

The NC Innovations Waiver incorporates self-direction, person-centered planning, individual budgets, participant protections and quality assurance to support the development of a strong continuum of services that enables individuals to live in integrated settings. Participants in the waiver and their families are provided the information and opportunity to make informed decisions about their health care and services. They are empowered to exercise more control over the decisions they make regarding services and supports. The NC Innovations Waiver has both Provider-Directed Supports and Individual/Family-Directed Supports options.

In Provider-Directed Supports, services are delivered in a traditional manner with staff in the employment of an agency. Participants and their families have the opportunity to choose their NC Innovations service providers and are included in support planning. The service provider is fully responsible for the employment of individuals who work with the participant.

There are two models of Individual/Family-Directed Supports. The Agency with Choice model will be available during the initial implementation of NC Innovations (first three
years). In the *Agency with Choice* model, the provider agency is the legal employer, but the participant/legally responsible person is the Managing Employer. The Managing Employer is responsible for interviewing, training, managing (with oversight by the agency Qualified Professional), and making recommendations to the provider agency for hiring and firing. Participants and their families may choose Provider-Directed Supports, Agency with Choice model of Individual/Family-Directed Support or a combination of both options.

A Community Navigator may be utilized to assist the participant and their family with any elements of Individual/Family-Directed Support.

A second model of Individual/Family-Directed Supports, *Employer of Record*, is an option offered to participants and their families after initial implementation. In the Employer of Record model, the staff are hired, directed and paid by the NC Innovations participant/legally responsible persons with the assistance of a Community Guide and a Financial Supports Agency.

The TBI Waiver offers services and supports to eligible individuals. The program will initially be available to individuals living in the Alliance Health (LME-MCO) catchment area (Wake, Durham, Johnston and Cumberland counties).

An individual may be eligible for the TBI waiver if they have cognitive, behavioral and physical support needs, the TBI occurred on or after the 22nd birthday, they need specialty hospital care or skilled nursing care, and they meet certain financial eligibility.

**TBI Services may include:**

- Staff supports to enable you to live independently or in a group-living situation
- Personal care services
- Life-skills training
- Cognitive rehabilitation
- Home and/or vehicle modification
- Technology supports
- Occupational, physical and speech therapy
- Activities to do during the day or help in finding a job
- Family/caregiver support

More information about the NC Innovations and TBI Waiver can be found on the Alliance and DHHS websites:

https://medicaid.ncdhhs.gov/nc-innovations-waiver
H. OTHER PUBLICLY-FUNDED SERVICES

Under the authority to operate as an LME/MCO, Alliance manages services funded by grants and with State or County funds. These services are limited both in funding and availability. The individuals eligible to receive these services must meet certain criteria (including but not limited to residence in a particular county). Access to State or locally-funded services is not an entitlement and is only available to the extent that funding is available.

Most State-funded services require prior authorization by Alliance and can be accessed by contacting the Alliance Access and Information Center. Part of the State-funded service eligibility process is based on an individual or family levels of income in addition to clinical needs. There are some crisis services available to individuals within the Alliance region that are available regardless of an individual’s ability to pay.

Alliance also manages a variety of County-funded programs, including but not limited to crisis and assessment centers and outpatient walk-in clinics.

Web References:

https://www.alliancehealthplan.org/consumers-families/non-medicaid-services/
www.Alliancehealthplan.org/Individuals-families/crisis-and-access
SECTION II: PROVIDER RESPONSIBILITIES AND INVOLVEMENT

A. Provider Responsibilities
B. Provider Involvement

A. PROVIDER RESPONSIBILITIES

Alliance requires each Provider enrolled in the Alliance Provider Network to deliver high-quality, medically-necessary services using best and evidence-based practices. These services are to be supported by all required documentation and in the best interest of individuals and their families. Please note that the requirements and responsibilities listed below are a summary and do not exhaustively list all the requirements applicable to Network Providers that are contained in this Manual.

Providers must be knowledgeable and compliant with all applicable requirements of State and Federal law, rules and regulations governing the provision of MH/IDD/SA services, NC Medicaid Clinical Coverage Policies, DMH Manuals including Confidentiality APSM 45-1 (1/05), Client Rights Rules in Community Mental Health, Developmental Disabilities & Substance Abuse Services APSM 95-2 (7/03), Records Management and Documentation Manual APSM 45-2 (effective December 1, 2016), DHHS Medicaid Bulletins, DMH/DD/SAS Communication Bulletins and Joint Implementation Updates, this Manual and any applicable supplements or revisions, the Alliance Weekly Update and other official Alliance or DHHS communications, and the terms and conditions in Provider’s contract(s) with Alliance. For clarification of Clinical Coverage Policies, Provider shall refer to DMH/DD/SAS Communication Bulletins.

As a part of the Alliance Network, providers should remain current about changes in the programs and clinical definitions, be culturally competent and comply with requirements regarding utilization/care management, care coordination, claims processing and documentation.

Alliance Network Providers are required to stay updated about current information affecting individuals we serve:

- Provide medically necessary services according to the most recent State standards and/or waiver service definitions.
- Participate and assist with utilization/care management, quality management, evaluation and monitoring activities, peer review, credentialing, recredentialing and appeals and grievances.
- Participate in Alliance organized collaborations when offered.
- Attend and participate in Provider Meetings.
- Subscribe to the Alliance Provider News feeds.
- Adhere to this Manual and review the Alliance website for updates on a regular basis: www.Alliancehealthplan.org.
• Review State and Federal websites for the most up-to-date information on a regular basis:
  www.ncdhhs.gov/mhddsas/
  https://medicaid.ncdhhs.gov/
  www.cms.gov/

• All providers of 1915(c) waiver services must adhere to the Home and Community Based Services (HCBS) Final Rule requirements and review the Alliance website for updates on a regular basis: www.Alliancehealthplan.org

• Keep all relevant staff in your agency informed of new and/or changing information as it relates to their function within the agency.

• Work in conjunction with the appropriate department at Alliance for technical assistance when needed.

Alliance Network Providers are required to comply with Provider Network and contracting requirements:

• Timely response to requests for information from Alliance.

• Submit credentialing and recredentialing information as required in credentialing/recredentialing notification.

• Obtain and maintain correct enrollment in the NCTracks system.

• Collaborate with monitoring and evaluation activities.

• Cooperate and comply with Plans of Corrections or other compliance activity.

• Submit all notice of change forms as indicated in your contract.

• Return all contracts and contract amendments within timeframes specified.

Alliance Network Providers are required to be active, engaged and culturally competent members of our System of Care:

• Let Community Relations know about events in your county for individuals.

• Participate in the education of stakeholders and individuals on system access, services and supports available, appeals and grievances, Advanced Directives and the Provider Network.

• Actively participate in community collaborative efforts to develop prevention, education and outreach programs.

• Work in collaboration with other Providers, individuals and families.

• Assist in the development of educational materials and brochures on mental illness, developmental disabilities and substance abuse to educate the community about the needs of people with disabilities.

• Be responsive to the cultural and linguistic needs of the individuals your agency serves.

• Pursue the acquisition of knowledge relative to cultural competence and the provision of services in a culturally competent manner. Provide culturally competent services and ensure the cultural sensitivity of staff members. Develop a Cultural Competency Plan and comply with cultural competency requirements.
• Demonstrate individual-friendly services and attitudes. The Network Provider must have a system to ensure good communication with individuals and families.
• Participate in quality improvement activities including individual satisfaction surveys, provider satisfaction surveys, clinical studies, incident reporting, and performance improvement projects and outcomes requirements.
• Participate in the coordination of care among different providers including other MH/IDD/SU providers as well as physical health care providers.

Alliance Network Providers must comply with all billing and claims processing requirements:
• Obtain authorizations as required for contracted services.
• Submit claims for reimbursement only for contracted and credentialed services and sites.
• Verify individuals’ insurance coverage at the time of referral, admission, each appointment, and at least on a monthly basis.
• Bill all first and third party payers prior to submitting claims to Alliance.
• Report all first party required fees and third party payments and denials on the claim you submit to Alliance.
• Timely submit Clean Claims electronically as stated in your contract.
• Ensure that your agency is monitoring your account receivable balance so that claims continue to be submitted in a timely manner.
• Submit all documentation that is required for Federal, State, or grant reporting requirements. This includes, but is not limited to, required individual enrollment demographics that must be reported to the State of North Carolina by Alliance.
• Never submit claims for payment with the intention or understanding that it will be used for any purpose other than that described in the supporting documentation for the payment as it is against the law to knowingly submit false, fraudulent or misleading claims, including claims for services not rendered, or claims which do not otherwise comply with applicable program contractual requirements.
• Ensure NCTracks enrollment and Provider information is up-to-date and correct for services being billed.
• Comply with NCTracks enrollment requirements (change requests, affiliation disclosures, etc.).
• Submit original Explanation of Benefits with all secondary claims.

Alliance Network Providers must comply with all Clinical, Utilization Management and Authorization requirements:
• Ensure that individuals meet medical necessity requirements for all services provided.
• Provide medically necessary covered services to individuals according to your Contract and as authorized by Alliance.
• Strive to achieve best practice in every area of service.
- Actively participate with the individual, their families, community resources, and other providers in development of a comprehensive Person-Centered Plan or Individual Service Plan.
- Develop methodologies for treatment, support, and/or habilitation programs that are in accordance with the Person-Centered Plan or Individual Service Plan.
- Communicate with the Alliance Care Coordinator (when assigned) about the needs of individuals receiving support from your agency.
- Notify the Care Coordinator of any changes, incidents or other information of significance related to the individual supported.
- Implement a clinical backup system to respond to emergencies on weekends and evenings for people you serve, or serve as a first responder as outlined in the applicable service definition and your contract.
- Provide services in accordance with all applicable State and Federal laws and regulations.
- Provide services in accordance with access standards and appointment wait time requirements.
- Maintain a “no-reject” policy for individuals who have been determined to meet medical necessity for the covered services provided.
- Work with Alliance to ensure a smooth transfer for any individuals who desire to change providers, or when you need to discharge an individual because you cannot meet his/her special needs.

Alliance Network Providers must comply with documentation requirements and participate in all reviews and audits:
- Document all services provided as required by the NC State Plan, Medicaid Clinical Coverage Policies, DMH/DD/SAS State Service Definitions, and any and all applicable Federal or State laws, rules, regulations, Manuals, policies and procedures.
- Cooperate and participate with all audits, investigations, post payment reviews, program integrity activities, and appeal and grievance procedures.
- Comply with all credentialing and recredentialing procedures including submission of complete and accurate applications and timely responses to requests for additional information.

Alliance Network Providers must have a Business Continuity Plan and participate in community disaster response and recovery efforts:
- Develop and maintain a plan for continued provider operations in the event of a natural disaster, weather event or other business interruption, including communication(s) with individuals, families and Alliance.
- Working proactively to ensure an individual crisis plan is in place for each individual served by the provider.
- Assist in community disaster response and recovery efforts.
- Licensed Professionals are encouraged to participate in the North Carolina Disaster Response Network.
B. TEMPORARY EMERGENCY RELOCATION

This section provides guidelines for providers to follow if experiencing an emergency that makes the site unavailable for use and requires a temporary relocation of a site and services provided at that site.

For purposes of this section, the term “emergency” refers to any situation that is sudden and unforeseen, such as a natural disaster, fire, or other site catastrophe that necessitates the removal of services from the site to protect health and safety.

Emergency Relocation Examples
- Hurricanes, snowstorms, tornadoes, floods, or other natural occurrence in which allowing individuals to remain at the site may jeopardize their health or safety.
- Fire, dysfunctional heating or cooling system (in cold or hot weather respectively), dysfunctional plumbing or septic system, or other situation in which allowing individuals to receive services at the site may jeopardize their health or safety.
- Other unforeseen occurrence not noted above in which allowing individuals to receive services at the site may jeopardize their health or safety.

Relocations that do not qualify as Emergency Relocation
- Relocations where there has been prior notice or knowledge of the need for relocation (eviction, foreclosure, planned moved, etc.).

Emergency Relocation guidelines for non-DHSR Licensed services
Submit the Alliance Emergency Relocation Form to: ProviderNetwork@AllianceHealthPlan.org.

Emergency Relocation guidelines for DHSR Licensed services
DHSR guidelines located at https://info.ncdhhs.gov/dhsr/mhlcs/relocation.html
Submit a copy of all information that was submitted to DHSR to Alliance at ProviderNetwork@AllianceHealthPlan.org.

C. PROVIDER INVOLVEMENT

Alliance encourages providers to actively participate in the Network. Alliance has a local office in 3 of the 4 counties, with Wake and Durham sharing a site. Education and training opportunities are offered throughout the year at the Alliance offices.

Web Reference: www.Alliancehealthplan.org
SECTION III: NETWORK DEVELOPMENT AND EVALUATION

A. Alliance Responsibilities
B. Sufficiency of the Provider Network
C. Network Provider Types and Specialties
D. Out-of-Network/Emergency Services Providers
E. Cultural Competency
F. Nondiscrimination and No-Reject Requirement
G. After Hours Coverage
H. Quality of Care
I. Provider Communication and Training
J. Credentialing and Recredentialing
K. Selection (Initial Participation) Criteria
L. Retention Criteria
M. Applying for Additional Sites and Services
N. Reporting Changes and Leave of Absence
O. Monitoring and Evaluation
P. Quality Improvement
Q. Documentation and Confidentiality Requirements

A. ALLIANCE RESPONSIBILITIES

Network Development and Evaluation Department overall functions and responsibilities include the following:

- Identify and eliminate gaps in Network services.
- Support the development and maintenance of best practices or emerging best practices.
- Support Network Providers as a resource for technical assistance.
- Keep providers informed through provider meetings, the Alliance provider news feed, social media, and the provider section on the Alliance website.
- Identify training needs for providers and if possible facilitate or provide the training.
- Credential and recredential providers in accordance with Federal and State laws, rules and regulations, Alliance Credentialing and Enrollment Procedure, the DHHS Contract and accreditation requirements.
- Contract with providers based on selection and retention criteria that addresses service needs, access to care, quality of care, provider compliance, provider performance and the business needs of the organization.
- Conduct performance evaluations and provider monitoring.
- Conduct quality improvement and quality management activities, including reporting, data analysis, focused studies and reviews.
B. SUFFICIENCY OF THE PROVIDER NETWORK

As discussed in the introductory section of this Manual, the NC MH/DD/SA Health Plan waives Section 1902(a)(23) of Title XIX of the Social Security Act, which is often referred to as the any willing provider or free choice of provider provision. This means that Alliance has the authority to determine the size and scope of the Provider Network, limit provider participation in the Network and operate a closed Network of providers. The waiver allows Alliance to right-size the Network which could occur when excess capacity exists, to encourage better outcomes or for other appropriate reasons. This ensures economic viability of providers in the Network and promotes efficiency while ensuring that individuals have access to necessary care. A primary goal of Alliance is to ensure that the System of Care and Provider Network can be shaped to better meet the needs of individuals through individual choice and provider expertise in evidence-based practices.

Alliance will maintain an appropriate Provider Network that is sufficient to provide adequate access to all services covered under our State contracts for the Medicaid and State-funded populations. Service providers will be of a sufficient number, mix and geographic distribution to assure that medically necessary, covered services are delivered in a timely and appropriate manner.

The accessibility standards are that most services will be available within thirty (30) to forty-five (45) miles or 30-45 minutes from an individual’s residence. However, some specialty providers may be located outside the individual’s county of residence.

C. NETWORK PROVIDER TYPES AND SPECIALTIES

Alliance has an array of providers ranging the service continuum from outpatient therapy to inpatient hospitalization. Alliance is committed to flexible, accessible, family-centered services which honor the dignity, respect the rights, and maximize the potential of the individual. To be accepted into the Network, providers must meet all credentialing criteria, including licensure. The provider types that are accepted in the Alliance Provider Network include:

- **Licensed Practitioners (LP)** – Licensed Practitioners in the areas of Psychiatry, Psychology, Counseling, Addictions and Social Work are enrolled in Alliance’s Provider Network. These providers may be Psychiatrists, Physicians for identified Specialty programs (M.D./D.O.), Practicing Psychologists (Ph.D.), Licensed Psychological Associates (Master’s Level Psychologist [LPA]), Master’s Level Social Workers (LCSW/LCSWA), Licensed Marriage and Family Therapists (LMFT/LMFTA), Licensed Professional Counselors (LPC/LPCA), Licensed Clinical Addiction Specialists (LCAS/LCASA), Advanced Practice Psychiatric Clinical Nurse Specialists, Psychiatric Nurse Practitioners, and Licensed Physician Assistants and Allied Health professionals. All Psychiatric Nurse Practitioners, Nurse Practitioners, and Licensed Physician Assistants are required to have a Psychiatrist identified in Board listings, as their supervisor. In addition, all Nurse Practitioners must meet requirements as outlined in Clinical Coverage Policy 8C. Licensed Practitioners provide Outpatient services such as psychiatric care, assessment and outpatient...
therapy. These services may be provided as a solo practitioner (outpatient treatment), or in a group practice (outpatient treatment), provider agency (outpatient treatment and enhanced benefit services) or hospital. Licensed Practitioners must meet all Alliance credentialing criteria but are not directly contracted with Alliance unless they are enrolled as a Licensed Independent Practitioner (LIP). Instead, LPs bill through the group practice, provider agency, facility or hospital with which they are affiliated. Every LP enrolled in a group, and the group practice itself, must meet all Alliance credentialing standards.

- **Licensed Independent Practitioners (LIPs)** – A Licensed Practitioner (not Associate level) who is organized as a sole proprietor/solo practitioner or a single-individual Limited Liability Company (LLC) is called a Licensed Independent Practitioner (LIP). If two or more LIPs seek to bill under one NPI with individual NPI billing numbers, they must be organized and enrolled as a provider agency or group practice. LIPs who share office space but do not commingle medical records or billing may not have to be organized and enrolled as a provider agency or group practice, depending upon the specific circumstances of each provider. LIPs provide important access to outpatient care for individuals.

- **Group Practices** – Group Practices consist of two or more individual Licensed Practitioners providing outpatient services and that are organized as a partnership, corporation, LLC, or other entity and are required to be registered with the NC Secretary of State’s office. Group practices may not be contracted to provide enhanced benefit services.

- **Provider Agencies** – Provider Agencies are providers of outpatient, enhanced benefit, specialty or other MH/IDD/SU services that are organized as a corporation, LLC, partnership or other entity required to be registered with the NC Secretary of State’s office. These agencies have completed a credentialing review of the infrastructure and capability of providing the services. A specialty provider agency may concentrate on a specific disability or service such as substance abuse, vocational, residential services, child mental health, eating disorders, autism and/or Down syndrome.

- **Critical Access Behavioral Healthcare Agency (CABHA)** – A CABHA is a type of provider agency that delivers a comprehensive array of critical mental health and substance abuse services in accordance with Medicaid State Plan requirements and under appropriate medical and clinical oversight that includes a Medical Director, Clinical Director and QM/Training Director. The CABHA’s role is to ensure that a robust array of critical services is delivered by a clinically competent organization with appropriate medical oversight. A CABHA is required to offer the following core services: comprehensive clinical assessment, medication management, and outpatient therapy, as well as being enrolled to deliver at least two of the following services in the age and disability-specific continuum served:
  - Intensive In-Home (IIH)*
  - Community Support Team (CST)*
  - Day Treatment*
- Substance Abuse Intensive Outpatient Program (SAIOP)
- Substance Abuse Comprehensive Outpatient Treatment (SACOT)
- Child Residential Level II, III, or IV
- Psychosocial Rehabilitation (PSR)
- Assertive Community Treatment Team (ACTT)
- Multi-Systemic Therapy (MST)
- Partial Hospitalization (PH)
- Substance Abuse Medically Monitored Community Residential Treatment
- Substance Abuse Non-Medical Community Residential Treatment
- Outpatient Opioid Treatment

* In accordance with the North Carolina State Plan for Medical Assistance, only CABHA agencies are permitted to be credentialed and contracted to provide: Intensive In-Home (IIH), Community Support Team (CST), and Day Treatment.

- **Facilities** – Facilities are any 24-hour residential facilities required to be licensed under Chapter 122C of the North Carolina General Statutes, such as Psychiatric Residential Treatment Facilities (PRTFs), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IIDs), Living-Facilities, Residential Treatment/Rehabilitation Facilities for Individuals with Substance Abuse Disorders, Outpatient Opioid Treatment Facilities, .5600 group homes or other licensed MH/IDD/SA facilities. These facilities may require a Certificate of Need or Letter of Support and must meet all applicable state licensure laws and rules, including but not limited to NCG.S. §122C-3 and Title 10A, Subchapter 27C, 27D, 27E, 27F, 27G, 26B and 26C. PRTFs provide non-acute inpatient care for recipients who have a mental illness and/or substance abuse/dependency and need 24-hour supervision and specialized interventions. ICF-IIDs provide services in a protected residential setting for persons with intellectual and/or developmental disabilities and/or a related condition. Services may include ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his or her greatest ability.

- **Hospitals** – Hospitals are facilities licensed under Chapter 131E of the North Carolina General Statutes and may provide inpatient and/or outpatient psychiatric, substance abuse treatment, detoxification, medical, or other services related to a primary diagnosis of mental health or substance abuse. Services may be provided in a psychiatric unit, outpatient clinic or in the Emergency Department.

- **Integrated Care Provider** – These providers render behavioral health services from a primary care setting. This generally involves a primary care physician employing or contracting with a licensed independent practitioner to provide outpatient treatment to individuals being served by the primary care physician.

Practice settings could include federally qualified health centers (FQHC), rural health centers, county health departments, hospital outpatient practices and general primary care practices.
D. OUT-OF-NETWORK/EMERGENCY SERVICES PROVIDERS

Alliance has an Out-of-Network (also referred to “OON”) procedure which is utilized to determine the need for an individual-specific contract with providers outside of the Alliance Network. Some individuals whose Medicaid eligibility arises from the Alliance catchment area live in other parts of the state. Alliance is committed to ensuring that providers are available to meet their needs and will make arrangements for Out-of-Network Agreements or contracts on an as-needed basis. **Alliance first makes every effort to link individuals to a Network Provider.** Out-of-Network providers are not considered to be individuals of the Alliance Network.

In accordance with 42 CFR 438.114(c), Alliance must cover and pay for emergency MH/IDD/SU services regardless of whether the provider that furnishes the services has a contract with Alliance. Emergency services means inpatient and outpatient services covered under the 1915(b)/(c) waiver that are furnished by a qualified provider, and are needed to evaluate or stabilize an emergency medical condition. An emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part.

If an individual served by Alliance is receiving non-emergency services from a provider who is not in the Alliance Provider Network or who has not received a fully executed Out-of-Network single case agreement and subsequent authorization., Alliance will not pay for the service. If a non-emergency Out-of-Network provider would like to be considered for an Out-of-Network Single Client Agreement they need to follow the Out-of-Network (OON) process that is outlined on the Alliance website. As noted above, Alliance will pay for acute behavioral emergency care for an individual served by Alliance by a non-contracted provider (subject to registration with NCTRacks). When an individual enrolled in the NC MH/IDD/SA Health Plan resides outside of the Alliance catchment area, we will work collaboratively with the individual and providers in that area to ensure that the individual has access to needed services.

E. CULTURAL COMPETENCY

Cultural and linguistic competency and the delivery of such services should be integrated into the overall fabric of service delivery, linked to quality of care and emphasized in policy, practice, procedures, and resources. Alliance recognizes that becoming culturally competent is an ongoing process in which we gain knowledge about one another and use that knowledge to build trust, break down barriers and improve the quality of care throughout the Network. In Network Agency and Group Providers are required to develop and submit to Alliance when requested a Cultural Competency Plan and comply with cultural competency requirements set forth herein. In Network LIP Solo providers are
required to obtain yearly (within each calendar year) Cultural Competency training and submit appropriate training certificates when requested.

Cultural awareness and sensitivity among Alliance’s staff and contracted providers enable us to work effectively with each other in cross-cultural situations. It is our intention to create an environment that protects and preserves the dignity of all by acknowledging cultural differences among us without placing values on those differences.

We encourage our staff and providers to recognize that culture makes us who we are. Culture not only determines how we see the world and each other, but greatly impacts how we experience physical and mental illness. It also shapes the recovery process, affects the types of services that are utilized, impacts diagnosis, influences treatment and the organization and financing of services. We envision that our Network includes providers who recognize that there is variation in behaviors, beliefs and values as they assess an individual’s wellness or illness and incorporate that awareness in treatment planning with competence and sensitivity. Alliance encourages providers to participate in the provider Cultural Competency Plan, which shall be developed and approved by a Provider Advisory Council composed of individuals of the Alliance Provider Network with representation across all disability groups.

Language interpretation services shall be made available by telephone or in-person to ensure that Enrollees are able to communicate with Alliance and Network Providers. Providers and Alliance shall make oral interpretation services available free of charge to each Enrollee. This applies to non-English languages as specified in 42 C.F.R. § 438.10. TDD (telecommunication devices for the deaf) must also be made available by providers for persons who have impaired hearing or a communication disorder.

F. NONDISCRIMINATION AND NO REJECT REQUIREMENTS

In accordance with 42 CFR § 438.214, Alliance provider selection policies and procedures do not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment. Discrimination by any Alliance employee, staff member or independent contractor against any individual, provider, employee or other stakeholder due to race, age, religion/spiritual beliefs, sex, national origin, political affiliation, culture, and/or language, ability, handicapping condition, sexual orientation, socioeconomic status, or other personal beliefs is strictly prohibited. Alliance staff will not impose their own personal beliefs on individuals, providers, employees and other stakeholders.

Likewise, discrimination by any contracted provider (including staff, employees or independent contractors of such provider) against any individual, employee or other stakeholder due to race, age, religion/spiritual beliefs, sex, national origin, political affiliation, culture, and/or language, ability, handicapping condition, sexual orientation, socioeconomic status, or other personal beliefs is strictly prohibited. Providers must not impose their own personal beliefs on individuals, employees and other stakeholders.
When screening individuals, Alliance staff and contracted providers must also take into account the visual, auditory, linguistic and motor limitations of the individual. When individuals with special needs are identified in the referral screening process, services will be tailored to meet those needs to the extent that resources are available.

Additionally, providers must have a no reject policy. Providers must agree to accept all referrals meeting criteria for service provided.

G. AFTER HOURS COVERAGE

Certain DMH/DD/SAS State Service Definitions and DMA Clinical Coverage Policies require first responder/crisis be delivered as part of the service definition. Providers contracted for those services are required to designate qualified staff who are available to accept and respond to after-hours calls from individuals or family members or to return the call within one hour. This includes but is not limited to all enhanced benefit service providers. All providers must provide access to 24-hour coverage for behavioral health emergency services. Those with first responder responsibilities should clearly define in their policy and procedures and PCP crisis plans how to access after-hours crisis calls and make those crisis plans available to their afterhours/on-call staff. If required by the applicable service definition, the designated after-hours on-call provider staff must be the individual’s licensed clinician or another qualified professional.

Upon receipt of an after-hours telephone call, the after-hours staff will assess the caller’s level of need. If the situation is determined to be of an emergent nature, whereby there is concern of imminent risk of harm to self or to others, and the individual does not respond to his/her individualized crisis plan, that professional will contact either the local crisis and assessment center and/or the appropriate community partner (e.g. law enforcement). In situations that call for immediate psychiatric intervention(s), a licensed clinician from the agency or a mobile crisis team may be deployed to make a home or on-site visit to help prevent hospitalization or to alleviate the potential for further decompensation. If the situation is of an urgent or routine nature, that individual will receive a follow-up contact from his or her licensed clinician or qualified professional on the next working day (or from that staff’s supervisor). The on-call staff shall be responsible for assuring the individual’s individual treatment provider (or direct supervisor) is notified of the situation no later than the next business day.

Outpatient and other Contracted Providers who are not required by the applicable service definition to maintain live staff for after-hours coverage shall provide, or have a written agreement with another entity, for access to 24-hour coverage for behavioral health emergency services. Enrolled providers shall arrange for coverage in the event that they are not available to respond to a beneficiary in crisis. This coverage shall include the ability for the beneficiary to speak with the licensed clinician on call either face-to-face or telephonically. Written agreements with another entity must be for the same service.

Providers contracted to serve NC Innovations Waiver participants are also required to respond to emergencies of participants and have a back-up system in place to respond to
emergencies/crises on weekends and evenings as outlined in the NC Innovations service definitions. NC Innovations Waiver Providers of In-Home Intensive Supports, In-Home Skill Building, Personal Care, and Residential Support services are required to have Qualified Professional (QP) staff available as Primary Crisis Services providers for emergencies that occur with participants in their care 24 hours per day, 7 days per week or have an arrangement (memorandum of understanding) with a Primary Crisis Services Provider.

When an individual present to a local crisis and assessment center after-hours requesting assistance, the crisis center staff must determine if the individual is enrolled with Alliance and the name of his or her primary provider. Crisis staff will perform an assessment to gather basic presenting information that includes determining the individual's needs and crisis lethality and attempt to contact the primary provider and access the crisis plan to obtain vital information to ensure that a thorough and comprehensive assessment is completed and an appropriate disposition is made. The primary provider will be contacted for assistance, information, and treatment recommendations. After-hours staff from the primary provider agency must respond telephonically to the local crisis and assessment center and have access to the individual's crisis plans and pertinent clinical information. Specific information regarding demographics, problem summary, diagnosis, substance use history, living situation, supports, health issues, medication regime, safety and security issues, history of suicidal or homicidal ideation/intent, the service delivery plan, and other pertinent details of the Crisis Plan should be provided. If there is no reason to contact the Primary provider after-hours on-call staff, the crisis center staff will contact the Primary provider the next business day to alert them of the contact they had with the individual.

This contact should be documented in the individual’s record. If the crisis center staff is unable to reach the Primary provider’s after-hours on-call staff or does not receive a call back within one (1) hour, this will be reported to the Alliance Access and Information Center immediately for follow-up by the Alliance Quality Management Department and/or the Office of Compliance.

H. QUALITY OF CARE

Alliance’s responsibility is to assure the quality of services provided by the Alliance Network of Providers. Alliance is accountable to the State in the management of publicly-funded services. In addition to state requirements, Medicaid waiver quality requirements are extensive and include but may not be limited to:

- Health and safety of individuals
- Rights protection
- Protection of health information
- Provider qualifications
- Individual satisfaction
- Management of complaints
- Incident investigation and monitoring
- Assessment of outcomes to determine efficacy of care
- Management of care for Special Needs Populations


- Preventive health care initiatives
- Clinical best practice
- Innovations back-up staffing
- Recovery-focused outcomes.

I. PROVIDER COMMUNICATION AND TRAINING

Alliance is committed to ensuring that Network Providers are aware of the information necessary to provide care to individuals served by Alliance and are able to comply with Alliance’s requirements. Alliance is committed to communicate through a variety of means in an effort to keep the community of Network Providers well informed of state and federal changes, new information, trainings, requests for proposals and opportunities for collaboration.

Alliance will assure the following:

- An orientation available for new Network Providers
- Regular and ongoing updates of Network activities.
- Timely notifications of any changes in fee schedules and Provider Operations Manual provisions (thirty (30) days advance notice unless such notice is not feasible due to state requirement or change).
- Informing providers of the dispute resolution mechanisms available to them in the event of sanctions or administrative actions.
- Informing providers of how to obtain benefit, eligibility, formulary, complaint and appeals information and their responsibilities therein.
- Assisting providers and their staff regarding Provider Network, claims and authorization issues.
- Mechanism(s) to receive suggestions and guidance from participating providers about how the Provider Network can best serve individuals.

The Alliance website is the central hub for information pertinent to Provider Network Operations. Regular updates on Network activities are posted to the Provider News page on the Alliance website and distributed through email daily or weekly news feeds to providers who subscribe at www.alliancehealthplan.org/category/provider-news/. Changes in fee schedules and/or contracting provisions are posted on the Alliance website and included in the news feed and where appropriate with direct email notification sent to specific providers of services that may be directly impacted by the changes. Providers are required to have an active email account on file with Alliance in order to receive communications, notifications and letters of authorization/notifications. Prior to the effective change date, Alliance must be notified of any changes to email address or other contact information that is different than what was provided in the application utilizing the Alliance Notice of Change Form.

On a quarterly basis, Alliance holds an “All Providers Meeting” at a central location and makes arrangements for provider participation, conference call, etc. Providers are also asked to provide input into the agenda and topics covered at the “All Providers
Meeting” to ensure content is relevant, mechanism(s) to receive suggestions and guidance from participating providers on the Network and how to best serve individuals are fully realized and being utilized, and assistance to providers and their staff regarding Provider Network issues is offered.

This Manual, the Alliance website and quarterly “All Provider Meetings” also serve as key components of an orientation for new providers. These resources include key documents and information, such as the Provider Operations Manual, key Alliance contacts in each functional area (e.g. Business Operations, Provider Network Operations, Utilization Management, etc.), as well as contact information for designated Provider Network Development staff available to answer provider questions. New Providers may request a New Provider Orientation through their assigned Provider Network Specialist.

Additionally, Alliance has established Provider Advisory Councils where clinical as well as administrative items are discussed. Provider Advisory Council members are nominated and elected by their peers, better ensuring a true and representative group inclusive of differing and important perspectives.

The Alliance Provider Advisory Council (APAC) includes representatives from each county within the Alliance catchment area and all age and disability areas. The APAC provides input to Alliance on identification of needs and gaps, and other areas in which provider input is critical. The APAC also coordinates provider feedback from local Provider Advisory Councils in each county.

 Providers of Innovations and TBI waiver services are encouraged to participate in the Innovations Stakeholder Committee and TBI Stakeholder Committee which meets monthly to discuss individual/family and provider concerns related to the Innovations waiver.

Lastly, Alliance has a dedicated Provider Network line through its telephonic helpdesk, (919) 651-8500, as well as a dedicated Provider Network email address (ProviderNetwork@Alliancehealthplan.org). Through the Helpdesk and dedicated email, providers are able to receive real-time assistance during normal business hours, and 24/7/365 assistance is available through Alliance’s Access and Information Center (Call Center). Providers are also encouraged to review information on the Alliance web site and may request technical assistance through the helpdesk. Access and Information Center staff members are updated on Network activities at regular staff meetings and receive all Weekly Updates and other communications to ensure they are best equipped to answer questions that may be received directly from providers.

**Provider Training Opportunities**

Alliance provides training opportunities for all its service providers, their staff, and community stakeholders. Alliance’s training opportunities are listed in the Alliance web-based calendar and often shared in the provider news feed. In addition, Alliance arranges for training in selected areas that Alliance or the State deems necessary. These trainings include but are not limited to the proper filing of claims for payment, Credentialing/Enrollment technical assistance, LOCUS/CALOCUS, and AlphaMCS. Alliance presents
many of these on-demand training opportunities as webinars posted on the Alliance website.

Alliance may also offer “best-practices” training opportunities to clinical provider staff to enhance quality-of-care rendered to our service populations. These trainings are sponsored in conjunction with North Carolina Evidence Based Practice Center/Southern Regional Area Heath Education Center (SR-AHEC) to assist clinicians in meeting licensure requirements.

Training activities offered are intended to support provider efforts to attain the skills that are important for quality service provision. Training events offered by Alliance and by community agencies will be posted on the Alliance website.

Alliance resources for providers and Training Opportunities:
www.alliancehealthplan.org/category/provider-news/
www.Alliancehealthplan.org/providers/training
http://alliancebh.academy.reliaslearning.com/

NC Department of Health and Human Services information can be found at the following websites:
www.ncdhhs.gov/
www.ncdhhs.gov/divisions/mhddsas
www.ncdhhs.gov/divisions/mhddsas/joint-communication-bulletins

J. CREDENTIALING AND RECredentialing

Credentialing is the process of determining whether a provider who applies to participate in the Alliance Provider Network meets the minimum criteria established by Alliance for participation. Recredentialing is a process to update and verify the accuracy of a Network Provider’s credentialing. Specific credentialing/recredentialing criteria that comply with federal and state law, rules and regulations as well as national accreditation standards are used in the process of determining initial and ongoing approval for participation. The following minimum criteria must be met in order to be approved for participation or remain enrolled in the Alliance Provider Network:

- **Good Standing** – All applicants for participation in the Alliance Closed Network must be in good standing with all applicable oversight agencies. This means the provider or applicant has submitted all required documents, payments and fees to the U.S. Internal Revenue Service, the NC Department of Revenue, NC Secretary of State (if organized as a corporation, partnership or limited liability company), the NC Department of Labor and the NC Department of Health and Human Services, has not filed or is currently in bankruptcy and has not had any sanction issued by those entities, including but not limited to:
  - LME-MCO: Contract Termination for cause related to services being provided or requested to provide, unresolved overpayment.
Providers are required to disclose any pending or final sanctions under the Medicare or Medicaid programs including paybacks, lawsuits, insurance claims or payouts, and disciplinary actions of the applicable licensure boards or adverse actions by regulatory agencies within the past five years or now pending. The provider’s or applicant’s owner(s) and managing employee(s) may not previously have been the owners or managing employees of a provider which had its participation in any State’s Medicaid program or the Medicare program involuntarily terminated for any reason or owes an outstanding overpayment to an LME/MCO or an outstanding final overpayment to DHHS.

For purposes of the credentialing procedure, Alliance considers an action of DHHS, including its Divisions and LME/MCO’s to be final upon notification to the provider, unless such action is under appeal. For actions by DHHS or LME/MCO under appeal, Alliance may, in its discretion, pend its award or enrollment for up to 90 days to allow for a final resolution or final decision by the NC OAH. If no final decision is rendered in that time period, then the provider or applicant is deemed not in Good Standing.

- **Eligibility to Participate in Federal and State Healthcare Programs** – Alliance is prohibited from contracting with providers who are identified on the List of Excluded Individuals/Entities (LEIE) maintained by the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) or, State of North Carolina State Excluded Provider List or the SAM maintained by the federal System for Award Management.

- **License Requirements** – Providers must have a valid unrestricted North Carolina license issued by the North Carolina Division of Health Service Regulation or
applicable professional licensure or certification Board (if applicable to the service type) before applying to the Network. All providers must have and maintain all required agency and facility licensure as specified in the North Carolina Administrative Code and North Carolina Medicaid Clinical Coverage Policies for the service(s) and/or facility(ies) identified in the application.

- **Insurance Requirements** – Providers are required to attain and maintain active insurance coverage as required by Provider’s contract with Alliance. This includes professional liability, comprehensive general liability, automobile liability, workers’ compensation and occupational disease insurance, employer’s liability insurance and tail coverage as applicable, with waivers for automobile and workers compensation requirements in limited circumstances. For Agencies/Groups employing LPs, each LP must be individually listed on any Group Practice, Agency or Facility insurance certificate or the Provider agency must submit a signed attestation stating the LP is covered under the Agency’s required Professional Liability and Comprehensive General Liability insurance.

- **Sanction/Criminal History Requirements** – All Owners/Managing Employees/Licensed Practitioners must be free of present illegal substance use, must make the necessary disclosures required by 42 CFR 455.106 and disclose any loss or limitation of licensure privileges or disciplinary activity, sanctions from professional societies, or sanctions by any applicable oversight agency, either in current provider organization or previous entities. All convictions and sanctions must be disclosed, but not all convictions or sanctions are a bar to enrollment. Criminal convictions and sanctions will be evaluated by the Provider Network Credentialing Committee based on nature and circumstances of the conviction/sanction, relevance to service(s) provided, length of time since conviction/sanction, and community and victim rehabilitation efforts following conviction.

- **General Requirements** – Providers shall submit a completed application with appropriate documentation, disclosures and signatures to join the Network, agreeing: (a) to comply with all Network requirements for reporting, inspections, monitoring, individual choice requirements; (b) to participate in the corporate compliance process and the Network continuous quality improvement process; (c) to undergo a criminal background check for all individual practitioners, owners and managing employees; The application must include a Signed Attestation Statement indicating the application is correct and complete and that the individual submitting the application is authorized to do so. Providers must provide accurate and truthful information on their application. Providers must disclose all required ownership information, affiliations (by contract or otherwise) with any other provider, any and all felony and misdemeanor convictions since the age of 18, and history of sanctions by applicable oversight agencies and accreditation/certification/licensure bodies. Providers are required to meet all other criteria outlined in applicable Federal and State laws, rules, regulations, policies, Manuals, the NC State Plan for Medical Assistance, the NC Medicaid 1915 (b)/(c) Waivers, Contracts between Alliance and NCDHHS, and the Alliance Selection and Retention Criteria Procedure, including but not limited to the following:
Providers shall have a “no-reject policy” for referrals within the capacity and the parameters of their competencies. Providers shall agree to accept all referrals meeting criteria for services they provide when there is available capacity.

Providers shall be able to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in the Alliance AlphaCM Provider Portal.

Providers (including sites and licensed professionals) shall be enrolled appropriately in the NCTracks system to account for all billable activities.

Providers shall demonstrate individual-friendly services and attitudes. During the application process, providers may be asked to demonstrate how individuals and families are involved in treatment and services. Providers shall have a good system of communication with individuals.

Providers shall demonstrate required education, experience and competency. Stability of past operations is important.

Providers shall have the capacity to respond to emergencies for assigned individuals according to State availability standards for emergent needs, Section VI C of this Manual, and service definition requirements for First Responder capacity.

Providers shall demonstrate that they have in place accounting systems sufficient to ensure fiscal responsibility and integrity.

- Licensed Practitioners are required to register and complete an application with the Council for Affordable Quality Healthcare (CAQH), be licensed and meet all requirements imposed by the applicable North Carolina licensing board. Alliance does not directly contract with associate licensed applicants.

- Licensed Practitioners are required to be enrolled with NC Medicaid prior to being enrolled with Alliance.

- Licensed Practitioners are required to submit any clinical specialties as part of their application. These specialties are required to be within the Licensed Practitioner’s scope of practice and training verification may be required.

- Applications are not accepted if incomplete. Incomplete application packets will be returned to provider as unable to process as submitted Providers will have the opportunity to resubmit the application to include any missing information.

- All applications and credentialing information is required to be submitted to Alliance electronically. Any information submitted by any other format will be returned to Provider.

- All signatures included on an application (including attachments) shall be dated no more than 30 days prior to the date Alliance receives the application.

- Licensed Practitioners working for a Network Provider are required to be credentialed and linked to that provider. The LP must be credentialed with Alliance prior to them being enrolled in Alpha, the effective date of the approval is the date that Alliance received the fully completed application or the NCTracks effective date - whichever comes last. The provider will receive notice of acceptance of the LP packet. Alliance will not accept incomplete application packets for Licensed Practitioners.
• If a Provider’s enrollment in NCTracks, the Medicaid Benefit plan or MH/DD/SAS Health Plan is terminated, that Provider’s enrollment in the Alliance Network will be suspended. The Provider will be responsible for notifying Alliance when the Provider’s enrollment is reinstated within NCTracks in order to reverse the suspension. The date of the suspension reversal will coincide with the NCTracks effective date or the suspension date-whichever comes last.

• All providers of services that require national accreditation as determined by the Secretary of DHHS must achieve and maintain national accreditation and be in Good Standing with their national accrediting body. Providers must submit a copy of their Accreditation letter within 30 days of receipt through the alliance accreditation portal.

The Alliance Provider Network Credentialing Committee (PNCC) meets on a regular basis to review provider applications. Alliance will deny the application or terminate the contract of a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, appears on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities, State of North Carolina State excluded providers list or has been convicted of a criminal offense related to that person’s involvement in any program established under Medicare, Medicaid, Children’s Health Insurance Program (NC Health Choice) or the Title XX Services Block Grants Program.

Alliance specifically reserves the right to deny the application or terminate the contract of any provider for any other reason deemed appropriate by the Credentialing Committee, including but not limited to:

1. Provider is not in compliance with applicable federal or state laws, rules or regulations, or is in breach of any provision of its current Contract with Alliance, including but not limited to the Scope of Work or requirements concerning clients’ rights, confidentiality and records retention; or
2. Provider has failed to implement a Plan of Correction issued by Alliance and the time for doing so has expired; or
3. Alliance has issued two (2) or more sanctions at different times against the Provider in the previous contract period; or
4. Provider has failed to remit an identified overpayment to or enter into and comply with an approved payment plan with Alliance within the designated timeframe; or
5. Alliance has logged quality of care concerns or other serious grievances about the Provider that have not been satisfactorily resolved in required timelines; or
6. Unacceptable liability history: Within the three (3) year period from the date of the initial credentialing approval (for re-credentialing applications) or within the five (5) year period immediately preceding the date of the application (for new applications) one or more legal actions resulted in:
   a. At least one (1) judgment; or
   b. One (1) settlement in an amount over $50,000; or
   c. Two (2) or more settlements in an aggregate amount of $50,000 or more; or
   d. As of the date of the Practitioner’s credentialing or re-credentialing application, there are legal actions pending; or
   e. Since the Practitioner was first licensed to practice, two (2) or more legal actions.
Alliance has identified excess capacity for the service(s) delivered by Provider and has issued an RFP or RFI for such service(s) finding that any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a felony or misdemeanor or has reprimands or other sanctions imposed by licensing boards. Providing false information or failing to disclose information in response to a question in the application will result in a denial of the Provider’s application and may subject the Provider to criminal prosecution by the NC Medicaid Fraud Investigations Unit or has been denied enrollment in the NC DMA program.

Providers are required to have their credentials reviewed and verified at a minimum of every thirty-six (36) months from the date of the last credentialing review. Alliance may suspend or terminate from the Network any provider that Alliance determines does not meet credentialing criteria or has not returned the completed recredentialing/application packet within the designated time period. Providers will be notified of the recredentialing process and are required to submit all requested documentation within thirty (30) days. Incomplete applications will not be accepted and will be returned to the Provider. All signatures required in the application must be dated no more than 30 calendar days prior to the date of submission of the application. Licensed Professionals who have no claims with dates of service 4 months prior to being identified for re-credentialing will be decertified with the de-credentialing date corresponding to their credentialing end date. These LPs are eligible to re-apply to the Network if there is Network need.

As part of the credentialing process, Alliance continually monitors good standing status and licensing board actions and sanctions. Any Provider who loses good standing status or has sanctions or a pattern of disciplinary actions that occur between credentialing and recredentialing cycles will be reviewed by the PNCC with action taken up to and including termination.

K. SELECTION (INITIAL PARTICIPATION) CRITERIA

Alliance operates and manages a Provider Closed Network. Annually, Alliance will complete an analysis of the Provider Network needs and gaps. This Needs Assessment will include input from individuals, families, community stakeholders and Individual and Family Advisory Committee (CFAC) as well as other sources of input. Based on the criteria for Network adequacy and access as defined in Alliance procedures, the analysis will result in a Network Development Plan to address any opportunities to strengthen the Provider Network. If the Network Development Plan identifies any service needs or gaps or access to care issues and Network Providers are not available to meet the identified needs, Alliance will seek to add providers through a variety of means, including but not limited to issuing Requests for Proposal or Requests for Information and Requests for Letters of Interest. Network participation opportunities will be posted on the Alliance website unless it is to meet an individual or family’s unique need or challenging geographic or transportation circumstances.

All providers identified or selected as a result of this process must meet Alliance credentialing requirements. Alliance is committed to ensuring the fiscal stability of its contracted Network Providers, and will only consider applications from new Applicants for...
MH/I-DD/SA services if service capacity is not met, i.e. there is a demonstrated community or individual service need. Alliance shall not be required to review the qualifications and credentials of Providers that wish to become a Network participant if Alliance deems that the Network has sufficient numbers of providers with the same or similar qualifications and credentials to meet existing enrollee demand.

When accepted in the Network, Alliance may execute a contract as required by federal law before any Medicaid services can be authorized or paid. Alliance is also required by state regulation to enter into contracts with providers of State-funded services before any

State-funded services can be authorized or paid. Network Providers are required to have a fully-executed Alliance contract which identifies all approved services and sites prior to the delivery of services to an individual served by Alliance regardless of the funding source.

**Contracting**

All Network Providers are required to have a contract with Alliance for all sites and services that they are providing services. Network Provider Contracts will be offered each fiscal year unless otherwise agreed to. Network Providers are required to submit signed contracts and amendments and required documentation within the timeframes required. Providers that do not submit contracts within the required timeframe will not be eligible to receive referrals, obtain authorizations or be paid for the outstanding contract issued.

Out of Network (OON) providers that have been approved for client specific agreements are required to submit signed contracts and required documentation within the timeframes required. All OON providers will need to meet contracting requirements and be successfully enrolled by NCTracks. If client specific agreements (also referred to as Out of Network agreements) are not returned completed within timeframes the OON approval is voided.

All contracts must be submitted electronically. Paper contracts will not be accepted.

Currently contracted Network Providers that do not return their contracts within the required timeframe will be placed in a suspended status, which means provider is not able to receive payment or request authorizations, until their contract is fully executed and any required contract documentation is returned.

**L. RETENTION CRITERIA**

In accordance with 42 CFR 438.214 and the terms and conditions of the Alliance contract with NC Medicaid to operate a Prepaid Inpatient Health Plan, Alliance is required to implement provider selection and retention criteria that does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. Alliance may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act or that are on State of North Carolina State Excluded Providers list. Alliance will not discriminate solely on the basis of the Provider's license.
Alliance has the right not to renew a contract with a Network Provider for any reason, or to reduce or limit the contracted services for a Network Provider in subsequent contract terms, at the sole discretion of Alliance. Contracts for services that have not been billed within 6 months of the contract start date will not be renewed.

If the Contract, or any service provided thereunder, expires, is not renewed or otherwise terminated, the Provider shall cooperate with Alliance efforts to safely and appropriately transition individuals to other providers in the Alliance Closed Network. Alliance will send written notification to all recipients currently in treatment with a Provider whose contract is terminated or voluntarily withdrawn, notifying them of the change as well as information regarding how to contact Alliance for assistance in securing another provider, if needed.

M. APPLYING FOR ADDITIONAL SITES OR SERVICES

To be considered for additional site locations or Medicaid services a current Network Provider must be in good standing and there must be an established need for the service(s), both of which are determined by Alliance. Additional services may not be added to an existing Contract unless:

- A Provider has been awarded the services based on a competitive process
- The site or service is a related expansion of a currently provided service if Alliance has identified a need.
- An emergency need has been identified that can only be filled by a specific provider
- A unique need has been identified that can only be filled by a specific provider, or
- A specific Provider has been designated by the funding source or grantor.

When any one of these requirements is met, providers may submit or be requested to submit a Provider Application Request form with all required elements to ProviderNetwork@Alliancehealthplan.org. All additional sites or services shall be subject to applicable credentialing requirements.

N. REPORTING CHANGES AND LEAVE OF ABSENCE

Network Providers are to report all changes as follows:

- Notify the Credentialing Unit in writing within one (1) business day of any changes in credentialed status, including but not limited to, the scope of their license, changes in licensure status, changes in privileged status at other organizations, pending citations or malpractice claims, Secretary of State status, IRS or Department of Labor status, sanctions related to federal programs (Medicaid, Medicare, etc.) and any other major change in status.

Providers are required to notify Alliance at ProviderNetwork@alliancehealthplan.org when organizational changes occur, including but not limited to changes in ownership, managing employees changes, Tax-ID changes, insurance, ability to accept referrals, office hours, specialty, coverage for off hours, address changes, name changes and contact information.
changes. Notice of Change forms will be made available on the Alliance website. Alliance must be notified at least 30 days in advance of these changes and may not process retroactive changes. Changes of ownership, site changes and changes to managing employees will require credentialing verification for the new owner(s)/managing employee(s), site changes, prior to approval of the change. Site location changes may require an on-site review prior to approval of the change. Changes of ownership, address and site location may require an executed contract amendment or new contract. Providers are required to have a fully executed Contract in the legal name of the organization before they can be reimbursed for services provided to any Alliance Individuals. Providers that have site changes that are not in NCTracks will not be contracted for services at the affected site until site is credentialed by Alliance and enrolled in NCTracks.

If a provider moves from a contracted site that site will be immediately end dated and removed from the Contract. The Provider is not allowed to bill or request authorizations from that site. If the provider relocates services to a new site, the new site will need to meet credentialing requirements, including NCTracks enrollment. If the site is not enrolled in NCTracks at the time of the move, the site will be placed in “pending” status until NCTracks enrollment is finalized and able to be verified by Alliance. The effective date of the new site will be dependent on the notification of the move date, the actual move, NCTracks enrollment and DHSR dates- whichever comes last. Once the provider meets all of these requirements the provider will receive a contract amendment to add affected site(s) and services. The provider will have a retrospective window of up to 90 calendar days from the date of contract entry to request authorizations and submit billing to cover this time period.

Providers are required to update the applicable modules in the Provider Portal in the timeframes as required by the specific module. The portal can be found here: https://portal.alliancehealthplan.org/Login/Index.

Licensed Independent Practitioners wishing to initiate a Leave of Absence (LOA) shall notify the Credentialing Unit in writing, no later than sixty (60) days prior to their desired effective date. Unless the leave is a result of disabling illness, a Licensed Independent Practitioner shall not request more than six (6) months in an initial Leave of Absence. An extension to the original leave may be requested if needed. The leave is not to exceed an additional six (6) months and must be submitted no later than sixty (60) days prior to the expiration of the original Leave of Absence. Alliance will respond to the request within ten (10) business days. A contracted LIP will be allowed a total of twelve (12) months LOA over any seven (7) year period and cannot exceed four (4) LOA requests. Failure to comply with LOA process may result in termination of the practitioner’s contract. The LIP is responsible for maintaining all credentialing requirements during the LOA period. Failure to comply or to be successfully re-credentialed will result in termination of the Alliance Provider Network LIP contract. If the LIP fails to return to the practice after the completion of the LOA, this will also be deemed notice of termination in accordance with the practitioner’s contract.
O. MONITORING AND EVALUATION

Alliance utilizes the State-mandated DHHS North Carolina Provider Monitoring Process for LME-MCOs for evaluating Provider compliance and performance. Provider monitoring consists of a routine review conducted at a minimum of every two years. Routine is defined as meeting compliance-based standards only. Practitioner solo and group practices as well as agencies which provide outpatient behavioral health services only are monitored using the DHHS Review Tool for Routine Monitoring of Licensed Independent Practitioners. All other providers are monitored with the DHHS Review Tool for Routine Monitoring of Provider Agencies using the sub tools required by the services which that agency provides. All Providers with the exception of those providing hospital, ICF-MR, residential level II other than therapeutic foster care services only are monitored according to this process.

As provider agencies offer a variety of services, requirements may differ due to any applicable licensure requirements, State Service Definitions or Medicaid Clinical Coverage Policies. Therefore, the DHHS Review Tool for Routine Monitoring of Provider Agencies and guidelines allow for these differences. To obtain inter-rater reliability within Alliance and between LME/MCOs, monitoring tools are scored according to guideline requirements. Routine monitoring may be comprised of a routine monitoring tool and a post-payment review or a post-payment review alone. Only the post-payment review tool is completed for Providers of services provided only in licensed facilities which are monitored annually by DHSR, agencies which are nationally accredited, LIPs, and agencies providing only outpatient services. Monitoring claims samples will typically consist of three (3) months of paid claims datstarting 6 months prior to monitoring date and moving forward 90 days but can include claims dating back a full year Alliance discretion. The following is a description of the Provider Monitoring Process as currently conducted by Alliance:

- Routine monitoring reviews are typically conducted on-site. A desk review may be conducted if only a post-payment review is required; the corporate site is outside the catchment area; and either there is no local office within the catchment area where a review could be conducted, or the corporate site is within the catchment area but has no office where reviews can be conducted. The selection of Providers for review is at the discretion of Alliance. Providers are notified in writing 21-28 calendar days prior to the date of the review, unless Alliance deems that circumstances warrant an unannounced site review. Except when an unannounced site review occurs, Provider agencies are notified of the specific service records needed for the review no less than 5 business days prior to the date of the review. Prior to the review, Providers may request technical assistance regarding review requirements and processes, and may be informed of the time period covered in the claims and other samples. Technical assistance will not include previewing Provider information to determine if it meets compliance criteria.

- During on-site reviews Alliance staff will provide identification and introduce themselves. Onsite reviews will include an opening conference as well as an exit conference. Any follow up to be completed by the Provider or Alliance will be reviewed during the exit conference. The Provider must present all information by the conclusion of the monitoring event. After the review is concluded any additional information located will not be used to change any established scores or out of
compliance findings, but will be considered in implementation of the Plan of Correction (if assigned).

- Monitoring tools will be scored in accordance with the guidelines provided with the tools. Providers are notified in writing of the results of the Routine Monitoring within fifteen (15) calendar days of completion of the review. The tools score automatically and note when Providers have not met threshold standards. Providers who score below 85% on a sub-tool or sub-section of the routine tool; or below 100% on the question regarding restrictive interventions; or who demonstrate systemic compliance issues will be issued a statement of deficiencies and will be required to submit a Plan of Correction. In addition, any claim date of service cited out-of compliance on the post-payment review shall be identified as an overpayment and require a payback to Alliance through the recoupment process.

- If the Provider disagrees with the monitoring action taken, Plan of Correction or recoupment, they may request reconsideration, as outlined in the results letter. Follow up with Providers who are required to complete a Plan of Correction will follow the DHHS Policy and Procedure of the Review, Approval and Follow-Up of Plan(s) of Correction (POC), Policy N. ACC002, Revision Date 12/10/2008. Failure to submit an acceptable Plan of Correction or substantially minimize or eliminate deficiencies will be presented to the Alliance Corporate Compliance Committee and may result in sanction up to and including termination from the Network.

More information about the DHHS North Carolina Provider Monitoring Process for LME-MCOs can be found at www.ncdhhs.gov/mhddsas/providers/providermonitoring/. Information regarding the Plan of Correction process can be found at www.ncdhhs.gov/providers/provider-info/health-care/plan-of-correction.

P. QUALITY IMPROVEMENT

The continual self-assessment of services, operations, and implementation of Quality Improvement Plans to improve outcomes to individuals is a value and expectation that Alliance extends to its Providers. Providers are required to be in compliance with all quality assurance and improvement standards outlined in North Carolina Administrative Code as well as in the Alliance Contract. These items include:

- The establishment of a formal continuous Quality Improvement Committee to evaluate services, plan for improvements, assess progress made towards goals, and implement quality improvement projects and follow through with recommendations from the projects. Providers are strongly encouraged to participate in Alliance Quality Improvement Projects and activities when requested. This does not apply to LIPs.

- The assessment of need as well as the determination of areas for improvement should be based on accurate, timely, and valid data. The provider’s improvement system, as well as systems used to assess services, will be evaluated by Alliance at the provider’s qualifying review.

- The submissions of accurate and timely data, as requested, including claims for services delivered, no later than the deadline set by Alliance. Assessment of program
fidelity, effectiveness, and efficacy shall be derived from data and any data requested. Providers shall be prepared to submit any and all data, reports, and data analysis upon request.

- Meeting performance standards set by Alliance and by the NC Health and Human Services for behavioral health services.

Q. DOCUMENTATION AND CONFIDENTIALITY REQUIREMENTS

For each person receiving services from a Provider in the Alliance Provider Network, the following information is the minimum documentation that Providers must maintain in an organized manner in a clinical service record and keep in a confidential and secure location. The forms in bold lettering must be submitted to Alliance when enrolling a new individual to services, when requesting a new authorization or annually (as required) per APSM 45-2.

1. Consents & Releases: (completed fully, then signed, dated, & witnessed)
   a. Informed written Consent for Treatment (must grant permission to seek emergency care from a hospital or physician);
   b. Individual Acknowledgement of Receipt of HIPAA Notice of Privacy Practices;
   c. Consent to Release Information;
   d. Documentation of written notice given to the individual/legally responsible person upon admission that disclosure may be made of pertinent confidential information without his or her expressed consent in accordance with G.S. § 122C-52 through 122C-56;
   e. Acknowledgement of Receipt of Client Rights Information;
   f. Emergency information for each individual which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and telephone number of the individual’s preferred physician;
   g. Log of releases and disclosures of confidential information;
   h. Third Party Release (to include private insurance carrier, public benefits and entitlements);
   i. Informed written Consent for Planned Use of a Restrictive Intervention (as applicable); and
   j. Informed written Consent for Participation in Research Projects (as applicable).

2. Evidence of a written summary of client rights given to client/legally responsible person, according to 10A NCAC 27D .0201 and as specified in GS §122C, Article 3.

3. Documentation that client rights were explained to the individual/legally responsible person.

4. NC-TOPPS (as required for NON-MEDICAID and Medicaid funded MH and SA). Additional information can be found at www.ncdhhs.gov/mhddssas/providers/NCTOPPS/userlinks.html

5. Person Centered Plan if an enhanced service or as required per the NON-MEDICAID benefit plan.
6. NC SNAP and/or SIS for individuals with a DD diagnosis.
7. ASAM score for individuals with a SA diagnosis.
8. LOCUS/CALOCUS scores for individuals in MH services.
9. Documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to the DSM-5 (or its successors) and documentation of physical disorders according to the ICD-10, including subsequent amendments and editions.
10. Screening—shall include assessment of presenting problem/needs, whether or not the agency can provide services that can address the individual’s needs, and disposition, including recommendations and referrals.
11. Admissions/Clinical Assessment(s) that contain the elements of a Comprehensive Clinical Assessment as described in Chapter 3 of APSM 45-2 for enhanced services and as required by Clinical Coverage Policies.
12. Applicable Service Order: for all services to be provided, signed by the appropriate professional. Note: Each community provider is responsible for obtaining the appropriate diagnoses and a physician's order for billing Medicaid-covered services that it is planning to provide.
13. Service Notes
14. Advance Directives
15. Service Authorizations
16. Discharge Plans/summaries
17. Other elements may be required or clinically relevant depending upon the services received (e.g. Crisis Plans, Medication Administration Record, etc.).
18. Allergies: Any known or suspected allergies or adverse reactions, or the absence of such, must be prominently noted in the record (preferably on the front cover of the record).

NOTE: This is not a complete list of all required record elements. The full list can be accessed at www.ncdhhs.gov/apsm-45-2-records-management-and-documentation-manuals.

Additional requirements may be listed in each Clinical Coverage Policy related to the service being provided at https://dma.ncdhhs.gov/behavioral-health-clinical-coverage-policies as well as the NCMMIS Provider Claims and Billing Assistance Guide (formally known as the Basic Medicaid Guide). Providers are expected to adhere to all minimum and service specific requirements.

Web Reference:
www.ncdhhs.gov/apsm-45-2-records-management-and-documentation-manuals
Network Providers are also required to comply with all applicable laws relating to confidentiality and/or security of protected health information (“PHI”) or other healthcare, public assistance or social services information, including but not limited to the Health
Information Portability and Accountability Act (HIPAA) and its implementing regulations, 45 CFR Parts 160, 162 and 164, as further expanded by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), which was adopted as part of the American Recovery and Reinvestment Act of 2009, commonly known as “ARRA” (Public Law 111-5) and any subsequent modifications thereof, the Substance Abuse Confidentiality regulations set forth in 42 CFR Part 2, NCG.S. § 122C-51, et seq., NCG.S. § 108A-80,10A NCAC Subchapter 26B, and DMH/DD/SAS Confidentiality Rules published as APSM 45-1 (effective January 2005).

Web Reference: www.hhs.gov/ocr/hipaa/

R. RECORDS RETENTION AND DISPOSITION

In addition to applicable documentation and medical/treatment records requirements found in Federal and State laws, rules and regulations, the NC State Plan for Medical Assistance, NC Medicaid Clinical Coverage Policies, and the DMH/DD/SAS State Service Definitions, all Network Providers must follow the Records Retention and Disposition Manual (APSM-10-5) for record and documentation requirements.

Providers shall retain service records of adults 11 years after the date of the last encounter. Service records of minors who are no longer receiving services shall be retained for 12 years after the minor has reached the age of majority (18 years of age), adhering to the most recent version of “Record Retention and Disposition Schedule” (APSM 10-5). Required time periods for retaining and maintaining records may be more stringent for grant funded services, and Providers are required to abide by those schedules. Providers shall abide by the most stringent retention time period. Records involved in any open investigation, audit, or litigation shall not be destroyed, even if the records have met retention. Following the conclusion of any legal action, investigation or audit, the records may be destroyed if they have met the retention period in the schedule. Otherwise, they should be kept for the remaining time period.

In the event a Provider closes its operations in the Alliance Network, whether the closure is voluntary, a result of bankruptcy, relocation to another state or any other reason, the Provider is required to submit a plan for maintenance and storage of all records for approval by Alliance Health or transfer copies of medical records for individuals served under its contract with Alliance within thirty (30) days of closing network operations. Alliance has the sole discretion to approve or disapprove such plan for the storage and maintenance of the medical records.

Alliance shall not be held liable for records not stored, maintained or transferred. Abandonment of records is a serious HIPAA and contractual violation which can result in sanctions and financial penalties. Alliance is required by contract with NC Medicaid to report abandonment of records to NC Medicaid Office of Compliance and Program Integrity.
If copies of individual medical records are transferred to Alliance, the records must be organized in boxes, by the Provider. Each box must include a completed Alliance Record Storage Log form which contains a detailed inventory list of the individual records submitted to Alliance. A copy of the storage log shall be taped to each box that contains records.

It is the Provider’s responsibility to develop a retention and disposition plan outlining how the records are stored, who will be the designated records custodian and how the records custodian is going to inform Alliance of what their process is and where the records will be located. This information is maintained and referenced for when an individual or other oversight organizations contact Alliance requesting either copies or access to these records, for Alliance to comply with audits and/or to ensure compliance with required record keeping practices.

Web Reference:
www.ncdhhs.gov/providers/provider-info/mental-health/records-management
SECTION IV: INDIVIDUAL RIGHTS AND EMPOWERMENT

A. Individual Rights
B. Individual Responsibilities
C. Consent for Treatment
D. Restrictive Interventions
E. Advance Instruction for Mental Health Treatment
F. Confidentiality
G. Use of Information Without Prior Consent
H. Client Rights Committee
I. The Consumer and Family Advisory Committee (CFAC)
J. Prohibited Restrictions on Providers
K. Second Opinion
L. Appeals of Decisions to Deny, Reduce, Suspend or Terminate a Medicaid Service
M. Frequently Asked Questions About Medicaid Appeals
N. State-funded Services Appeals Process
O. Grievances
P. Complaints
Q. Client Rights Resources

A. INDIVIDUAL RIGHTS

Unless a person has been declared incompetent by a court of law, an individual has the same basic civil rights as other citizens. Civil rights include the right to marry and divorce, to sue others in court, to have and raise children, to sign contracts, the right to vote, and the right to sell, buy and own property. Persons determined to be incompetent and that are assigned a court-appointed guardian retain all legal and civil rights except those rights that are granted to the guardian by the court. For example, many incompetent persons retain the right to vote.

The guardianship order signed by the court must be reviewed to determine an individual’s status with respect to his or her civil rights. Providers should maintain a copy of the guardianship order in an individual’s case file and should never rely solely on the word of the guardian or family member in determining the status of an individual.

Individuals receiving mental health, substance abuse and developmental disability services have the following rights:

- The right to receive information about Alliance, its services, its providers/practitioners, and individual rights and responsibilities presented in a manner appropriate to your ability to understand.
- The right to be treated with respect and recognition of your dignity and right to privacy.
- The right to participate with providers/practitioners in making decisions regarding your health care.
The right to a candid discussion with service providers/practitioners on appropriate or medically-necessary treatment options for your conditions, regardless of cost or benefit coverage. You may need to decide among relevant treatment options, the risks, benefits and consequences, including your right to refuse treatment and to express your preferences about future treatment decisions regardless of benefit coverage limitation.

The right to voice grievances about Alliance or the care you receive from providers in the Alliance network.

The right to appeal any Alliance decision to deny, reduce, suspend or terminate a requested service.

The right of individuals who live in Adult Care Homes to report any suspected rights violation to the appropriate regulatory authority.

The right to make recommendations regarding the organization's member rights and responsibilities policy.

The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

The right to refuse treatment.

The right to request and receive a copy of your medical record, subject to therapeutic privilege, and to request that the medical record be amended or corrected. If the doctor or therapist determines that this would be detrimental to your physical well-being, you can request that the information be sent to a physician or professional of your choice.

If you disagree with what is written in your medical records, you have the right to write a statement to be placed in your file. However, the original notes will also stay in the record until the statute of limitations ends according to the MH/DD/SA retention schedule (11 years for adults, 12 years after a minor reaches the age of 18, 15 years for DUI records).

The right to a second opinion from a qualified health care professional within the network, or Alliance will arrange for the individual to obtain one outside the network, at no cost to the individual.

The right to participate in the development of a written person-centered treatment plan that builds on your individual needs, strengths and preferences. A treatment plan must be implemented within 30 days after services start.

The right to take part in the development and periodic review of your treatment plan, to request a copy of your treatment plan, and to consent to treatment goals in it.

The right to freedom of speech and freedom of religious expression.

The right to equal employment and educational opportunities.

The right to treatment in the most natural, age-appropriate and least restrictive environment possible.

The right to ask questions when you do not understand your care or what you are expected to do.

The right to free oral translation services.
Individuals are free to exercise their rights and the exercise of those rights shall not adversely affect the way that Alliance or its providers treat the individual.

- The right to recommend changes to Alliance policies and services.

Minors have the right to agree to some treatments without the consent of a parent or guardian:

- For treatment of venereal diseases
- For pregnancy
- For abuse of controlled substances or alcohol
- For emotional disturbances.

Providers in the Alliance Network must respect the rights guaranteed by the above laws, rules and regulations at all times. All Network Providers must be familiar with all Federal and State laws, rules and regulations regarding individual rights and the use of restrictive interventions/protective devices and develop operational procedures that ensure compliance. All Network Providers must maintain an ongoing knowledge of changes to Federal and State laws, rules and regulations and immediately alter operations to meet changes.

Providers are required to make a copy of client rights material available to each individual at admission and to have this information publicly available in their offices for individual review. Whenever needed, Providers are also required to offer and provide individuals with education on their rights and responsibilities and assistance in exercising those rights to the fullest extent. When this is not possible, Providers should refer the individual to the Alliance Individual and Family Affairs Department for assistance.

If at any time an individual needs information on his/her rights or believes that his/her rights have been violated, they may contact the Alliance Access and Information Center at (800) 510-9132 twenty-four hours a day/7 days a week/365 days a year.

The Alliance Access and Information Center will take complaint information and help resolve issues or may refer the complaint to the Quality Management Department by the next business day. Alliance also has a Community Health and Well-Being Department that is responsible for assisting individuals and families with concerns.

Web Reference: [www.alliancehealthplan.org/Individuals-families/](http://www.alliancehealthplan.org/Individuals-families/)

**B. INDIVIDUAL RESPONSIBILITIES**

Individual rights information available from Alliance also outlines the corresponding responsibilities of individuals receiving services. Additional responsibilities may be required in 24-hour facilities. The individual responsibilities are to:

- Seeking help when needed and calling the provider or Alliance if in crisis.
- Supplying all information (to the extent possible), including information about pertinent health problems that Alliance and its providers need in order to provide care.
• Following the plans and instructions for care that are agreed upon with providers.
• Understanding health problems and participating in developing mutually agreed-upon treatment goals, to the degree possible, telling the doctor or nurse about any changes in the individual’s health, and asking questions when necessary to understand the individual’s care and what you the individual is expected to do.
• Inviting people who will be helpful and supportive to be included in treatment planning.
• Working on the goals of the Person-Centered Plan.
• Respecting the rights and property of other individuals and of Alliance and provider staff.
• Respecting the privacy and security of other individuals.
• Keeping all the scheduled appointments whenever possible and being on time for appointments.
• Canceling an appointment at least 24 hours in advance if unable to keep it.
• Meeting financial obligations according to established agreements.
• Informing staff of any medical condition that is contagious.
• Taking medications as they are prescribed.
• Telling the doctor if the individual is having unpleasant side effects from medications, or if medications do not seem to be working to help the individual feel better.
• Refrain from “doctor shopping” in an attempt to obtain more prescriptions than needed.
• Telling the doctor or therapist if the individual does not agree with their recommendations.
• Telling the doctor or therapist if and when the individual wants to end treatment.
• Carrying Medicaid or other insurance cards at all times, and not allowing friends, family members or others to use the individual’s Medicaid card.
• Cooperating with those trying to care for the individual.
• Following the rules posted in day, evening or 24-hour service programs.
• Being considerate of other individuals and family members.
• Seeking out additional support services in the community.
• Reading, or having read to the individual, written notices from Alliance about changes in benefits, services or providers.
• When leaving a program, requesting a discharge plan, being sure the individual understands it and is committed to following it.

C. CONSENT FOR TREATMENT

Individuals have a right to consent to treatment support in advance. Any individual requesting and receiving services from an Alliance provider must be informed in advance of the potential risks and benefits of treatment support options. Individuals have the right to
be informed of and refuse to take part in treatment or research studies.

Individuals maintain their right to consent to, or refuse, any treatment support unless:

- Treatment is provided in an emergency situation.
- The individual is not a voluntary patient and treatment has been ordered by a court of law.
- The individual is under eighteen (18) years of age, has not been emancipated, and the parent, guardian or conservator gives permission. Exceptions may apply related to substance abuse treatment for minors.

D. RESTRICTIVE INTERVENTIONS

North Carolina statutes and regulations outline specific policy and procedural requirements for the use and reporting of restrictive interventions and other types of protective devices. All Network Providers and their staff are expected to be knowledgeable about and adhere to all statutes and regulations regarding individual rights and the use of restrictive interventions/protective devices. Providers are required to develop operational procedures that ensure compliance. Providers are also responsible for keeping their policies and daily practices updated as changes to statutes and regulations affecting the rights of individuals may occur over time.

E. ADVANCE INSTRUCTION FOR MENTAL HEALTH TREATMENT

In 1997, the North Carolina General Assembly mandated a way for individuals to plan ahead for mental health treatment they might want to receive if they experience a crisis and are unable to communicate for themselves or make voluntary decisions of their own free will. The statutes concerning this type of Advance Instruction are found at NCGS Chapter 122C, Part 2 (§§122C-71 through 79) and include examples of forms.

Advance Instruction for mental health treatment or Advance Instruction is a legal document that tells physicians and mental health providers what mental health treatments the individual would want or not want, if they were to have a crisis in the future and cannot make their own mental health treatment decisions. This type of Advance Instruction is not designed for people who may be experiencing mental health problems associated with aging, such as Alzheimer’s disease or dementia. To address these issues, a general health care power of attorney is used.

An Advance Instruction can include a person’s wishes about medications, treatment modalities, admission to a hospital, restraints, whom to notify in case of hospitalization, and instructions about paying rent or feeding pets while the individual is in the hospital.

The individual can also put in an Advance Instruction in place such as “please call my doctor or clinician and follow his/her instructions”. If the person is in an emergency room and unable to speak for him/herself or is confused, these instructions can be used as a means to secure help from experienced caregivers who are familiar with them during
critical moments. An Advance Instruction can be a separate document or combined with a health care power of attorney or a general power of attorney.

The Advance Instruction must be in writing, signed by the individual while he or she is still able to make and communicate health care decisions in the presence of two (2) qualified witnesses, as defined by NCGS § 122C-72. The document becomes effective upon its proper execution and remains valid unless revoked.

If you are assisting an individual complete an Advance Instruction, plan on several meetings to thoroughly think about crisis symptoms, medications, facility preferences, emergency contacts, preferences for staff interactions, visitation permission, and other instructions. Involvement by the individual with persons included in the Advance Instruction and notification of those named is encouraged. An individual shall not be required to execute or to refrain from executing an Advance Instruction as a condition for insurance coverage, as a condition for receiving mental or physical health services, as a condition for receiving privileges while in a facility, or as a condition of discharge from a facility.

Upon being presented with the Advance Instruction the physician or other provider must make it a part of the person’s medical record. The attending physician or other mental health treatment provider must act in accordance with the statements expressed in the Advance Instruction when the person is determined to be incapable, unless compliance is not consistent with NCG.S. § 122C-74(g). If the physician is unwilling to comply with part or all of the Advance Instruction he or she must notify the individual and record the reason for noncompliance in the patient’s medical record.

Web Reference:
NC Division of Health Benefits on Your Rights
www.ncdhhs.gov/dma/medicaid/rights.htm#advance
North Carolina Advance Health Care Directive Registry
www.sosnc.gov/ahcdr/

F. CONFIDENTIALITY

Alliance privacy practices, and those of our Network Providers, must be based on applicable federal and state confidentiality laws and regulations including but not limited to the Health Information Portability and Accountability Act (HIPAA) and its implementing regulations, 45 CFR Parts 160, 162 & 164, as further expanded by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), which was adopted as part of the American Recovery and Reinvestment Act of 2009, commonly known as “ARRA” (Public Law 111-5) and any subsequent modifications thereof, the Substance Abuse Confidentiality regulations set forth in 42 CFR Part 2, NCG.S. § 122C-51, et seq., NCG.S. § 108A-80,10A NCAC Subchapter 26B, and DMH/DD/SAS Confidentiality Rules published as APSM 45-1 (effective January 2005). Individuals can request restrictions on use and disclosure of PHI. Individuals have the right to receive a report of disclosures that have been made of PHI.
Each Alliance provider shall ensure that all staff providing services to individuals of Alliance maintains confidentiality of individuals, as well as information related to their treatment. Providers will not discuss, transmit or communicate in any form individual information of a personal nature, medical or otherwise, except as authorized in writing by the individual or his legally-responsible person; or as otherwise permitted by applicable federal and state confidentiality laws and regulations.

Please note that federal regulations do not allow the sharing of information related to drug and alcohol abuse records without the individual’s consent unless there is a specific court order, medical emergency, in order to place an initial report of suspected abuse or neglect of a child or to report to law enforcement officer if the client commits a crime on the program premises or against program personnel. Other very few and specific exceptions are referenced in 42 CFR Part 2. These regulations pre-empt State statutes and regulations and HIPAA.

G. USE OF INFORMATION WITHOUT PRIOR CONSENT

Information can be used without consent to help in treatment, for health care operations, for emergency care, and provided to law enforcement officers to comply with a court order or subpoena. A disclosure to next of kin can be made when an individual is admitted or discharged from a facility, if the person has not objected to this disclosure. A minor has the right to agree to the following treatment(s) without the consent of his/her parent or guardian:

- Treatment for venereal diseases
- Treatment for pregnancy
- Treatment for the abuse of controlled substances or alcohol
- Treatment for emotional disturbance.

If individuals disagree with what a physician, treating provider or clinician, has written in their record, the individual can write a statement from their point of view to go in the record, but the original notes will also stay in the record for the required minimum retention period.

There are various degrees of risk associated with the use of electronic mail to send or exchange protected health information (PHI). Providers that choose to use regular email services to communicate with Alliance must use an encrypted email system, or expunge all individual identifying information prior to sending. The use of first and last initials and Alliance Record Number is permitted. Providers may utilize Alliance ZixMail which is a secure, encrypted email system.

H. CLIENT RIGHTS COMMITTEE

Each Network Provider agency is expected to maintain a Client Rights Committee. Two or three smaller Providers may share a Client Rights Committee. Providers are required to
maintain and submit the minutes of their Client Rights Committee meetings to Alliance upon request. Client Rights Committee minutes or other QA/QI reports should not include client identifying information. Additional Client Rights regulations are set forth in NCGS §122C-51 through 67, APSM 95-2 and APSM 30-1 and NCAC 27G.0504 and 10A NCAC 27G.0103.

The Alliance Board of Directors maintains a Human Rights Committee that is responsible for the monitoring and oversight of the Provider Client Rights Committee functions. The Human Rights Committee receives and reviews relevant reports submitted from other Alliance departments or committees including reports on the use of restrictive interventions, Critical Incidents, rights violations and incidents of abuse, neglect and exploitation across the Alliance Network.

I. CONSUMER AND FAMILY ADVISORY COMMITTEE (CFAC)

The Alliance CFAC is an advisory committee to the Board of Directors, and as such it plays a key role in operations. CFAC consists of representatives of the individuals and families receiving services in our Network. As representatives they speak not only on behalf of their individual family members but for a specific disability population, as well as their home county. CFAC members are volunteers and as such commit hundreds of hours to work toward improving the quality of services across Alliance.

CFAC monitors Client Rights issues in general, maintains active participation through membership on the Client Rights Committee, and serves on many workgroups associated with the Medicaid Waivers. CFAC members are critical in helping the Network identify the needs of individuals and barriers to accessing services and working to bring about resolutions to issues that satisfy the needs of individuals and their families. CFAC members are an informed, available and valued voice for individuals served by Alliance.

The Alliance CFAC holds regular public meetings in accordance with state law and rules and Alliance policies and procedures. Any individual, provider or family member of an individual can bring issues of concern to the attention of CFAC by attending meetings. Individuals or family members who are interested in becoming a member of CFAC can also request information.


J. PROHIBITED RESTRICTIONS ON PROVIDERS

Alliance will not prohibit or restrict any provider acting within the lawful scope of practice from taking any of the following actions:

- Advising or advocating on behalf of an individual who is his or her patient.
- Advocating for the individual’s medical care or treatment options.
- Providing information the individual needs in order to decide among all relevant treatment options.
• Providing information about the risks, benefits, and consequences of treatment or non-treatment options to the individual.
• Providing information to the individual about his/her right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.

K. SECOND OPINION

Individuals with Medicaid have the right to a second opinion if they do not agree with the diagnosis, treatment, or the medication prescribed by an Alliance provider. Provider staff should be aware of this right and refer the individual to the Appeals Department at Alliance (UMAppeals@Alliancehealthplan.org) when a second opinion is requested. Individuals are informed of their right to a second opinion in the Alliance Individual and Family Handbook sent to them when they are initially enrolled in the Medicaid Program.

L. INDIVIDUAL APPEALS OF DECISIONS TO DENY, REDUCE, SUSPEND OR TERMINATE A MEDICAID SERVICE

Medicaid beneficiaries have the right to appeal Alliance decisions to deny, reduce, suspend or terminate a Medicaid service because Medicaid is an entitlement program. Specifically, Medicaid beneficiaries have the right to appeal whenever they do not agree with an “Adverse Benefit Determination” made by Alliance regarding a request for services. An “appeal” is the request for review of an Adverse Benefit Determination.

An Adverse Benefit Determination as defined in federal law, means any of the following:
• The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit
• The reduction, suspension or termination of a previously authorized service
• The denial, in whole or in part, of payment for a service
• The failure to provide services in a timely manner
• The failure of Alliance to act within the timeframes provided in 42 CFR 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. Grievances are not appealable outside of Alliance.

If Alliance makes a decision to deny in whole or in part the request for service authorization or other Adverse Benefit Determination, the individual/guardian will receive a letter by trackable mail within fourteen (14) calendar days of the request for service for a routine request or verbal notification within 72 hours for an expedited request (see also Section VI-H) explaining this decision and how to request LME/MCO Level Appeal if they disagree. During this time, Alliance will not authorize the requested service in dispute.

If Alliance makes a decision to reduce, suspend or terminate a service the individual is currently authorized to receive, the individual/guardian will receive a letter by trackable
mail at least ten (10) days before the change occurs explaining how to request a LME/MCO Level Appeal. If the individual/guardian requests a LME/MCO Level Appeal by the deadline stated in the letter, the services may be able to continue through the end of the original authorization. The Notice of Adverse Benefit Determination sent to the individual/guardian will explain how this “Continuation of Benefits” may be able to occur.

The individual/guardian will receive a Notice of Adverse Benefit Determination and an appeal form. Providers will receive a copy of the Notice of Adverse Benefit Determination but will not receive the appeal form. Providers should understand Medicaid beneficiary due process/appeal rights so they can assist individuals with filing an appeal, with the individual’s written consent. Providers should never pressure or force an individual to file an appeal against the individual’s wishes. The first step in appealing Alliance’s denial of a request for Medicaid services is to ask for a LME/MCO Level Appeal. The request for a LME/MCO Level Appeal must be filed with Alliance within sixty (60) days of the mailing date on the notice of adverse determination. A LME/MCO Level Appeal means that someone at Alliance who was not involved in the individual’s case will take a second look at our decision about the individual’s Medicaid services.

If the appeal request does not include enough information for Alliance to process the request (for example, the name, Medicaid Identification (MID) number or other identifying information), Alliance will return the request without offering appeal rights.

Upon receipt of a valid request for a LME/MCO Level Appeal, an Acknowledgement of LME/MCO Level Appeal notice will be mailed to the individual/guardian within one (1) business day of the receipt of the Appeal request. Upon receipt of a request for a LME/MCO Level Appeal that is not valid a Notification of an Invalid LME/MCO Level Appeal will be mailed to the individual/guardian. This notification explains the reason the request is not valid and is mailed within one (1) business day of the receipt of the request for a Reconsideration.

Alliance can extend the appeal timeframe for up to fourteen (14) days upon (i) request by an Enrollee, his/her representative or provider on the Enrollee’s behalf, or (ii) if additional information is needed, the delay in obtaining that information is outside of Alliance’s control, and the extension is in the Enrollee’s best interest. Alliance will notify the Enrollee in writing before the expiration of the designated timeframe and this Notice of Extension explains the Enrollee’s right to file a grievance if they disagree with Alliance’s decision to extend the review timeframe.

Alliance must provide the individual/guardian the opportunity, before and during the appeals process, to examine the individual’s case file, including medical records, and any other documents and records considered during the appeals process. Alliance shall also give the individual/guardian a reasonable opportunity to present evidence and allegations of fact or law, including evidence that was not presented at the time of the original request. The opportunity by the individual/guardian to review the case file and submit additional information is explained in the LME/MCO Level Appeal Instructions and Information that are mailed to the individual/guardian and found on the Alliance website.
The medical policies and criteria for Medicaid services authorized by Alliance can be found at [https://medicaid.ncdhhs.gov/nc-innovations-waiver](https://medicaid.ncdhhs.gov/nc-innovations-waiver) in The NC MH/IDD/SAS Health Plan and NC Innovations Waiver. If a person does not have internet access or wishes to receive written copy of these documents, a request may be made by calling (800) 510-9132 to receive a copy by mail.

Alliance has information regarding the appeal process available to individuals. This information can be found on the Alliance website, [www.Alliancehealthplan.org](http://www.Alliancehealthplan.org), in brochures distributed in the catchment area or upon request. Providers should be aware that all individual confidentiality and privacy requirements apply to appeals. Alliance offers training to providers about the individual appeal process.

**NOTE:** Alliance is prohibited from implementing utilization management (UM) procedures that provide incentives for the individual or entity conducting utilization reviews to deny (reduce, terminate or suspend), limit or discontinue medically necessary services to any Enrollee. UM decision-making is based on medical necessity and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) criteria. Alliance does not reward staff for issuing denials of coverage or services. There are no financial incentives for UM decision-makers that would encourage decisions resulting in underutilization. The laws governing Medicaid enrollee appeals of Medicaid managed care decisions can be found at 42 CFR Part 438 and Chapter 108D of the North Carolina General Statutes.

Alliance will not attempt to influence, limit or interfere with an individual’s right to file or pursue a grievance or request an appeal.

**M. FREQUENTLY ASKED QUESTIONS ABOUT INDIVIDUAL MEDICAID APPEALS**

**Q: How much time does an individual/guardian have to ask for a LME/MCO Level Appeal?**
A: The request for a LME/MCO Level Appeal must be filed with Alliance within Sixty (60) days of the mailing date on the notice of action.

**Q: How does an individual/guardian ask for a LME/MCO Level Appeal?**
A: To request a LME/MCO Level Appeal, complete the appeal form included with the Notice of Adverse Benefit Determination and fax, email, mail or hand deliver the form to Alliance at:
- Fax: (919) 651-8682
- Email: [UMAppeals@Alliancehealthplan.org](mailto:UMAppeals@Alliancehealthplan.org)
- Mail or Hand Delivery: Alliance Health, Attention: Appeals Coordinator 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560

**Q: Can the request be submitted over the phone?**
A: Individuals may call (800) 510-9132 or (919) 651-8545 if they want to make a request by phone, but they will still have to file a signed LME/MCO Level Appeal request within sixty (60) days after the mailing date of the notice of adverse benefit determination. If an individual needs assistance with the form, they can contact Alliance at (800) 510-9132 or (919) 651-8545 and someone will help him or her.
Q: Can a provider file the appeal?
A: A provider may help the individual with completing the form and filing the appeal if the individual gives them written permission. There is a space on the form for the individual to identify someone who is going to help them with their appeal.

Q: What is the timeline for the LME/MCO Level Appeal?
A: The LME/MCO Level Appeal must be completed within thirty (30) days after the request is filed. Alliance will schedule a review with a health care professional who has no prior involvement in the case. This person will review the information used in making our decision, in addition to any other information that the individual/guardian wishes to submit. Additional information must be sent to us within ten (10) days of filing this LME/MCO Level Appeal request form. We will mail a decision within thirty (30) days.

Q: What if the individual needs the LME/MCO Level Appeal to be processed faster?
A: An individual/guardian may ask for an expedited Reconsideration Review if waiting thirty days might seriously jeopardize the individual’s life, health, or functional abilities. A provider or any other individual may also help with asking for expedited review if they have been authorized in writing to do so by the member/guardian. A written appeal request is not required for expedited appeal requests filed orally. If Alliance approves a request for an expedited Reconsideration Review, we will make reasonable efforts to provide oral notification and provide written notification of the determination within 72 hours of the request.

Q: What if the request for expedited review is denied?
A: If we deny a request for an expedited LME/MCO Level Appeal, we will call the individual as soon as possible to tell them that expedited review was not approved, and we will mail a notice within two (2) calendar days. An individual can contact (800) 510-9132 to file a grievance about our decision to deny expedited review. If the request for expedited review is denied, we will make a decision on your appeal within the standard timeframe (thirty [30] calendar days) and there is no need to resubmit appeal request.

Q: Will services be authorized during the appeal process?
A: If Alliance terminates, suspends, or reduces an individual’s current Medicaid services before the authorization period ends, they may continue to receive those services if they meet all of the following conditions:

- The LME/MCO Level Appeal request is filed within 10 days of Alliance mailing the Notice of Adverse Benefit Determination.
- The decision involves the termination, suspension, or reduction of currently authorized services.
- The services were ordered by an authorized provider.
- The authorization period for the services has not expired.
- The individual/guardian requests that services continue.
If all of these conditions are met, the individual will continue to be authorized for current services unless and until:

- The individual/guardian withdraws the request for a LME/MCO Level Appeal, or
- Ten days after we mail the LME/MCO Level Appeal decision, unless the individual/guardian requests a State Fair Hearing within those ten (10) days, or
- The individual/guardian loses the State Fair Hearing, or
- The authorization period for the services expires or authorization service limits are met.

For more details about continuation of benefits, see 42 C.F.R. § 438.420.

Q: What happens if the individual loses the appeal?
A: If the individual loses the appeal, Alliance is allowed to recover the cost of the Medicaid services received during the appeal process. We cannot recover these costs from the parents or guardians of individuals over 18 or from providers.

Q: What if the individual/guardian disagrees with the LME/MCO Level Appeal decision?
A: If the individual disagrees with the LME/MCO Level Appeal decision, they may request a State Fair Hearing with the North Carolina Office of Administrative Hearings (OAH). Information explaining how to request a State Fair Hearing with OAH will be enclosed with the LME/MCO Level Appeal decision. The first step in a State Fair Hearing is the opportunity for mediation. Individuals and Providers can learn more about requesting a State Fair Hearing by visiting www.ncoah.com/hearings/medicaid.html or by calling (919) 431-3000.

Q: What appeal or grievance rights are provided for B3 services?
A: Medicaid 1915(b)(3) services enable states to provide health-related services in addition to those in the approved State plan. 1915(b)(3) services are subject to Medicaid due process and appeal rights in the same manner as other Medicaid services provided under the waiver. Medicaid due process and appeal rights must be provided to Medicaid beneficiaries when there is a denial or limited authorization, reduction, suspension, or termination of a previously authorized 1915(b)(3) service based on medical necessity criteria. LME-MCOs receive a separate 1915(b)(3) capitation rate. Total expenditures on 1915(b)(3) services cannot exceed the resources available. 1915(b)(3) services that are denied based on funding exceeding the resources available are subject to the grievance process.

PLEASE NOTE: Individuals must request a LME/MCO Level Appeal and receive a decision before they can request a State Fair Hearing.

N. STATE-FUNDED SERVICES APPEAL PROCESS

An appeal of a denial, reduction or termination of State-funded services is handled differently from a Medicaid Reconsideration and State Fair Hearing. State-funded services are not an entitlement and there is no right to appeal to OAH. Alliance is not required to pay for services during the appeal of State-funded services.
The appeal may only be filed by a client or legal representative and must be received in writing within fifteen (15) working days of the date of the notification letter. Alliance will help any individual who requests assistance in filing the appeal and will acknowledge receipt of the appeal in writing in a letter to the appellant dated the next working day after receipt of the appeal.

Alliance will notify the individual of the decision in writing within seven working days from receipt of the appeal request. If the individual/guardian disagrees with Alliance’s decision, the individual may submit an appeal form entitled “Non-Medicaid Appeal Request Form” to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) at the following address. A verbal appeal will not be accepted.

State MH/DD/SA Appeals Panel  
NC Department of Health and Human Services, Division of MH/DD/SAS  
3003 Mail Service Center, Raleigh, NC 27699-3003

O. GRIEVANCES

A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination, by an enrollee, their legal guardian, or Provider, authorized in writing and acting on behalf of the enrollee/Individual about matters involving Alliance or an Alliance Network Provider. Possible subjects for grievances include, but are not limited to, the quality of services provided through Alliance, and aspects of interpersonal relationships such as rudeness of a Network Provider or an employee of Alliance, or failure by Alliance or a Network Provider to respect the rights of an Enrollee.

A provider may not violate or obstruct the rights of an individual to make a grievance and must not take or allow staff to take any punitive action whatsoever against an individual who exercises this right.

The provider must have a grievance policy and procedure to address any concerns of the individual and the individual’s family related to the services provided. The procedure to file a grievance shall be posted in the individual waiting area. Instruction about the provider’s grievance process must be provided in writing to all individuals and families of individuals upon admission and upon request. The providers written materials on grievances must advise individuals and families that they may contact Alliance directly at (800) 510-9132 or at Complaints@Alliancehealthplan.org about any complaints or grievances.

The provider must keep documentation on all grievances received including date received, points of grievances, and resolution information. At its request Alliance has the right to review provider documentation on grievances. Any unresolved complaints or grievances must be referred to Alliance. Alliance contact information ((800) 510-9132) and the toll-free telephone number for Disability Rights of North Carolina ((877) 235-4210) must be published, posted and made available to the individual and family individuals.
Any individual, legally responsible person and/or Provider is encouraged to contact Alliance if they feel that services being provided to an individual are unsatisfactory or if the individual’s emotional or physical well-being is being endangered by such services. A grievance may be submitted as follows:

- The individual may call Alliance Access and Information Center at (800) 510-9132 or TTY at (800) 735-2962.
- A written statement of the concern may be faxed to (919) 651-8687.
- A written statement of the concern may be emailed to Complaints@Alliancehealthplan.org.
- The complainant may deliver their verbal or written grievance in person at the Alliance Home Office, located at 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560 or any of the Alliance Community Site Locations, which are posted on the Alliance website (www.Alliancehealthplan.org).

QM staff will notify, in writing by U.S. mail, the complainant within five (5) working days of receiving the grievance to acknowledge receipt of the grievance and communicate whether the grievance will be initially addressed informally or by conducting an investigation. Alliance’s initial response to a grievance shall be to attempt to resolve the issue through informal dialogue and to reach agreement between the parties.

Grievances will be designated by Alliance as Medicaid related or Non-Medicaid related grievances depending on individual eligibility.

**For Medicaid Related Grievances**

1. Alliance will seek to resolve grievances expeditiously and provide a written resolution of the grievance by U.S. mail to all affected parties no later than thirty (30) calendar days from the date Alliance received the grievance. Alliance may extend the timeframe by up to fourteen (14) calendar days if (i) the individual requests extension or (ii) there is a need for additional information and the delay is in the best interest of the individual. Any extension granted shall be communicated to the individual within one (1) business day either verbally or in writing. Verbal notifications shall be followed up in writing to the individual.

2. QM staff will notify the individual in writing by U.S. mail within five (5) working days of receiving the grievance to acknowledge receipt of the grievance and communicate whether the grievance will be initially addressed informally or by conducting an investigation. Alliance’s initial response to a grievance shall be to attempt to resolve the issue through informal dialogue and to reach agreement between the parties.

3. If the grievance is filed against a Provider:

   a. As part of the conflict resolution process QM staff shall offer the complainant the option of engaging in the Provider’s internal grievance process or to receive conflict resolution services facilitated by Alliance.

   *Note: Individuals are not required to participate in a Provider’s conflict resolution or grievance process before submitting a grievance to Alliance.*
b. If the issue is resolved by the Provider’s grievance resolution process, the Provider shall submit the results of the resolution to Alliance’s Quality Management Department for entry into Alpha.

4. If information gathered during the informal resolution process is indicative that provider’s practice does not meet required standards as defined by statute, rule, clinical coverage policy, contract, etc., and targeted monitoring would provide additional information to determine regulatory compliance then the grievance shall be referred to the Provider Network Evaluation Team for investigation. Referrals to the Evaluation Team should also be made in situations in which there are current concerns requiring on-site monitoring to assess the health and safety of enrollees/individuals.

a. Referrals to investigations shall be communicated to complainant via U.S. mail.

b. Within fifteen (15) calendar days of the completion of the investigation Alliance will provide a written resolution of the investigation findings to the complainant and provider via US Mail. The resolution shall include:

i. Statements of the allegations;

ii. Steps taken and information reviewed to reach conclusions of each allegation or complaint;

iii. Conclusions reached regarding each allegation or complaint;

iv. Citations of statutes and rules pertinent to each allegation or complaint; and

v. Required action regarding each allegation or complaint.

c. An individual who disagrees with the results of the investigation may file an LME/MCO level appeal as set forth below.

Non-Medicaid Related Grievances

1. Alliance will seek to resolve grievances expeditiously and provide a written resolution of the grievance by U.S. mail to all affected parties no later than fifteen (15) working days of the date Alliance received the grievance. If the grievance is not resolved within fifteen (15) working days, then QM staff will send a letter to the complainant updating progress on the grievance resolution and the anticipated resolution date.

2. QM staff will notify the complainant in writing by U.S. mail within five (5) working days of receiving the grievance regarding whether the grievance will be initially addressed informally or by conducting an investigation. Alliance’s initial response to a grievance shall be to attempt to resolve the issue through informal dialogue and to reach agreement between the parties.

3. If the grievance is filed against a Provider:

a. As part of the conflict resolution process QM staff shall offer the complainant the option of engaging in the Provider’s internal grievance process or receiving conflict resolution services facilitated by Alliance.

Note: Individuals are not required to participate in a Provider’s conflict resolution or grievance process before submitting a grievance to Alliance.
b. If the issue is resolved by the Provider’s grievance resolution process, the Provider shall submit the results of the resolution to Alliance’s Quality Management Department for entry into Alpha.

4. If information gathered during the informal resolution process is indicative that provider’s practice does not meet required standards as defined by statute, rule, clinical coverage policy, contract, etc., and targeted monitoring would provide additional information to determine regulatory compliance then the grievance shall be referred to the Provider Network Evaluation Team for investigation. Referrals to the Evaluation Team should also be made in situations in which there are current concerns requiring on-site monitoring to assess the health and safety of enrollees/individuals.

a. Upon completion of the complaint investigation Alliance will submit a report of investigation findings to the complainant and provider. The report will be submitted within fifteen (15) calendar days of the completion of the investigation and shall include

i. Statements of the allegations;

ii. Steps taken and information reviewed to reach conclusions of each allegation or complaint;

iii. Conclusions reached regarding each allegation or complaint;

iv. Citations of statutes and rules pertinent to each allegation or complaint; and

v. Required action regarding each allegation or complaint.

b. A complainant or provider who disagrees with the results of the investigation may file an LME/MCO level appeal as set forth below.

LME/MCO Level Appeals

1. If the complainant is not satisfied with the resolution of their grievance, the complainant, or their provider authorized in writing to act on their behalf, may file an appeal in writing to Alliance’s Chief Executive Officer (CEO). The appeal request must be received within twenty-one (21) working days of the date of the resolution letter. Information related to filing an appeal is included in the resolution letter. An individual, or a Provider authorized in writing to act on behalf of the individual receiving a grievance disposition has no right to the administrative appeal procedures described in N.C.G.S. 108D.

2. The CEO shall:

a. Provide notification of an investigative appeal to the complainant. The appeal is limited to items identified in the original grievance record and the investigation report;

b. Convene an appeal review committee (following policy and procedure approved by the client rights committee). The committee’s recommendation shall be by majority vote; and

c. Issue an independent decision after reviewing the committee’s recommendation. The decision shall be dated and mailed to the appellant within twenty (20) working days from receipt of the appeal by either QM staff or the CEO Executive Assistant.
The Alliance grievance policy and actions are closely monitored by the Division of Health Benefits, the Alliance Quality Management Department, and the Global Quality Management Committee. Alliance maintains an electronic record where all grievances and resolutions are recorded.

Alliance maintains documentation on all follow ups and findings of any grievance, and any investigations undertaken.

If problems are identified related to a provider agency, the provider may be required to complete a Plan of Correction.

There is no right to appeal the resolution of a grievance to the Office of Administrative Hearings or any other forum.

P. COMPLAINTS

Complaints are those concerns identified by Alliance staff, other providers, community partners and other external stakeholders that is not a Grievance as described above. Any stakeholder (internal and external) is encouraged to contact Alliance if they feel that services being provided to an individual are unsatisfactory, if the individual’s emotional or physical well-being is being endangered by such services, if there are other practice concerns, either clinical or administrative or if the functions of the Local Management Entity/Managed Care Organization (LME/MCO) that are being provided are unsatisfactory. A Complaint may be submitted either through the Alliance Access and Information Center at (800) 510-9132 or TTY at (800) 735-2962, by written statement of the complaint faxed to (919) 651-8687, by email to Complaints@Alliancehealthplan.org or verbally in person at the Alliance Home Office, located at 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560, or any of the Alliance Community Offices posted on the Alliance website (www.Alliancehealthplan.org).

Alliance Quality Management (QM) staff will notify (verbally or in writing) the complainant within five (5) working days of receiving the Complaint. If the complaint requires an immediate response (defined as urgent follow-up with a provider or safety issue) staff receiving the complaint are to handle the information and resolve the immediate need. QM staff will follow-up on the specific complaints of the complainant. Alliance’s initial response to a Complaint shall be to attempt to resolve the issue through informal dialogue and to reach agreement between the parties. QM staff will notify the complainant in writing of the results of the informal process within fifteen (15) working days from receipt of the complaint unless circumstances require additional time. If the complaint is not resolved within 15 working days, then QM staff will notify the complainant of progress on the Complaint resolution. Once a Complaint has been resolved, QM staff shall document the results in Alpha. QM staff shall notify the complainant, in writing, of the resolution within five (5) working days after resolution of the Complaint. If a Complaint cannot be resolved informally, it will be referred to the Provider Network Evaluation Section (Evaluators), Special Investigations Unit (SIU) or Corporate Compliance Committee or designee, depending on the nature of the Complaint.
Q. CLIENT RIGHTS RESOURCES

Alliance Network Providers can access additional Client Rights information by using the DMH/DD/SAS Website to obtain the following resources:

- APSM 30-1, Rules for Mental Health/Substance Abuse/Developmental Disabilities Facilities and Services.
- ASPM 45-1, Confidentiality Rules.
- North Carolina General Statues (NCGS) 122C Article 3; 10A North Carolina Administrative Code (NCAC) 27G.0504, 10A NCAC 27G.0103.
- NCGS 143B-147(a) and NCAC 10A-27I.0600-.0609.

Web Reference:
SECTION V: BENEFIT PACKAGE

A. Eligibility for the Medicaid Waivers
B. Medicaid Waiver Disenrollment
C. Eligibility for Reimbursement by Alliance
D. Registration/Enrollment of Individuals
E. Service Definitions and Service Array
F. Hospital Admissions
G. Medicaid Transportation Services

A. ELIGIBILITY FOR THE MEDICAID WAIVERS

The NC MH/DD/SAS Health Plan (1915(b) Waiver)

Individuals must be eligible for Medicaid as determined by their county Department of Social Services in order to be eligible for inclusion in the waiver. Covered Medicaid eligibility categories include:

- Individuals covered under Section 1931 of the Social Security Act (TANF/AFDC)
- Optional Categorically and Medically Needy Families and Children not in Medicaid Deductible status (MAF).
- Blind and Disabled Children and Related Populations (SSI) (MSB).
- Blind and Disabled Adults and Related Populations (SSI, Medicare).
- Aged and related populations (SSI, Medicare).
- Medicaid for the Aged (MAA).
- Medicaid for Pregnant Women (MPW).
- Medicaid for Infants and Children (MIC).
- Adult Care Home Residents (SAD, SAA).
- Foster Care and Adopted Children.
- Participants in Community Alternatives Programs (CAP/DA, NC Innovations, CAP-C).
- Medicaid recipients living in Intermediate Care Facilities.
- Work First Family Assistance (AAF).

AND the individual’s Medicaid County of Origin is in the Alliance catchment area.

Enrollment for individuals meeting the criteria listed above is mandatory and automatic. Children are eligible beginning the first day of the month following their third birthday for 1915(b) services, but can be eligible from birth for 1915(c).

Note: 1915(c) NC Innovations Home and Community Based (HCBS) waiver is available for children birth to three years as capacity allows for those deemed eligible.
1915 (c) NC Innovations HCBS Waiver

A person with an intellectual disability and/or a related developmental disability may be considered for NC Innovations funding if all of the following criteria are met:

- The individual is eligible for Medicaid coverage, based on assets and income of the applicant whether he/she is a child or an adult.
- The individual meets the requirements for ICF level of care as determined by a PhD level Psychologist, Psychiatrist or Primary Care Physician based on the nature of the disability. Refer to the NC Innovations Operations Manual for ICF level of care criteria.
- The individual lives in an ICF or is at high risk for placement in an ICF. High risk for ICF placement is defined as a reasonable indication that an individual may need such services in the near future (one month or less) but for the availability of Home and Community Based Services.
- The individual’s health, safety, and well-being can be maintained in the community with waiver support.
- The individual is in need of NC Innovations waiver services.
- The individual, his/her family, and/or guardian desires participation in the NC Innovations program rather than institutional services.
- For the purposes of Medicaid eligibility, the person is a resident of, or their Medicaid originates from, one of the counties within the Alliance region and the individual will use at least one waiver service per month for eligibility to be maintained.
- All individuals initially selected and deemed eligible as NC Innovations participants after January 3, 2012, must live independently, with private families, or in living arrangements with six or fewer persons unrelated to the owner of the facility.
- The individual is determined to be eligible for and assigned to the NC Innovations and TBI waivers.

Web Reference:
Additional information regarding the NC Innovations HCBS Waiver: https://files.nc.gov/ncdma/documents/files/8p.pdf

B. MEDICAID WAIVER DISENROLLMENT

When an individual changes county of residence for Medicaid eligibility to a county other than Cumberland, Durham, Johnston and Wake (referred to as the Alliance catchment area), the individual will continue to be enrolled in the NC MH/DD/SA Health Plan until the disenrollment is processed by the Eligibility Information System at the State.

Disenrollment due to a change of residence is effective at midnight on the last day of the month.

Individuals will be automatically removed from enrollment in the NC MH/DD/SAS Health Plan if they are:
- Living in a county other than Cumberland, Durham, Johnston and Wake, and Medicaid changes to the new county.
- Deceased.
- Incarcerated in a correctional facility for more than thirty (30) days.
- No longer qualify for Medicaid or are enrolled in an eligibility group not included in the NC MH/DD/SAS Health Plan or NC Innovations 1915(b)(c) waivers.
- Admitted to a state psychiatric facility, State drug treatment program, or other State facility for more than thirty (30) days.
- Residing in a facility of any kind deemed to be an Institute of Mental Disease (IMD).

C. ELIGIBILITY FOR REIMBURSEMENT BY ALLIANCE

Medicaid-eligible individuals in the Alliance catchment area are automatically enrolled into the Alliance Health Plan. If a Provider wants to provide services to an individual who is not Medicaid-eligible with State or local funds, Alliance must first approve the individual's enrollment into our individual electronic information system (AlphaMCS). The individual will also have to meet authorization and/or eligibility criteria. If you have any questions about an individual's eligibility, please contact the Access and Information Center at (800) 510-9132.

State funding is not available for individuals with the ability to pay, or who have insurance coverage that pays for their services. However, the person may still receive and pay for services from a Provider independent of Alliance involvement. Medicaid and State funds are payment of last resort. All other funding options need to be exhausted first. Individuals with private or group insurance coverage are required to pay the co-pay assigned by their insurance carrier.

Medicaid regulations prohibit the use of Medicaid funds to pay for services provided to individuals who are inmates of public institutions such as correctional facilities, or to pay for services provided to individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services. Institution for mental diseases means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Medicaid IMD recipients are allowed 15 days a month for inpatient services.

Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases.

Note: Provider contracts specify the funding source available for Provider billing. Providers should know if they have been contracted for Medicaid, State, local or grant funds or any combination thereof. If you have questions, please contact your assigned Provider Network Specialist.
D. REGISTRATION/ENROLLMENT OF INDIVIDUALS

It is important for all Providers to ensure that individual registration or enrollment data is up-to-date based on the most current Alliance Enrollment Procedures and training. If registration or enrollment data is not complete prior to service provision, authorizations and claims may be impacted. This could result in denial of authorizations requested and/or claims submitted for reimbursement. See the section on Claims Reimbursement for details related to individual eligibility and enrollment.

Service Eligibility

Services are divided into multiple service categories:

Basic Services

The Basic Benefit package includes those services that will be made available to Medicaid-eligible individuals and, to the extent resources are available, to non-Medicaid individuals. These services are intended to provide brief interventions for individuals with acute needs. The Basic Benefit package is accessed through a simple referral from Alliance to an enrolled Alliance Provider. Once the referral is made, there are no prior authorization requirements for these services. Referred individuals can access up to twenty-four (24) outpatient therapy visits from the Basic Benefit package per fiscal year. Evaluation and Management services furnished by an appropriately credentialed practitioner are also available to individuals without prior authorization. Unmanaged Evaluation and Management visit limitations are listed on the Alliance Benefit Plan, which can be found under authorization information via the Provider tab at www.Alliancehealthplan.org.

Enhanced Services

The Enhanced Benefit package includes those outpatient services that will be made available to Medicaid-eligible individuals and to non-Medicaid individuals meeting NON-MEDICAID Target Population criteria. Enhanced Benefit services are accessed through a person-centered planning process and are intended to provide a range of services and supports, which are more appropriate for individuals seeking to recover from more severe forms of mental illness, substance abuse and intellectual and developmental disabilities with more complex service and support needs as identified in the person-centered planning process. The Person-Centered Plan also includes both a proactive and a reactive crisis contingency plan.

Enhanced Benefit services include services that are comprehensive, more intensive, and may be delivered for a longer period of time. An individual may receive services to the extent that they are identified as necessary through the person-centered planning process and are not duplicated in the integrated services offered through the Enhanced Benefit (e.g., Assertive Community Treatment). The goal is to ensure that these Individuals’ services are highly coordinated, reflect best practice, and are connected to the person-centered plan authorized by Alliance.
**Target Populations**

NON-MEDICAID Target Population designation is related to State-funded services only. It does not apply to individuals who are only receiving Medicaid services. The Provider, based on the individual’s assessment, must determine the specific Target Population for the individual according to DMH/DD/SAS Criteria. Each Target Population is based on diagnostic and other indicators of the individual’s level of need. If the MH/IDD/SAS system does not serve these individuals, there is no other system that will serve them. The MH/IDD/SAS system is the public safety net and resources will be focused on those most in need.

**Web Reference:** NON-MEDICAID link on the NC Division of MH/DD/SAS website: www.ncdhhs.gov/divisions/mhddsas/FY2018Documents

**E. SERVICE DEFINITIONS AND SERVICE ARRAY**

**NC MH/DD/SAS Health Plan – 1915(b) Waiver**

All NC Medicaid State Plan behavioral health (MH/IDD/SA) services must be covered under the 1915 (b) waiver. When the NC State Medicaid Plan changes, the services covered under the NC MH/DD/SAS Health Plan (1915 (b) waiver) will also change. Visit the DHHS website for the most current version of the service definitions and admission, continuation, and discharge criteria.

**Web Reference:** Service Definitions (Medicaid Clinical Coverage Policies) may be found at https://dma.ncdhhs.gov/behavioral-health-clinical-coverage-policies

For State-funded services, refer to the DMH/DD/SAS Service Definitions available here: www.ncdhhs.gov/mhddsas/Providers/servicedefs/index.htm

**1915(c) NC Innovations HCBS Waiver and TBI Waiver**

Services defined in the 1915(c) NC Innovations Home and Community Based Services waiver replace CAP-I/DD services outlined in Clinical Coverage Policy #8M. An individual must be assigned to NC Innovations in order to receive these services. Please refer to the most current version of the Service Definitions. For services available under the NC Innovations Waiver, further detail can be found on in the NC Innovations website at https://medicaid.ncdhhs.gov/nc-innovations-waiver and on the Alliance website. https://www.alliancehealthplan.org/Individuals-families/traumatic-brain-injury-tbi/#toggle-id-3

**(b)(3) Alternative Services**

(b)(3) services are Medicaid services that are funded through a separate capitation payment. These are considered additional Medicaid services that are not entitlements, meaning they can only be authorized and provided based on the funding available to pay
for these services. These services are intended to support individuals with intellectual and
development disabilities who are not on the NC Innovations Waiver and individuals with
mental health and substance abuse disorders.

The full array of services offered by Alliance is available on the Alliance website at
https://www.alliancehealthplan.org/providers/um-information-and-resources/

F. HOSPITAL ADMISSIONS

Alliance will provide authorization for all covered services, including inpatient and related
inpatient services, according to Medical Necessity requirements.

G. MEDICAID TRANSPORTATION SERVICES

Transportation services are among the greatest needs identified to assist individuals in
accessing care. It is Alliance’s goal to assist individuals in accessing generic public
transportation. Providers are requested to assist in meeting this need whenever possible.

Each city and/or county has access to Medicaid approved transportation. Transportation is
for medical appointments or getting prescriptions at the drug store. Riders have to call two
(2) to four (4) days ahead to arrange a ride. There is no fee for individuals who are
enrolled in Medicaid. For those who are not enrolled in Medicaid, transportation
depends on available space, and there is a fee. County-specific information about
Medicaid transportation is available in the Member Handbook.
SECTION VI: CLINICAL MANAGEMENT

A. Introduction
B. Access and Information Center
C. Access to Services
D. Process for Telephonic Acute Care Pre-Authorization
E. Registry of Unmet Needs
F. Individual Enrollment
G. Initial Assessment
H. Initial Authorization
I. Continued Authorization of Services
J. Discharge Review
K. Utilization Review
L. Care Coordination and Discharge Planning

A. INTRODUCTION

Clinical management covers the clinical infrastructure and processes of Alliance that define the continuum of care available to individuals within the region and the management of the healthcare system. Clinical infrastructure refers to functions, staff, departments, tools and strategies for the management of service provision. The continuum of care refers to an organized array of services and supports, ranging in level of intensity and operated by a Network of well-trained Providers. The continuum is accessed by individuals at the level most appropriate to an individual’s need.

Alliance maintains an Access and Information Call Center 24 hours a day, 7 days a week, 365 days a year and is staffed with Masters-level, licensed clinicians for screening and triage purposes, as well as trained Qualified Professionals and other staff for general inquiries, connections to community resources, etc. Individuals, Providers and family individuals can call to access crisis services, or to access routine services, general information including help with filing an appeal or grievance, and/or community resources. Alliance is responsible for timely response to the needs of individuals and for quick linkages to qualified Providers. Access and Information Center staff provide critical monitoring and management of referral and follow-up to care in emergent, urgent and routine cases.

The Utilization Management/Care Management Department is responsible for making decisions about initial and ongoing requests for services as well as discharge and retrospective reviews of services. Decisions are based on medical necessity and EPSDT criteria and the frequency, intensity and duration of the service request.

The UM Department has clinicians that specialize in reviews for Mental Health/Substance Use Disorder (MH/SUD) and NC Innovations. The MH/SUD reviewers are licensed clinicians with five (5) years post master degrees. Licensed clinicians review for Medicaid (b) and state funded NON-MEDICAID services. I/DD Care Managers review for NC Innovations and TBI Waiver services delivered under the Medicaid (c) waiver and are Qualified IDD professionals.
Utilization management is the process of evaluating the necessity, appropriateness, and efficiency of behavioral health care services against established guidelines and criteria. Our goal is to ensure that individuals receive the right service, at the right time, at the right level, thus creating the most effective and efficient treatment possible.

Working with Providers, the UM Department manages care through consistent and uniform application of authorization protocols. Each individual’s needs are evaluated to determine the appropriate type of care, service, frequency of care, intensity of services, and in the appropriate clinical setting. UM Care Managers maintain contact with Providers through individuals’ episodes of care to help ensure that adequate progress is being made and treatment plans are adjusted as needed.

The UM Department has two sections. One is responsible for managing I/DD, TBI Waiver and NC Innovations services and the other manages MH/SUD services. The I/DD UM section consists of qualified professionals and Masters-level, licensed clinicians. Licensed clinicians make initial decisions about service approval for non-Innovations I/DD services, such as inpatient and (b)(3) services. Qualified professionals make initial decisions about service approval for NC Innovations. The MH/SUD section is comprised exclusively of licensed clinicians. Each section monitors the utilization of services and reviews utilization data to evaluate and ensure that services are being provided appropriately within established benchmarks and clinical guidelines and that those services are consistent with the authorization and the Person-Centered Plan (PCP), Individual Service Plan (ISP), or Treatment Plan.

Providers are required to follow the clinical guidelines adopted by Alliance in the provision of care and Alliance will measure adherence to these guidelines. The Alliance Clinical Guidelines can be found on the Alliance website https://www.alliancehealthplan.org/alliance-clinical-guidelines/. Both Providers and Enrollees can obtain hard copies of the Clinical Guidelines by contacting Alliance.

Care Coordination is focused on the individual as part of a population and in relationship to the overall System of Care. Care Coordinators address the needs of individuals across the continuum of care, throughout various care settings, and work in conjunction with the person, Providers, and others to improve outcomes for the individual while maximizing efficient use of resources. This is both a risk management and quality management function with significant impact on both resource management and individual quality of care.

B. ACCESS AND INFORMATION CENTER: (800) 510-9132

Access to services is a critical function of an LME/MCO. Alliance is responsible for timely response to the needs of individuals and for quick linkages to qualified Providers of the Network including referrals to emergency levels of care and activating mobile crisis and first responder services when needed. To ensure simplicity of the system, Alliance maintains a toll-free number, (800) 510-9132, called the Access and Information Line that is answered by a live person and is available 24 hours a day, 7 days a week, 365 days a year for telephonic Screening, Triage and Referral (STR) and crisis intervention for people
seeking assistance with mental health, substance abuse, and intellectual or developmental disability issues.

Additional Access and Information Center duties include:

- Collection of demographic information.
- Assisting with referral to inpatient facilities when appropriate.
- Follow-up to ensure that individuals discharged from inpatient and crisis facilities are engaged in the next level of care.
- Assisting individuals find community resources.
- Linking individuals with new service Providers in the event that an individual is dissatisfied with services and has not been successfully transferred by their current Provider.

Alliance’s Responsibility

Access and Information Line calls are answered within thirty (30) seconds, primarily by Access and Information Specialists who are qualified professionals. During times of heavy call volume, excess calls may be routed directly to Access Clinicians. Alliance contracts with a qualified vendor for call center back-up coverage. Incoming calls will be answered by the qualified vendor when the Alliance Access and Information Center is unable to answer a call within 22 seconds.

Access and Information Center staff screen the urgency of the call and collect important demographic information such as name, address and telephone number to identify the individual (person requesting services or information) and his/her current location in case the call becomes emergent. Based on the individual’s response to the greeting and questions asked by Access and Information Center staff, the call will address the following issues:

- Information about community (non-treatment) resources.
- Eligibility questions.
- Referral for routine assessment.
- Transfer to a licensed clinician to manage and provide referrals for urgent calls.
- Transfer to a licensed clinician to manage and provide referrals for emergent calls.
- Referral to Care Coordination when Alliance receives notification of an inpatient or other crisis service admission.
- Documentation of complaints or grievances and routing of the information to the appropriate unit for attention.
- Assistance to Providers.
- Referral of calls to appropriate department for specialized questions.
- Provide general information regarding mental health, substance abuse, and intellectual/developmental disabilities.
C. ACCESS TO SERVICES

Access to Routine Services

This process pertains to referrals for Routine Services. The access standard for routine services is to arrange for face-to-face services (assessment and/or treatment) within fourteen (14) calendar days of contacting the Access and Information Center and/or requesting care. The geographic access standard for services is thirty (30) miles or thirty (30) minutes driving time in urban areas, and forty-five (45) miles or forty-five (45) minutes driving time in rural areas.

Routine Referral Process

Access and Information Center staff collects demographic information about the individual and searches for the individual in the Alliance system. If the individual is not located in the eligibility file and has not been previously enrolled with Alliance, the Access and Information Center staff advises the individual of this, and proceeds with collection of enrollment data.

Access and Information Center staff evaluates the individual’s clinical need as follows:

- Initiates the State-mandated Screening, Triage and Referral form (STR) and documents the information obtained following the current Alliance protocol.
- Retrieves and reviews the individual’s historical information as needed.
- Uses information provided to determine the type of clinical services indicated.
- Provides the individual a choice of at least three Providers (when available). Fewer than three Providers may be offered to individuals accessing benefits through State funding.
- Choice is provided by weighting Providers in the following areas:
  - Availability of service.
  - Proximity to the individual.
  - Individual’s desired attribute in Provider or Provider specialty.
- Access and Information Center staff electronically schedules an appointment for the individual. Appointments are viewable to the receiving Provider in the Alliance AlphaMCS Provider Portal. The Provider will receive an email alerting them of the referral. If an appointment is not available within availability guidelines, the individual may choose another Provider.
- Access and Information Center staff gives the Provider a brief overview of the individual’s need for service. Alliance ensures appointments are being set within the State-required timeframe for the determined level of care and are documented in the computer system.
- In the event that the individual chooses to contact the selected Provider on his/her own, Access and Information Center staff indicates this in the documentation.
Urgent Services

The Access standard for Urgent Care is to arrange for face-to-face services (assessment and/or treatment) within forty-eight (48) hours of contacting the Access and Information Line and/or requesting care. The geographic access standard for services is thirty (30) miles or thirty (30) minutes driving time in urban areas, and forty-five (45) miles or forty-five (45) minutes driving time in rural areas.

An individual’s clinical need may be considered urgent if, but not limited to, the following:

- An individual is reporting a potential substance-related problem.
- An individual is being discharged from an inpatient mental health or substance abuse facility.
- The individual is assessed to be at risk for continued deterioration in functioning if not seen within forty-eight (48) hours.

Urgent Referral Process

- Urgent calls are transferred to Licensed Clinicians within the Access and Information Center.
- A licensed clinician collects and proceeds with the screening, triage and referral (STR) to identify treatment needs.
- After initiating the STR, Access and Information Center staff offers the individual a choice of at least three Providers (when available), and documents the Providers offered and the Provider selected in the Alliance system. Individual without insurance coverage may not have the choice of three Providers.
- Access and Information Center staff schedules an appointment, or arranges care at a Crisis Walk-In Center. This appointment must be available within forty-eight (48) hours.
- Access and Information Center Clinician reminds the individual that the Alliance Access and Information Center is available twenty-four (24) hours a day and instructs the individual to re-contact the Access and Information Center by telephone at any time should the situation escalate and require immediate attention.
- Access and Information Center staff continues to follow-up with any Urgent contact until it is ascertained that the individual has been able to receive the care that is most appropriate to meet the individual’s clinical needs.

Emergent Services

The Access standard for Emergency Services is for face-to-face emergency care within no more than two (2) hours (or immediately, for life-threatening emergencies) of contacting the Access and Information Line and/or requesting care. The geographic access standard for services is thirty (30) miles or thirty (30) minutes driving time for urban settings and forty-five (45) miles or forty-five (45) minutes driving time in rural areas.
Federal law defines emergency services in the managed care setting as covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition. An emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

An emergent situation is indicated if the individual demonstrates one or more of the following, including, but not limited to:

- Real and present or potential danger to self or others as indicated by behavior, plan or ideation.
- Labile or unstable mood or behavior, and demonstrates significant impairment in judgment, impulse control, and/or functioning due to psychotic symptoms, chemical intoxication, or both.
- Immediate and severe medical complications concurrent with, or as a consequence, of psychiatric and/or substance abuse illness and its treatment.
- Caller indicates, either by request or through assessed need, a need to be seen immediately.
- Access and Information Center Clinicians determine through clinical screening and the STR whether the individual represents an immediate danger to self or others. If the individual is an imminent danger to self or others, Access and Information Center Clinicians implement crisis intervention procedures as an attempt to stabilize the individual.
- Access and Information Center Clinician staff attempts to determine any available supports for the caller and when possible speak to them directly for assistance.

If the individual is able to be stabilized, an Access and Information Center Clinician may initiate a call to Mobile Crisis Management to follow up with the individual.

If the individual is unable to be stabilized, an Access and Information Center Clinician, with assistance from another staff member when needed, contacts the appropriate emergency agency (i.e. law enforcement, emergency medical services) to respond and attempts to keep the caller on the phone until they arrive. Access and Information Center Clinicians continue to follow-up with any emergency contact until it is ascertained that the individual has been able to receive the care that is most appropriate to meet the individual’s clinical needs.

Individuals are informed of the availability and types of emergency services through advertising and development and distribution of brochures on emergency services in the local community. Also, the Individual and Family Handbook is accessible on the Alliance website and available in hard copy by request. This handbook contains information on the
ways individuals can access emergency services. In addition, Access and Information Center staff members inform individuals of the availability and type of the nearest emergency services.

Note: In potentially life-threatening situations, the safety and well-being of the individual has priority over administrative requirements. Eligibility verification is deferred until the caller receives appropriate care.

APPOINTMENT WAIT TIMES – Providers are required to meet minimum appointment wait times as follows:
- Scheduled appointments – 60 minutes
- Walk-in appointments – 2 hours
- Emergencies – face to face within 2 hours; if life threatening then immediate attention is required.

D. PROCESS FOR TELEPHONIC ACUTE CARE PRE-AUTHORIZATION

With the exception of NC Innovations crisis services, Access and Information Clinicians do not authorize crisis services. Under the Alliance Benefit Plan, acute psychiatric inpatient Providers are required to notify Alliance of an admission within four (4) hours of an individual admission and request initial authorization within 72 hours of admission.

The following services do not require prior authorization, but do require notification to Alliance within four (4) hours of an individual admission:
- Crisis evaluation and observation detoxification services.
- Facility-based crisis services.
- Mobile crisis management services.
- Non-hospital medical detoxification.

Authorization Requests for Acute Psychiatric Inpatient Services

Requests for concurrent authorizations are submitted through the Alliance AlphaMCS Provider Portal and reviewed during regular business hours. A licensed Care Manager in the Utilization Management Department reviews requests. Requests received less than 24 hours prior to the expiration of the active authorization will be reviewed within 72 hours. Expedited Requests received at least 24 hours prior to the expiration of the active authorization will be reviewed within 24 hours.

Discharge

Discharge planning begins at the time of the initial assessment and is an integral part of every individual’s treatment plan regardless of the level of care being delivered. The discharge planning process includes use of the individual’s strengths and support systems, the provision of treatment in the least restrictive environment possible, the
planned use of treatment at varying levels of intensity, and the selected use of community services and support when appropriate to assist the individual with functioning in the community.

Alliance Hospital Liaisons assist with discharge planning for individuals in acute levels of care and work through the Access and Information Center to secure an aftercare appointment with a Network Provider.

Follow-Up After Discharge

Alliance recognizes the importance of follow up care after an individual is discharged from an acute level of care. Every effort is made to ensure the individual is engaged in treatment. All discharge appointments are tracked to make sure the individual has been seen and linked to services. When an aftercare appointment is electronically scheduled, the Provider will note in the AlphaMCS Provider Portal if an individual has kept an aftercare appointment. In the event that a Provider does not note follow-up, the system will notify the Access and Information Center Clinician who scheduled the appointment. The Access and Information Center Clinician will follow up with the Provider to inquire of the appointment status and will follow-up with the individual if the appointment is not kept.

E. REGISTRY OF UNMET NEEDS

A registry of unmet needs is maintained to ensure a standardized practice of initiating, monitoring and managing for I/DD services that reach capacity as a result of limitations of non-Medicaid funding sources. The registry of unmet needs is also used to record and track individuals who may be eligible for ICF level of care.

Process

A registry of unmet needs for I/DD services may be necessary when the demand for services exceeds available State funding, when service capacity is reached as evidenced by no available Provider for the service needed and to track individuals who are potentially eligible for NC Innovations when slots are available. The process includes:

- Standardized protocols for evaluating the needs of individuals seeking I/DD services or an NC Innovations slot and placement on the registry
- Reports are monitored by Quality Management and by the Clinical Operations Department.
- Should funding levels reach a predetermined percentage of obligated/projected expenditures, the Operations Team will be notified and make a determination whether to begin a waitlist process.
- The Clinical Operations Department will maintain a registry of unmet needs for all services meeting the service capacity or funding limitation criteria listed above.
A registry of interest (ROI) for TBI Waiver services may be necessary when waiver slots are still available.

- Standardized protocols for evaluating the needs of individuals seeking TBI services or a TBI WAIVER slot and placement on the ROI
- Reports are monitored by Quality Management and by the Clinical Operations Department.
- Should all waiver slots be filled, the Operations Team will be notified and make a determination whether to begin a formalized waitlist process. (RUN)
- The Clinical Operations Department will maintain a registry of unmet needs for all services meeting the service capacity or funding limitation criteria listed above.

A registry of unmet needs (RUN) for TBI WAIVER services may be necessary when the demand for services exceeds available State funding, when service capacity is reached as evidenced by no available Provider for the service needed and to track individuals who are potentially eligible for TBI WAIVER when slots are available. The process includes:

- Standardized protocols for evaluating the needs of individuals seeking TBI services or a TBI WAIVER slot and placement on the RUN
- Reports are monitored by Quality Management and by the Clinical Operations Department.
- Should funding levels reach a predetermined percentage of obligated/projected expenditures, the Operations Team will be notified and make a determination whether to begin a waitlist process.
- The Clinical Operations Department will maintain a registry of unmet needs for all services meeting the service capacity or funding limitation criteria listed above.

For additional information or a copy of the most recent Alliance procedure on the registry of unmet needs, please call (800) 510-9132 to request this procedure.

If a Medicaid funded service is needed by a Medicaid recipient, and there is no capacity within the Network to provide this service or an alternative service agreeable to the individual, the service will be sought from an Out-of-Network Provider.

F. INDIVIDUAL ENROLLMENT

Registration Process

See the section on Claims Reimbursement for details related to individual eligibility and enrollment.

Process for Providers with an Electronic Link to Alliance

Providers with the ability to electronically submit confidential documents securely to Alliance are to follow the steps below for individuals who are catchment area residents that present to their agency by phone or in person (“No Wrong Door Policy”).
Individuals Walking In to a Provider Site

When a person walks in to a Provider’s facility, the Provider shall assess the person for a life threatening situation:

- If a life-threatening situation is present, the Provider is responsible to proceed with an emergency response as clinically indicated.
- If not life threatening, the Provider shall determine if the person is actively enrolled with Alliance by:
  - Checking the status in the Alliance AlphaMCS Provider Portal. If the person has Medicaid or has been previously enrolled in State-funded services with Alliance, the Provider will be able to locate the person in the portal.
  - Contacting the Access and Information Center to inquire about the person’s status.
- If the person is in the Alliance system, the Provider updates individual information as needed.
- If the person is not in the Alliance system, Provider staff enrolls the individual through the AlphaMCS Provider Portal.
- When an enrollment request is submitted to Alliance through the Provider Portal, an Alliance staff member will review and approve the enrollment or return it to the Provider with a reason for return.
- The Provider should ensure the enrollment has been accepted in order to obtain reimbursement of on-going treatment services.

G. INITIAL ASSESSMENT AND REQUEST FOR AUTHORIZATION

Providers should complete an initial assessment addressing the elements required in the current Records Management and Documentation Manual (APSM 45-2). Following that assessment, if the Provider believes that a service requiring prior authorization is medically necessary and the individual meets eligibility criteria, a request for authorization must be submitted for review and approval.

Service Authorization Requests

The Alliance Service Authorization Request (SAR) is completed and submitted by the Provider through the AlphaMCS Provider Portal. The SAR captures demographic and clinical information. When this form is properly completed, Utilization Management staff use the information documented on this form to make the clinical determination required for the individual’s needs. If the form is not completed in full, including all clinical information required, a delay in the approval of a service request or a denial of the SAR may occur. In some cases, Utilization Management staff will attempt to gather the information through contact with the Provider, but this may take several days to resolve in some cases. Providers are monitored for accuracy and completeness in submitting SARs, and may be identified for additional training as needed. Authorization is not a guaranty of payment.
Any Provider may request specific technical assistance on SAR submission by contacting the Alliance Provider Helpdesk. If experiencing technical difficulties please contact the Alliance Provider Helpdesk at (919) 651-8500.

Web Reference:
https://www.alliancehealthplan.org/providers/um-information-and-resources/

EPSDT

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit entitles Medicaid beneficiaries under the age of 21 to medically necessary screening, diagnostic and treatment services within the scope of Social Security Act that are needed to “correct or ameliorate defects and physical and mental illnesses and conditions,” regardless of whether the requested service is covered in the NC State Plan for Medical Assistance. This means that children under 21 years of age can receive services in excess of benefit limits or even if the service is no longer covered under the State Plan.

According to CMS, “ameliorate” means to improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Basic EPSDT criteria are that the service must be covered under 1905(a) of the Social Security Act, and that it must be safe, effective, generally recognized as an accepted method of medical practice or treatment, and cannot be experimental or investigational (which means that most clinical trials cannot be covered).

Requests for MH/IDD/SUservices for Medicaid-eligible children under the age of 21 will be reviewed using EPSDT criteria. Requests for NC Innovations Waiver services will be reviewed under EPSDT if the request is both a waiver and an EPSDT service. Most NC Innovations Waiver services are not covered under the Social Security Act (i.e. respite, home modifications and all habilitative services).

H. INITIAL AUTHORIZATION

Obtaining service authorization is the responsibility of the Provider. The process required to obtain initial authorization of services is outlined below.

Authorization Request Process

Prior-authorization is required for all Alliance covered services, with the following exceptions as outlined in the Alliance Benefit Plan:

- Initial outpatient services
- Evaluation and management services
- Some emergency and crisis services for behavioral healthcare
- Codes specifically agreed upon by Alliance and Provider to be listed as “No Authorization Required” under a contract. Reference your contract for applicability.
To remain consistent with Division of Health BenefitsNC Medicaid guidelines, the Utilization Management Department is only able to make formal decisions (approval, denial, or extensions when appropriate) when a complete request is received. For an authorization request to be considered “complete” it must contain the following elements:

- Recipient name.
- Medicaid ID.
- Date of birth.
- Provider contact information and signatures.
- Date of request.
- Service(s) requested.
- Clinical information to support the service(s) requested. This should include information that supports the eligibility for service(s) requested.
- Additional documentation may be required as referenced on the Alliance published Benefit Plan or Clinical Coverage Policy.
- Documents and forms as required by law.

Service authorization requests are completed using the Service Authorization Request (SAR) form. A SAR constitutes a service request and starts the timeline for review. A Person-Centered Plan (PCP) alone does not initiate a request for service, as it does not meet the criteria identified above since it does not indicate the service Provider and requested services dates.

If a SAR is received that requires a corresponding PCP, ISP or other approved treatment plan and none is submitted or there is not enough clinical information to support the request, the request will be administratively denied as an incomplete request. Both the individual and the Provider will be notified. Medicaid enrollees have appeal rights to administratively denied service authorization requests.

Providers are encouraged to supplement the information requested on Alliance forms with clinical information that the Provider believes documents medical necessity if the Provider believes the information requested on the form is not sufficient to fully document medical necessity for the requested service. This additional documentation could include recent evaluation reports, recent treatment records and letters signed by treating clinicians explaining why the service is medically necessary. If the additional information does not support the requested service(s) when evaluated against medical necessity criteria, other information may be requested from the Provider. This may include assessments, treatment notes, and plan updates.

Initial and re-authorization requests should be submitted prior to service delivery. Masters-level licensed clinicians enter the approval. In the event that the initial reviewer cannot determine medical necessity, the request will be forwarded to a psychiatrist or psychologist (PhD), who will complete the review and issue an adverse decision if medical necessity cannot be established through the review. When an adverse decision is made, the requesting Provider will be offered a period of up to three (3) days to request a “peer-to-peer” conversation to offer additional information that may have not been provided at the time of the service request submission to Alliance.
Initial Authorization of Enhanced Services

Enhanced level services are authorized through the review of the SAR and approved Person-Centered Plan as submitted by the clinical home Provider. Services are identified through the person-centered planning process in a coordinated effort between the clinical home Provider, the individual, the individual's family, other Providers, and other involved professionals or supports when indicated.

Authorization of Enhanced Services

A SAR is required to request initial authorization of enhanced services:

- The clinical home Provider completes the Person-Centered Plan (PCP) with input from the individual, the individual's family, Providers, and other involved professionals or support as indicated.

- The services requested are listed with any limitations noted.

- The Provider for each service is listed on the SAR. Multiple services may be requested on one SAR, however, only one Provider can be listed per SAR.

- The PCP and SAR are submitted to UM for review.

- All UM actions are documented in AlphaMCS and Providers have access to the decisions through the Provider Portal.

Alliance Timeliness Standards

The grid below displays the timeliness standards to which Alliance adheres for initial and re-authorization requests. The standards comply with Medicaid, state-funding and URAC requirements.

<table>
<thead>
<tr>
<th>Alliance Timeliness Standard</th>
<th>Turnaround Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent/ Expedited Review</td>
<td>72 hours</td>
</tr>
<tr>
<td>Standard Review</td>
<td>14 calendar days</td>
</tr>
<tr>
<td>Urgent/Expedited Re-Authorization Review*</td>
<td>24 hours/72 hours</td>
</tr>
</tbody>
</table>

* If a request for re-authorization of involving an urgent/expedited request (typically for inpatient services) is received at least 24 hours prior to the expiration of the authorization, the request is reviewed within 24 hours (excluding non-working days). If the request is received less than 24 hours prior to expiration, the request is reviewed within 72 hours of receipt.

Alliance may extend the expedited or routine time review period up to fourteen (14) additional calendar days if:

a. An extension is necessary due to matters outside of Alliance's control; and
b. Alliance justifies (to DMA upon their request) a need for additional information and how the extension is in the individual’s interest; or
c. If requested by the individual or Provider.

Alliance will notify the individual in writing if there is a decision to extend the review timeframe.

I. CONTINUED AUTHORIZATION OF SERVICES

In order for services to continue beyond the initial authorization time frame, a new service authorization request is required.

Continued Authorization of an Enhanced Service

If a Provider believes continued authorization is medically necessary, the Provider completes a SAR online and submits it electronically to UM via the Alliance AlphaMCS Provider Portal. The information required to establish the need for continued medical necessity and service continuation criteria must be included. The SAR is validated against the Person-Centered Plan (PCP) and the UM criteria. A PCP is only required if there has been an update or the PCP on file with Alliance has expired. The PCP must be updated at least annually.

J. DISCHARGE REVIEW

Discharge planning begins at the time of the initial assessment and is an integral part of every individual’s treatment plan, regardless of the level of care being delivered. The discharge planning process includes use of the individual’s strengths and support systems, the provision of treatment in the least restrictive environment possible, the planned use of treatment at varying levels of intensity, and the selected use of community services and supports when appropriate to assist the individual with functioning in the community. Involvement of family members and other identified supports, including members of the medical community, requires the individual’s written consent.

Discharge Review Process

The UM Care Manager and/or Care Coordinator reviews the status of the discharge plan at each review to ensure that:

- A discharge plan exists.
- The plan is realistic, comprehensive, timely and concrete.
- Transition is coordinated from one level of care to another.
- The discharge plan incorporates actions to assure continuity of existing therapeutic relationships.
- The individual and Providers understand the discharge plan.
- When the discharge plan does not meet the needs of the individual, the UM Care Manager addresses the relevant issues with the Provider. The UM Care Manager
may provide assistance with the development of discharge plans for individuals in all levels of care, including:
  
  o Individuals who remain hospitalized, or at any other level of care, who do not meet criteria for that particular level of care. Alliance consults with providers to develop a plan to provide services to address the individual’s treatment needs within the least restrictive levels of care.

  o Whenever an individual is discharged from detoxification, inpatient psychiatric or partial hospitalization care, the discharge plan should include a follow-up appointment within seven calendar days. Access and Information Center staff works with the discharging facility to ensure that an appointment is made and monitors whether the individual kept the appointment.

  o The UM Care Manager coordinates with the person’s clinical home to ensure there are appropriate services in place following discharge from a residential program. If the person does not have a clinical home, and the person meets special needs population criteria, the UM Care Manager refers to Care Coordination for follow-up.

K. UTILIZATION REVIEW

The primary function of utilization review is to monitor the utilization of services and review utilization data. The review of data is to evaluate and ensure that services are being provided appropriately within established benchmarks and clinical guidelines and that services are consistent with the authorization and approved PCP/ISP/treatment plan.

Utilization review is an audit process that involves a review of a sample of services that have been requested and provided. Information from the individual’s record (assessment information, treatment plan and progress notes) is evaluated against medical necessity criteria. This review may be done concurrently (during re-authorization) and retrospectively (after the service has been provided). The outcomes of this review can indicate areas where additional Provider training is needed, detect services that were provided that did not meet medical necessity, and reveal situations where the individual did not receive timely or appropriate services. Indicators are identified to select cases for review, such as high utilization of service, frequent hospital admissions, unnecessarily high usage of crisis services and emergency departments for outpatient-level care, as well as random samples of other billed events. Alliance utilizes both focused utilization reviews and a sampling process across Network Providers in its utilization review methodologies.

Focused Utilization Reviews are conducted based on the results of monitoring reports that identify outliers as compared to expected/established service levels or through specific cases identified by the Clinical Operations Team. Focused samples may include:

- High-risk individuals
- Over-utilization of services
- Services infrequently utilized
- High-cost treatment.
Routine Utilization Reviews focus on the efficacy of clinical practice in cases related to attaining the goals in the individual’s ISP/PCP/treatment plan. Alliance also reviews the appropriateness and accuracy of the service provision in relation to authorizations. All Network and Out-of-Network Providers are subject to utilization reviews to ensure that clinical standards of care and medical necessity are being met. A routine utilization review is inclusive of, but not limited to the following:

- Evaluations of services across the service array
- Evaluations of individuals by diagnostic category or complexity level
- Evaluations of Providers by capacity and/or service delivery
- Best-practice guidelines and evaluations of utilization trends.

The criteria used in the utilization review processes are based on the most current approved guidelines and service Manuals utilized in the 1915(b) and (c) waivers and practices identified for State funded services. These documents include, but are not limited to:

- Current NC State Plan service definitions with admission, continuation, and discharge criteria.
- Alliance approved clinical guidelines.
- Current approved NC MH/DD/SAS service rules.
- Current, approved NC DMA Clinical Coverage Policies.
- EPSDT criteria.

L. CARE COORDINATION AND DISCHARGE PLANNING

Certain individuals at risk for crisis and individuals with special healthcare needs, including those at risk for therapeutic foster care placement, are eligible for Alliance care coordination as long as coordination is not duplicative of what is required of enhanced service providers (found in NC Medicaid Clinical Coverage Policies 8A, 8A-1 and 8A-2, 8A-6). All individuals enrolled in Innovations and TBI waivers will receive Care Coordination support from Alliance.

The primary purpose of care coordination is the deliberate organization of care activities among individuals involved in an individual’s care to facilitate the appropriate delivery of health care services, connect individuals to the appropriate level of care, and identify and address needs and barriers to treatment engagement. Alliance also provides care coordination to individuals deemed high-risk and individuals who have special healthcare needs that require a high level of coordinated care and monitoring to ensure that services are addressing multiple needs, safely, and at the least restrictive level of care possible.

While individuals with special healthcare needs, those at risk for crisis, and individuals discharged from 24-hour facilities are eligible for care coordination, Alliance prioritizes individuals within these categories according to needs for which care coordination functions can be effective and according to the level of need and risk for each eligible individual, as well as whether they are connected with a provider who can meet their needs through case management as specified in the applicable service definition. For most enhanced providers,
case management functions include coordinating care during provision of services, helping individuals transition between services, assessment of needs, developing Person-Centered Plans/service planning, linkage/referral to paid and natural supports, monitoring, follow-up and crisis management and planning.

The following are Alliance care coordination functions:

- **Clinical care coordination functions include, but are not limited to:**
  - Identification of clinical needs
  - Determination of level of care through case review
  - Enrollee contacts
  - Arranging for assessments
  - Clinical discussions with Enrollee’s treatment providers, and
  - Assistance with development and monitoring of Enrollee treatment plans, including but not limited to Person-Centered Plans and Individual Service Plans.

- **Administrative care coordination functions include, but are not limited to:**
  - Addressing additional support services and resources
  - Assisting Enrollees with obtaining referrals and arranging appointments
  - Educating Enrollees about other available supports as recommended by clinical care coordinators, and
  - Monitoring Enrollee attendance in treatment.

Children receive more comprehensive care coordination under a System of Care model. Providers may refer individuals for care coordination who have unmet needs related to their engagement in mental health, IDD or substance use treatment/recovery for which the provider is not otherwise responsible for addressing. Providers can make the referral either through Alliance Care Management (UM) or the Customer Service/Access Line. Providers will be promptly notified whether individuals referred meet criteria for care coordination.

Care coordination is intended to be a time-limited, population-based method of ensuring individuals are well-connected to effective and safe treatment. Most often, care coordination is involved in addressing barriers to treatment related to social determinants of health and/or highly complex (or treatment resistant) clinical cases requiring additional clinical support such as further assessments and identification of additional treatment needs. Alliance is committed to working with providers and understands that the most important relationship in treatment is the relationship between the therapist/team and the individual. Therefore, once individuals are connected to a treating provider, care coordination will focus efforts on supporting the provider in meeting the needs of the individual.

Care coordination assesses individuals for unmet clinical and social needs, works to meet those needs (in so far is it is not duplicative with the provider’s responsibilities and is consistent with the functions of care coordination set forth by NC Medicaid), and transfers the plan of care to the provider to be included in the Person-Centered Plan to facilitate whole-person treatment. Alliance is also committed to offering resource information and technical assistance to providers who may struggle with their case management responsibilities. Linkage to other services and communication with other
service providers may be facilitated by Alliance care coordination as needed, but remains the responsibility of the treating provider to form collaborative relationships with others involved in the individual’s treatment.

In addition to provider responsibilities for case management, providers of enhanced services are expected to develop, document, monitor and discuss (with the individual) discharge plans related to eventual discharge from the enhanced service. Discharge plans should be linked to Person-Centered Plans, and requirements are further listed in NC Medicaid Clinical Coverage Policies. Discharge planning involves arrangement for and linkage to additional treatment or supports needed upon discharge from the service. Assistance with linkage may be available through the Alliance Customer Services/Access Line.

Inpatient psychiatric treatment facilities are expected to develop discharge plans within the first few days of treatment, including arranging for post-discharge appointments, procedures to follow in case of crisis between discharge and community care, any necessary medical or therapeutic regimens, and other activities as required. Alliance Hospital Liaisons and the Customer Service/Access Line are available for assistance identifying post-discharge treatment providers. Hospitals and other 24-hour facilities are expected to share discharge plans with Hospital Liaisons or other Alliance representatives (care coordination) as quickly as possible to facilitate the smooth transition of individuals from inpatient units or 24-hour facilities to community treatment.

**Long-Term Supports (LTS) Care Team**

Individuals receiving Innovations will have their services managed by the Long-Term Supports (LTS) Care Team. The roles and responsibilities of these Care Team members are listed below:

**Care Navigators**

- Serve as the main point of contact for the member.
- Communicate updates and submit referrals to other Care Team members.
- Identify and document needs for services and supports.
- Develop the person-centered ISP with long-range outcomes in collaboration with the individual, their family, and others of their choice.
- Assure that short-range goals are developed by the provider agency in accordance with the annual plan.
- Complete the individual budget form.
- Identify choices and coordinate services.
- Offer information on self-directed options.
Service Integrity Consultants
- Enhance the member’s experience with network providers to achieve identified treatment and recovery goals.
- Monitor the delivery of services to the member, and assess member satisfaction and engagement.

Behavioral Health Consultants
- Review and recommend evidence-based practices (EBPSs) and services.
- Educate the treatment team about latest behavioral health and research findings to promote optimal outcomes for the member.
- Help coordinate a higher level of care when someone has a behavioral health concern.

Community Health Workers
- Help address unmet social service needs (housing, food, utility payments, employment, and community inclusion).
- Connect members to community resources to meet identified needs.
- Assist with coordination of member payers, resolve Medicaid enrollment issues, and support NC SOAR(SSI/SSDI Outreach, Access and Recovery) activities if applicable.

Physical Health Consultant
- A member of the Alliance Medical Team who reviews physical health needs and consults with community physical health providers if needed.
- May also suggest equipment or technology that would promote positive health outcomes for the member.
SECTION VII: CLAIMS AND REIMBURSEMENT

A. Introduction
B. Individual Enrollment and Eligibility Process
C. Authorizations Required for Payment
D. Payment of Claims and Claims Inquiries
E. Service Codes and Rates – Contract Provisions
F. Definition of Clean Claim
G. Coordination of Benefits
H. Response to Claims

A. INTRODUCTION

This section of the Provider Operations Manual provides general information related to the submission of claims and the reimbursement for services. Providers should refer to the Claims Manual for further details.

B. INDIVIDUAL ENROLLMENT AND ELIGIBILITY PROCESS

MCS Provider Portal

AlphaMCS is a secure, web-based system that can be used by Network Providers to:

- Submit service authorization requests (SAR).
- Key and submit professional , emergency department, and inpatient claims.
- Reverse and replace claims.
- Inquire about an individual’s eligibility.
- Inquire about the status of a claim or SAR.
- Obtain weekly report on submitted claims.
- Obtain weekly remittance advices (RA).

Each Provider will be contacted and provided with the user ID and password upon execution of a Network Contract. Providers are required to access the AlphaMCS Access Request form at AlphaSupport@AllianceHealthPlan.org when their employees that have access to Alliance AlphaMCS Provider Portal terminate employment so that the logins can be disabled.

Eligibility Determination

Individuals who have their services paid in whole or in part by Alliance must be enrolled with Alliance. Alliance reviews new enrollments and enrollment updates to confirm eligibility prior to approval.

Providers must conduct a comprehensive eligibility determination process before beginning services for an individual. The eligibility determination must include whether the individual has private insurance, Healthchoice, is Medicaid or Medicare eligible, or has another payor source. Providers must review and update individual eligibility information annually to determine if there are any changes to first- or third-party liability. Changes in income or
family size affecting first party liability, changes to third party insurance information must be added to the individual’s profile in AlphaMCS as necessary.

Individuals with applicable Medicaid coverage originating from counties within the Alliance catchment area are automatically enrolled with Alliance and do not require enrollment by the Provider. Individuals enrolled in Medicaid are financially eligible for Medicaid reimbursable services from Alliance that are not covered by other insurance or third party payer. Determination of financial eligibility by the Provider is not required for Medicaid recipients.

If the individual is not yet registered or no longer active in the system, the Provider must enroll the individual or update individual information through the AlphaMCS Provider Portal. All individuals not enrolled in Medicaid must be evaluated by the provider at the time of enrollment for their ability to pay. This determination must be updated at least annually by the provider. Any changes in information related to the individual’s household size and income must be updated in the individual’s profile in AlphaMCS as necessary.

It is the responsibility of the service Provider to ensure individual financial eligibility for state and county-funded services prior to enrolling an individual with Alliance. At the time of initial engagement in services by the individual with the provider and annually, the provider must:

- Obtain proof of the individual’s household income, and
- Verify the individual’s county of residence, and
- Obtain attestation from the individual or legally responsible person that neither the individual, the individual’s family, nor the legally responsible person have assets or third-party funding/insurance available to pay for services.

The individual must be at or below 300% of the federal poverty level based on income and household size in order for the individual to be eligible for non-Medicaid funded services. The Division of MH/DD/SAS definitions for family size and family income for eligibility determination can be found here:


The provider is required to enter the verified household income when enrolling a non-Medicaid individual through the provider portal, and to update existing household income information for individuals previously enrolled.

A person is considered a resident of an Alliance covered county if he or she lives in one of the counties at the time he or she is seeking service. Residence in an adult care home, nursing facility, group home or other similar facility within the Alliance catchment area does not establish county of residence. The county in which the individual lived prior to entering the facility is considered the county of residence. A county of residence is not changed because an individual is temporarily out of his/her county in a facility or otherwise. If an individual reports that he/she is homeless, and no known address can be determined, residency shall be established according to where the individual states his/her intent to remain.
If an individual does not meet eligibility guidelines s/he is responsible for 100% of the cost for services provided. In this case, the individual must not be enrolled in the AlphaMCS system and claims must not be submitted to Alliance for reimbursement. Cost sharing is not permitted for individuals covered by Medicaid.

For individuals that have not been enrolled with Alliance or are no longer active in the system, the Provider must complete an electronic enrollment request within fourteen (14) days of the individual’s intake appointment.

All Providers are required to ensure demographic data is up-to-date and accurate in the AlphaMCS individual profile. If enrollment is not complete prior to service provision, authorizations and claims payment may be affected. This could include denials of authorizations and claims for these services.

To complete registration/enrollment, Providers need to confirm individual’s identity and register them with their legal name, birth date, Social Security number or Medicaid identification number. Additional information may be required including but not limited to:

- Individual’s maiden name, when applicable, to determine if the individual has already been registered under another name.
- Insurance information for any policy that may be cover services including: insurance company name, policy name and or group number, effective dates, and name of policy holder.

Once the individual is enrolled, an Alliance Consumer Identification Number is assigned and viewable to the Provider in the AlphaMCS Provider Portal. This number can be used for submitting claims to Alliance. Instructions for how to register/enroll an individual are available on the Alliance website under the Provider section.

**Effective Date of Registration/Enrollment**

Individual registration or enrollment into the Alliance system must be completed prior to providing services beyond the initial assessment except in emergency situations. Crisis services provided in an emergency situation are an exception to this rule. It is the Provider’s responsibility to submit required registration or case activation information within fourteen (14) calendar days of initial contact, and to obtain authorization prior to service delivery when required. In crisis cases, the Provider must still enroll the individual within five (5) days and indicate the date of enrollment as the date that the emergency services were provided. The enrollment date entered on registration forms must be on or before the date of any billed service, but can be no more than fourteen (14) calendar days from date of submission. Service dates prior to an enrollment or activation date are denied.

**Individual ID**

The Alliance Client ID number is assigned by the Alliance Information System once an individual is enrolled as a member. To obtain this number, the individual must be confirmed as eligible and registered/enrolled with Alliance. Claims are denied if submitted with an incorrect Alliance Client ID number, or with a valid number that is not registered or active to the Provider on the date of service billed.
The six (6) digit Alliance Client ID number is required to identify an individual in CCIS and to bill claims through the online DDE system. Claims submitted by HIPAA compliant 837 transaction files may identify recipients of service with their Alliance Client ID number or their active Medicaid ID number.

**Individual Confidentiality**

Providers are responsible for securing a consent to treatment and informing individuals that their Protected Health Information (PHI) will be used to obtain payment from Alliance. Providers should never send an individual’s protected health information (PHI) through unencrypted/unsecure email. Protected health information can be sent by fax or through the Alliance’s secure ZixMail system.

Other demographic information may be required for Alliance to report enrollment information to the Consumer Data Warehouse (CDW) as required by the NC Division of MH/DD/SAS.

### C. AUTHORIZATIONS REQUIRED FOR PAYMENT

**System Edits**

Prior to paying a claim and when required, Alliance’s claims adjudication system looks for a valid authorization for services billed. System edits verify if services were authorized and delivered within the appropriate limitations. The Provider must be attentive to services and authorization limitations to ensure correct reimbursement.

**Authorization Number and Effective Dates**

Each authorization has a unique number, a start date, a site, and an end date. Only dates of service within the specified effective dates of the authorization are paid. Service dates outside these parameters are denied.

**Service Categories or Specific Services**

Each authorization indicates specific services that have been authorized or, in some cases, categories of services or service groups. Each procedure code billed is validated against the authorization. Claims must reference the specific procedure code or revenue code for the service rendered.

**Units of Service**

Each authorization indicates the maximum number of units of service allowed. The claim adjudication system checks to make sure that the units being claimed fall within the units of services authorized, and any established daily, weekly, monthly or other period of delivery limitations. If the number of units billed exceed the authorized number of units remaining,
this system cuts back the units paid to the remaining authorized unit limit. Claims submitted after all of the authorized units for the period have been fully utilized are denied. Providers need to establish internal procedures to monitor their utilization of authorized units and obtain additional authorization to ensure payment for services delivered.

Exceptions to Authorization Rule

Certain Medicaid and State-funded services are paid without an authorization during the initial period of unmanaged care each fiscal year (July-June). These services are limited in scope to basic services or services with an allowable pass-through period/unit and are limited to the total number of encounters allowed for the individual with any Provider without authorization. Once the unmanaged limit has been reached for an individual, all services without an authorization are denied, regardless of the Provider of the service. Once prior approval is on file for the recipient, the system considers the unmanaged count as fully utilized for that fiscal year, regardless of the amount of previous services provided. Providers must be constantly aware of this issue in order to avoid denied claims.

D. PAYMENT OF CLAIMS AND CLAIMS INQUIRIES

ICD-10 Compliance

All HIPAA covered entities shall be compliant with ICD-10 on and after October 1, 2015. ICD-10 compliance means that all Health Insurance Portability and Accountability Act (HIPAA) covered entities are required to use ICD-10 diagnosis and procedure codes including outpatient claims for dates of service on or after October 1, 2015 and inpatient claims with dates of discharge on and after October 1, 2015. ICD-9 diagnosis and procedure codes can no longer be used for health care services provided on or after this date. Without ICD-10, providers will experience delayed payments or even non-payment and a possible increase in rejected, denied or pended claims. Payments to providers cannot be made without the proper ICD-10 coding. Additional information regarding ICD-10 can be found on line at:

- www.nctracks.nc.gov/content/public/providers/ICD10.html
- www.cms.gov/Medicare/Coding/ICD10/index

Timeframe for Claim Submission

Medicaid claims must be submitted within ninety (90) calendar days post service date for payment consideration. Claims submitted past this timely filing requirement result in a denial for payment. Providers have an additional ninety (90) days to re-submit corrected claims that were originally denied within the initial timely filing limit.

State-funded claims must be submitted within sixty (60) days post service date. Claims submitted past this timely filing requirement result in a denial for payment. There is no right to appeal denials of claims based on not meeting timely filing.
Submitting Claims Outside of Filing Period

If a claim is submitted outside of the contractual timeframes, proper documentation supporting the reason for late filing must be attached and submitted for consideration. Acceptable proof of timely filing includes:

- Documentation of the cause of the delay in submitting a claim to Alliance when the Provider experiences exceptional circumstances beyond his/her control.
- Copy of the Original Remittance Advice or Evidence of Benefits from the primary payer indicating the date of resolution (payment, denial, or notice) when the claim was denied for timely filing. Claim must have been filed with primary payer and to Alliance within 180 days of the date of service.
- Evidence of retroactive Medicaid eligibility.

The information must be submitted to the Director of Claims via secured email or regular mail. The information will be reviewed for acceptance or denial of filing outside of the timely filing deadline. Provider will be notified in writing within 30 days of the request.

Process for Submitting Claims to Alliance

Providers are required to submit claims electronically via the web-based AlphaMCS Provider Portal and/or a HIPAA compliant 837 transaction set. Paper claims will be accepted upon approval from the Director of Claims. A request for approval can be submitted to the Director of Claims via email or regular mail. The request will be reviewed and a response will be given within ten (10) business days.

837 Claim Submissions

Detailed instructions are provided in the Alliance 837 Companion Guides located at www.alliancehealthplan.org/providers/publications-forms-documents/#Finance_and_Claims_Forms_for_Providers. The Companion Guides are NOT intended to be used as stand-alone requirements. The ASC X12 version 5010 Implementation Guides define the national data standards, electronic format and values for each data element within an electronic transaction. The National Implementation Guide can be obtained from the Washington Publishing Company’s web site at http://wpc-edi.com/.

Claim Format Requirements

Professional Services including Outpatient Therapy, Periodic services, NC Innovations Services and Medicaid and State-funded Residential Services must be submitted on Professional (837P) ASC X12 005010X222A1 file format.

Institutional services including inpatient and outpatient hospital services, PRTF, child residential services (program Level II or higher), ICF/DD, therapeutic leave and other services reported with revenue codes must be submitted on Institutional (837I) ASC X12 005010X223A2 file format.
Claim Receipt Verification

Alliance acknowledges receipt of 837 transaction file by providing the 997 X12 File available for download from the online system. Providers, billing services or clearinghouses wishing to submit claims to Alliance by HIPAA compliant 837 transaction file must complete a Trading Partner Agreement, with Alliance and submit a test file for format compliance approval prior to submitting 837 files for payment. Instructions for 837 testing can be found in the Companion Guides.

Submitting Voided Claims and Replacing a Paid Claim

Providers may submit a voided claim for a previously paid claim or replace a paid claim within 90 calendar days post service date. Replacement claims submitted past 90 calendar days are denied for exceeding the timely filing requirements. Voided or Replacement claims may be submitted electronically through the AlphaMCS Provider Portal or via an 837 transaction set. Detailed instructions can be found in the Claims Manual or 837 Companion Guides.

Paper Claim Submission

Providers are required to submit claims electronically. Paper claims will be rejected and returned to the Provider. For a claim to be accepted as valid, the submission must meet the following criteria:

- Must be submitted on a standard current version of a CMS 1500 for Professional Services or UB 04 form for Institutional Services.
- Contains all appropriate information in the required fields.
- Contains correct current national standard coding, including but not limited to CPT, HCPCS, Revenue Codes, DRG and ICD-9 and ICD-10 (as of October 1, 2015) Diagnosis Codes. Forms should not be altered by handwritten additions to procedure codes or charges.

Claim Inquiries

The status of a claim can be obtained through the AlphaMCS Provider Portal. This is available to Providers submitting 837s as well. For additional claim inquiries, Providers can email claims@Alliancehealthplan.org or call the Alliance Provider Helpdesk at (919) 651-8500 Monday through Friday between the hours of 8:30am and 5:15pm. When requesting the status of a claim, the caller must identify himself/herself and provide the following information:

- Provider name
- Recipient’s name
- Recipient’s identification number
- Date of birth of recipient
- Date of service of recipient
- Billed services.
Claim Processing Time

Alliance will follow the Prompt Pay Guidelines which requires that all clean claims are approved or denied within eighteen (18) days and payment is made within thirty days (30) of adjudication.

Response to Claims

- Remittance Advice (RA): A Remittance Advice (RA) is available for Providers electronically to download on the AlphaMCS Provider Portal. The RA will include paid, denied, and adjusted claims. Instructions on resolving denied claims can be found in the Alpha Claim Adjudication Codes document located at www.alliancehealthplan.org/providers/publications-forms-documents/#Finance_and_Claims_Forms_for_Providers.

- Electronic Remittance Advice (ERA): Providers may also request an 835 electronic transaction in addition to the Explanation of Benefits (EOB). The 835 returns information for paid and denied claims in a standard HIPAA compliant format.

E. SERVICE CODES AND RATES – CONTRACT PROVISIONS

Reimbursement Rates

Provider contracts include a listing of eligible sites and services for which the Provider is eligible to be reimbursed. All Providers are reimbursed at the Alliance published standard rates for the service rendered unless otherwise stated in their contract.

Providers must only bill the service codes in their contract or reimbursement is denied as non-contracted services. If the billed rate is higher than the Alliance contracted rate, only the published or contracted rate will be paid. If a Provider submits a service claim for less than the published rate, the lower rate is paid. Any change in the published Fee Schedule rates will be announced in the Alliance provider feed and on the Provider News page on the Alliance website at least thirty (30) days in advance of the new rate effective date. It is the Provider's responsibility to monitor the published rates and make necessary changes to their billing systems.

The published rates can be found at www.alliancehealthplan.org/providers/publications-forms-documents/#Alliance_Rate_Sheets.

F. DEFINITION OF CLEAN CLAIM

A clean claim is defined as a claim that has all of the required data elements, is submitted in the correct format, requires no other documentation for payment, and meets the terms of the contract between Alliance and the Provider for the billed service. Additionally, Federal Medicaid regulations define a clean claim as one that can be processed without obtaining
additional information from the Provider of the service or from a third party. It does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

G. COORDINATION OF BENEFITS

Alliance is the payer of last resort. Providers are required to collect all third-party funds prior to submitting claims to Alliance for reimbursement. Third party payers are any other funding sources that are liable to pay for the services provided. This can include workers’ compensation, disability insurance, Medicare, or other health insurance coverage. It is the Provider’s responsibility to monitor this information and to adjust billing accordingly.

All claims must identify the amounts collected by third parties, and must only request payment for any remaining reimbursable amount. Only the remaining amount of the individual responsibility under their insurance policy is a possible reimbursement by Alliance when Medicaid is secondary coverage. Alliance uses the lesser of methodology and only pays up to the published or contracted rate.

Obligation to Collect

Providers must make good faith efforts to collect all first- and third-party funds prior to billing Alliance. First party charges must be shown on the claim whether they were collected or not. The Alliance Claims Adjudication System has the ability to validate third party payer liability and will deny a claim that is missing required coordination of benefits information.

Reporting of Third-Party Payments

Providers are required to record on the claim either the payment or denial information from a third-party payer. Copies of the RA or EOB from the insurance company must be uploaded into the billing system when the secondary claim is submitted. Review of the claims without an attached RA or EOB may result in denial or recoupment of funds. Recouped claims are not eligible for resubmission outside timely filing period.

Providers must bill any third-party insurance coverage including worker’s compensation, Medicare, EAP programs, etc. Providers must wait a reasonable amount of time to obtain a response from the insurance company. However, it is important that Providers not exceed the 90-day rule before submitting claims. If an insurance company pays after a claim has been submitted to Alliance, the Provider must notify Alliance and reimburse the amount recovered from other insurance within thirty (30) calendar days.
H. RESPONSE TO CLAIMS

Management of Accounts Receivable – Provider Responsibility

Providers are responsible for maintaining their individual accounts receivable. Alliance will produce an 835 electronic remittance advice for 837 submitters, and a remittance advice (RA), for those submitting CMS 1500/UB04 claims, for each check write. The RA and/or 835 can be accessed through the AlphaMCS Provider Portal. Providers can export reports from their user outbox into Excel documents to sort and manage billings, payments and denials.
SECTION VIII: PROVIDER COMPLIANCE AND PROVIDER ACTIONS

A. Introduction
B. Code of Ethics
C. Corporate Compliance
D. Compliance Hotline and Investigations of Violations
E. Guarding Against Fraud and Abuse
F. Provider Actions
G. Identification and Recovery of Overpayments and Underpayments
H. Incident Review

A. INTRODUCTION

Alliance has the absolute right and responsibility to conduct announced and unannounced program integrity activities including but not limited to investigations, audits, post-payment reviews, performance reviews and quality of services evaluations of Network Providers or any Provider who has received reimbursement from Alliance.

Alliance may take action or impose penalties deemed necessary to ensure the health, safety and welfare of individuals served by Alliance or the integrity of the Network, including but not limited to the requirement for a Plan of Correction, suspension or freeze of referrals, transfer of Alliance funded clients to another Provider, additional audits and monitoring, paybacks and interest charges on paybacks, de-credentialing of individual practitioners within the agency, and suspension or termination from the Network.

The Alliance Compliance Committee will review documentation and recommendations regarding Provider audits and investigations and determine actions or penalties to be assessed to Providers.

B. CODE OF ETHICS

All contracted Providers will be required to adhere to all relevant codes of ethics associated with individual professional licensure. Providers should attempt to resolve ethics concerns internally, and should encourage their staff to report unresolved concerns about ethics violations to Alliance.

C. CORPORATE COMPLIANCE

Alliance Network Providers are required to practice honesty, directness and integrity in dealings with one another, individuals, payors including Alliance, business partners, the public, internal and external stakeholders, “customers,” suppliers, elected officials, and government authorities. Corporate Compliance deals with the prohibition, recognition,
reporting and investigation of suspected fraud, abuse, misappropriation, and other similar irregularities.

The term *fraud* includes misappropriation and other irregularities including dishonest or fraudulent acts, embezzlement, forgery or alteration of negotiable instruments such as checks and drafts, misappropriation of a Provider, employee, customer, partner or supplier assets, conversion to personal use of cash, securities, supplies or any other agency assets, unauthorized handling or reporting of agency transactions, and falsification of an agency’s records, claims or financial statements for personal or other reasons. With respect to Medicaid, it means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

The above list is not all-inclusive but intended to be representative of situations involving fraud. Fraud may be perpetrated not only by a Provider’s employees, but also by agents and other outside parties. All such situations require specific action. Within any agency, management bears the primary responsibility for detection of fraud. Finance management in particular is accountable to monitor any potentially fraudulent situations.

**Reporting to State and Federal Authorities**

Alliance is required to notify NC Medicaid when it receives an allegation of fraud about a Provider. The Provider name, number, address, source of complaint, type of Provider, date of complaint, nature of complaint, amount paid to the Provider in the previous three years, funds involved and the legal and administrative disposition of the case will be submitted to NC Medicaid. A formal referral to DMH/DD/SAS may also be made for possible suspension and/or revocation of authorization to receive public funding for State and Federal MH/IDD/SU services.

**Provider Compliance Plan**

Alliance requires contracted Agency Providers to have in place a Compliance Plan that includes procedures designed to guard against fraud and abuse. All Providers must monitor for the potential for fraud and abuse and take immediate action to address reports or suspicion. Alliance Office of Compliance reviews Provider compliance programs as necessary for quality and consistency with Federal and State laws.

The plan should include:

- Written policies, procedures and standards of conduct that articulate the agency’s commitment to comply with all applicable State and Federal standards for the protection against fraud and abuse.
- Designation of a Compliance Officer and Compliance Committee.
- A training program for the Compliance Officer and agency employees.
- Systems for reporting suspected fraud and abuse by employees and individuals and protections for those reporting.
• Provisions for internal monitoring and auditing, including an audit process to verify that services billed were provided by appropriately credentialed staff and was appropriately documented and a process to ensure that staff performing services under the Alliance contract has not been excluded from participation in Federal Health Care Programs under either Section 1128 or 1128A of the Social Security Act. The agency consults with the Health and Human Services Office of the Inspector General’s list of Excluded Individuals, the Medicare Exclusion Databases (MED), and the System for Award Management (SAM).
• Procedure for response to detected offenses and for the development of corrective action plans.
• Procedures to promptly report to Alliance, other outside agencies and law enforcement as indicated.

Note: All Providers must monitor for the potential for fraud and abuse and take immediate action to address reports or suspicion.

D. COMPLIANCE HOTLINE AND INVESTIGATIONS OF VIOLATIONS

Alliance employees, individuals served by Alliance, and Network Providers (including employees and contractors of Providers) are encouraged to report any known or suspected fraud and abuse directly to the Alliance Chief Compliance Officer or to the confidential 24-hour Fraud and Abuse Line.

Alliance has established a reporting system to support efforts to identify non-compliance issues. Providers may access this reporting system’s toll-free number at (855) 727-6721. Reporters may make reports anonymously or leave their name. Reports may also be made by calling (800) 510-9132 and asking for the Chief Compliance Officer or Chief Executive Officer.

Alliance is prohibited by law from retaliating in any way against any Employee or Provider who reports a perceived problem, concern or fraud and abuse issue in good faith. However, appropriate action may be taken against such employee, agent or Provider if the individual is implicated as one of the wrongdoers.

The Office of Compliance Special Investigations Unit receives all reports and conducts a pre-investigation for each report. If the pre-investigation indicates a potential compliance violation or suspicious fraudulent activity the Special Investigations Unit will conduct an investigation to evaluate such information, which may include a billing audit. All suspicious fraudulent activity is reported to NC Medicaid Office of Compliance and Program Integrity within five (5) business days. Alliance may also disclose the results of investigations to regulatory and/or law enforcement agencies depending on the nature of the allegation.

E. GUARDING AGAINST FRAUD AND ABUSE

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or
some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Provider abuse consists of Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to Alliance, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes individual/enrollee practices that result in unnecessary cost to Alliance. This definition applies to all funding sources managed by Alliance: Medicaid, state and local funding.

Prevention

Alliance has internal controls and procedures designed to prevent and reduce instances of fraud and abuse. Preventive activities are integrated in daily operations throughout the organization and include but are not limited to the following:

- **Employee Education and training** regarding the compliance plan, what constitutes fraud and abuse, reporting of suspected fraud and abuse, fraud and abuse in a Managed Care environment, and Alliance Code of Ethics and Conduct is ongoing. Utilization Management (UM) awareness training for UM staff is conducted regularly to prevent, reduce, and detect behaviors associated with inappropriate care or requests for services. Claims awareness training is conducted regularly to Finance staff to prevent, reduce, and detect fraudulent billing practices.

- **Provider Education** related to compliance, fraud and abuse, and contractual provisions is ongoing through a variety of mechanisms. This Manual includes compliance requirements and information on how to report suspected fraud and abuse. Educational materials include reporting suspected cases through the use of the Fraud and Abuse Line and indicate the responsibility of the Provider to promptly report all cases of suspected fraud and abuse. Periodic articles, updates, and reminders will be produced in the Provider newsletters and presented in All Provider Meetings to further communicate the Compliance Plan.

- **Member Outreach and Education** through materials to ensure that Members understand the benefits to which they are entitled, the right to select and change a Network Provider, Members’ responsibilities and rights including the right to receive a copy of the medical record, and information of how to report fraud and abuse and overpayments.

- **Fraud and Abuse Hotline** – (855) 727-6721.

- **Gatekeeping** – the Credentialing and Enrollment process is part of the selection and retention of quality Providers but also serves as a means to control access to the Network by Providers that have been excluded from participation in Federal programs. Upon applying for enrollment with the Alliance Network, applicant’s eligibility and enrollment is determined in part by reviewing the Department of Health and Human Services (DHHS) Office of Inspector General List of Excluded Individuals and Entities (LEIE), and the System for Award Management (SAM) to ensure that Providers who are excluded from participation in Federal programs are not enrolled. Alliance searches the LEIE and the SAM upon enrollment and monthly thereafter.
Alliance will also conduct checks with the National Practitioner databank (NPD), the North Carolina Secretary of State registry, and NC DHHS and other LME/MCOs in North Carolina for good standing.

- System Edits – Internal controls related to fraud and abuse specific to encounter data and claims are primarily geared around the edits in the adjudication system. Prior to a claim being approved for payment, the claim is subject to a series of edits to validate the appropriateness of the claim. These edits include a review of Provider and individual eligibility, authorization for service and that the service has been previously been billed. The adjudication system has multiple levels of system edits that review a claim prior to approval for payment. These edits are configured based on specific rules established by the allowable billing procedures.

**Detection**

One of the primary responsibilities of Alliance is to monitor Providers for fraud and abuse. Alliance is responsible for monitoring and conducting periodic audits to ensure compliance with all applicable federal and state laws, rules and regulations, and in particular with the Medicare/Medicaid fraud and abuse laws. Mechanisms available to detect potential fraud and abuse include but are not limited to the following:

- **Data Analysis** – The Special Investigations Unit (SIU) uses data analysis for ongoing and systematic attempts to detect waste, program abuse or fraudulent activities. Suspicious patterns are investigated and if findings indicate fraud they are reported to NC Medicaid Office of Compliance and Program Integrity within five (5) business days for determination of Credible Allegation of Fraud.

Alliance systematically monitors paid claims data, Provider and Enrollee grievances, reports from routine monitoring and other data and reports for trends or patterns of fraud and abuse. Trends are used to select Providers to audit. This analytical approach to fraud and abuse detection is conducted by the Special Investigations Unit on an ongoing basis and as needed, including trends related to claims submission, billing patterns, service authorization and utilization, grievances, and quality reviews such as:

- Improper coding including up-coding and unbundling or bundling.
- Double-billing.
- Failing to reimburse Alliance for funds paid by Alliance and collected from another source.
- Billing for ineligible individuals, i.e. deceased or missing eligibility span.
- Services not rendered.
- Individual enrollee billing for family or group services that should only be billed once.
- Inappropriate use of services to maximize revenue.
- Pattern of claims for services that are not medically necessary or, if necessary, not to the extent rendered.
- Not meeting with patients in a timely manner for first contact.
- Failure to see individuals with cultural or language barriers.
- Inappropriate refusal to accept a new patient due to prior utilization history or diagnosis.

- A random sample of enrollees are contacted monthly using an Explanation of Benefits survey to verify that services billed by a particular Provider were rendered.

- Alliance employees report any suspected fraud and abuse activities detected during a routine or focused monitoring to the Office of Compliance to determine the appropriate course of action.

Enforcement

Substantiated non-compliance will be reported to the next scheduled Alliance Compliance Committee for determination of sanctions or administrative actions. Substantiated fraud will be reported at the next scheduled Compliance Committee meeting following notification from NC Medicaid Office of Compliance and Program Integrity, for recommended actions or administrative actions.

Data and Reporting

The Office of Compliance maintains a system for tracking all allegations of potential fraud and abuse including investigative activities, results, resolution and disposition. Data is trended, analyzed and reported to the Compliance Committee on a regular basis.

F. PROVIDER ACTIONS

Alliance maintains standards for Provider participation that will ensure competent, effective, and quality care for each individual. Alliance has the right to deny or revoke credentialing, take action against a Provider, (up to and including termination from the Network) for activity, actions, and/or non-actions which are contrary to state and federal laws, rules and regulations, the terms and conditions of the Alliance contract, or this Manual. The Alliance Office of Compliance and the Provider Network Evaluations Unit conduct ongoing audits, reviews, investigations and/or evaluations of Provider activities that include but are not limited to:

- Targeted post-payment reviews
- Targeted compliance reviews and investigations
- Routine monitoring
- Complaint and grievance investigations
- Claims audits.

The Office of Compliance is responsible for all reviews, audits and investigations of alleged Provider fraud and abuse as well as routine and focused claims audits. Provider Network Evaluations is responsible for all routine monitoring and/or quality of care complaint investigations. Post-payment reviews may be part of any monitoring or investigative activity.
When the outcome of any of these reviews, audits or investigations result in findings of noncompliance, a report shall be made to the Compliance Committee for determination of the appropriate actions, if any. The Alliance Provider Network Credentialing Committee is tasked with assuring that all Providers, including licensed practitioners, meet standards for initial and continued participation in the Alliance Network as described in Section III: Network Development and Evaluation Part J: Credentialing and Recredentialing.

Types of Provider Actions
- Limiting referrals
- Suspension of referrals
- Payment suspension
- Suspension form closed network
- Site or service specific termination
- Termination from closed network
- Exclusion from participation in closed network
- Moratorium on expansion of sites or services
- Warning letter
- Plan of correction
- Probation (increased monitoring)
- Recovery or recoupment of identified overpayments
- Denial of recredentialing

Any Notice of Provider Action will explain how to request reconsideration as outlined in the Dispute Resolution section below, and the timeframes for doing so.

The Provider may also be placed on prepayment review, which is a mechanism by which Alliance does not pay claims until the Provider has submitted written support for each claim and the claims have been approved for payment by Alliance or any prepayment review vendor retained by Alliance. **State law does not allow a Provider to appeal a decision to be placed on pre-payment review. Prepayment review is not subject to the Dispute Resolution process described below.**

Network Provider Suspension for Health, Welfare and Safety Issues

If the Alliance Chief Medical Officer (CMO) learns that a Network Provider or a credentialed licensed practitioner enrolled with Alliance through a Network Provider is engaged in behavior or practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of any individual, the CMO may immediately issue a Suspension from the Closed Network, pending investigation. The CMO may also choose to issue a Suspension of Referrals pending investigation.

Written Notice of Action, including the effective date, the general basis for the determination, and how to request reconsideration will be sent within one (1) business day of the CMO’s decision.
Following issuance of the Notice of Action, Alliance will complete a full investigation into the allegations and issue a final decision, which may include further Provider Action(s), and will include an explanation of the reconsideration process. Alliance makes every effort to expedite these investigations to validate or refute the allegations, given that the Network Provider has been suspended. However, Alliance will not compromise the outcome to complete the case quickly.

The Alliance dispute resolution process for Provider Actions is described in Section IX.

G. IDENTIFICATION AND RECOVERY OF OVERPAYMENTS AND UNDERPAYMENTS

Alliance has the responsibility to ensure that public funds are being used for the appropriate level and intensity of services/supports, as well as in compliance with applicable federal and state laws, rules, regulations, the NC State Plan for Medical Assistance, the 1915 (b)/(c) Medicaid Waivers, Clinical Coverage Policies, State Service Definitions, Department or Alliance requirements (including but not limited to the DMH/DD/SAS Records Management and Documentation Manual - APSM 45-2, the Alliance Claims Manual, and the Alliance Provider Operations Manual) or any other Alliance revenue source requirements and Generally Accepted Accounting Practices. The Office of Compliance, Claims Department and Provider Network Evaluation Unit perform a variety of audits and review to identify overpayments and underpayments. The Alliance Finance Department conducts reviews of financial reports, financial statements, and accounting procedures. A non-exhaustive list of the types of audits and reviews are listed below:

Post Payment Reviews/Billing Audits – To validate the presence of material information to support billing of services consistent with Medicaid and State regulations and to ensure that funds are being used for the appropriate level and intensity of services, Alliance will conduct audits on a predetermined scheduled basis, as needed or as part of fraud and abuse investigations.

- Claims audit may include a review of the Provider’s evaluation of individual’s income, individual’s determined ability to pay, third party insurance verification, first and third party billing, receipts and denials. A review of Coordination of Benefits information may also be conducted to verify support of claimed amounts billed to Alliance.

- Post-payment reviews are conducted at a minimum of every two (2) years. The Provider Network Evaluators are responsible for conducting these audits. The Billing Audit Sample will consist of three (3) months of paid claims data from the current or previous fiscal year. Results that indicate waste, abuse or fraud will be reported to the Office of Compliance upon completion of the audit.

- Justified Cause Billing Audits can be recommended by CCC or CQIT as a result of previous issues cited or observations noted during a routine billing audit including but not limited to the following:
  - Unavailability of medical records documentation for billing (service notes).
  - Inconsistent documentation to support billing.
Concerns regarding potential fraud or abuse, and/or
Concerns regarding falsification of a Provider’s credentials.
Concerns regarding lack of required supervision documentation.
Concerns regarding possible double billing.
Concerns regarding staffing ratios for service provision.

- Focused post-payment reviews will be conducted as part of Alliance monitoring responsibilities. Focused post-payment reviews may be conducted on-site at the Provider agency or as a desk review and may include but not be limited to the following:
  - High-Cost/High-Volume/High-Risk audits will be conducted in conjunction with scheduled post-payment reviews where applicable.
  - A Service Specific Audit can be conducted when a new contracted Provider enters the Alliance Network, a contracted Provider has been approved to provide an additional service, new or revised service definitions/rule changes occur, or when concerns arise regarding service delivery with a specific service.
  - Block Grant Audits will be conducted in conjunction with scheduled post-payment reviews where applicable.
  - Alliance will conduct annual monitoring reviews of the following service provision: Self-Directed Services, Financial Management and Support Brokerage Service Provider(s).
  - Contract Termination Audits may be conducted upon notice of termination, and prior to final payment as appropriate and necessary. Alliance will perform a Contract Termination Audit on unpaid claims to ensure that all Contractual and other fiscal requirements have been fulfilled.

- Pre-payment Reviews may be conducted while the Special Investigations Unit is investigating a Provider for allegations of fraud and/or abuse. The Corporate Compliance Committee oversees the Provider sanctions process in accordance with Alliance policies and procedures.

Voluntary Repayment of Claims

Providers must conduct self-audits to identify overpayments and ensure all claims submitted for reimbursement are supported by documentation that meets all requirements for billing a service and that billing was not submitted in error. An example of a Provider Self-Audit Template and Instructions are housed on the Alliance web site for the Provider’s convenience.

Under federal law, Providers are required to report and return self-identified overpayments within sixty (60) days of identification, and to provide written notification to Alliance of the reason for the overpayment. Failure to do so may be a violation of the False Claims Act or result in the imposition of sanctions, up to and including termination, by Alliance.
Claims which require repayment can be voided electronically within 180 days from the date of service either through the AlphaMCS Provider Portal, or an 837 file submission. Repayments of $10,000 or more may be made by check or recoupment. Repayments under $10,000 shall only be repaid by recoupment, unless there are inadequate claims to allow for repayment via recoupment. In these cases, Alliance will notify the Provider that a check is required. Provider Refund forms and claims details must be included with all repayments and provided to the Finance Department for processing. Any Provider Refund forms not submitted with payment will be requested from the provider before processing. The Claims Department will deduct voids or refund requests from future claim payments. All voided claim recoupment and approved adjustments will be processed and reported on the Alliance Remittance Advice after the request has been thoroughly reviewed by Alliance Claims Department.

For State-funded: overpayments will be recouped immediately upon identification and will appear on the Provider’s next remittance advice (RA) unless there are inadequate claims to allow for repayment via recoupment. In these cases, Alliance will notify the Provider that a check is required.

**Notices of Overpayment and Recoupments**

If Alliance identifies an overpayment based on a determination that the Provider has failed to bill a third party (including but not limited to Medicare) prior to billing Alliance, or because a claim that was paid with State funds should have been paid by Medicaid due to a retroactive Medicaid eligibility determination, or because of an incorrect site or other authorization or claim error that requires rebilling by the Provider, Alliance will automatically recoup the amount owed from current and/or future claims unless there are inadequate claims to allow for repayment via recoupment. In these cases, Alliance will notify the Provider that a check is required.

If Alliance identifies an overpayment based on a determination that the Provider has failed to comply with applicable federal and state laws, rules, regulations, the NC State Plan for Medical Assistance, the 1915 (b)/(c) Medicaid Waivers, Clinical Coverage Policies, State Service Definitions, Department or Alliance requirements (including but not limited to the DMH/DD/SAS Records Management and Documentation Manual - APSM 45-2, the Alliance Claims Manual, and the Alliance Provider Operations Manual) or any other Alliance revenue source requirements, the Alliance Compliance Committee will notify the Provider of the identified overpayment and process for requesting reconsideration in accordance with the Alliance *Provider Dispute Resolution Procedure* and will recoup the amount owed from current and/or future claims.

Provider will have thirty (30) calendar days from the invoice date to remit the total amount owed to Alliance.

If Provider fails to remit an identified overpayment within thirty (30) calendar days, Alliance reserves the right to charge interest at the legal rate established in NCG.S. § 24-1, impose a 10% late payment penalty, take action to collect the outstanding balance from the Provider and suspend payment beginning on the thirty first (31st) day after
notification of overpayment. The payment suspension will not exceed the amount owed to Alliance.

Alliance may establish a payment plan for the amount owed including interest and any penalty upon the approval of the Chief Financial Officer or designee and may not exceed a term of six (6) months. A request for a payment plan must be submitted on agency letterhead and signed by an authorized person. A payment plan will not be approved if the full amount owed is less than the sum of payments made to Provider in the immediately preceding three (3) month period. Regardless if a payment plan is approved, repayments of $10,000 or more may be made by check or recoupment. Repayments under $10,000 shall only be repaid by recoupment, unless there are inadequate claims to allow for repayment via recoupment. In these cases, Alliance will notify the Provider that a check is required.

If the Provider submits a Request for Reconsideration within the allowable time frame, reimbursement will continue through completion of the reconsideration process unless the Provider is cited for gross negligence or fraud and abuse. However, the Provider may be required to submit documentation of services prior to reimbursement as a condition of continued payment. This determination will be made by the Corporate Compliance Committee. If the reconsideration overturns the original overpayment determination, Alliance will refund any amounts recouped in the next checkwrite following the reconsideration decision.

All overpayments are due and payable by the Provider within thirty (30) days of issuance of the final reconsideration decision. After thirty (30) days, reimbursement to the Provider shall cease, regardless of the funding source, unless and until the overpayment is paid in full by the Provider, either by direct repayment to Alliance or by the withholding by Alliance of reimbursement payments due to the Provider as stated above.

**Identification and Reimbursement of Underpayments**

If an audit or post-payment review reveals that a Provider has been underpaid or Alliance otherwise identifies an underpayment, the Alliance Business Operations Department is responsible for calculating the amount of the underpayment, notifying the Provider and remitting the underpayment electronically within thirty (30) days of identification. Alliance is required to pay interest in the amount of eight percent (8%) of a Medicaid claim amount beginning on the date following the day on which the payment should have been made.

**Provider Name Change and Mergers**

If a provider changes name or other identifying information and stays in Alliance’s network or merges with another provider in Alliance’s network, any current or future amounts due to Alliance as a result of recoupments or overpayments, are due and payable by the new Provider within thirty (30) days of notification from Alliance. After thirty (30) days, all reimbursement, regardless of funding source, the Provider shall cease unless and until
the overpayment is paid in full by the Provider. Due to the change in provider, all repayments must be made via check and cannot be recouped.

H. INCIDENT REVIEW

Part of Alliance’s role as an LME/MCO is to monitor the performance and compliance of Providers in its Network. Alliance maintains the following systems to assist in monitoring the health and safety of individuals, rights protections, and quality of care through the monitoring and review of incidents.

Monitoring of Incidents

An incident is an event at a facility or in a service/support that is likely to lead to adverse effects upon an individual. Incidents are classified into several categories according to the severity of the incident. Providers are required to develop and maintain a system to collect documentation on any incident that occurs in relation to an individual. This includes all State reporting regulations in relation to the documentation and reporting of critical incidents. In addition, Providers must submit all Level II and Level III incident reports in the State’s Incident Response Improvement System (IRIS) and a summary of all Level I incidents must be submitted quarterly.

Providers must implement procedures that ensure the review, investigation, and follow up for each incident that occurs through the Providers’ internal quality management process. This includes:

- A review of all incidents on an ongoing basis to monitor for trends and patterns.
- Strategies aimed at the reduction/elimination of trends/patterns.
- Documentation of the efforts toward improvement as well as an evaluation of ongoing progress.
- Internal root cause analyses on any deaths that occur.
- Mandatory reporting requirements are followed.
- Entering Level II and III incidents into the State’s Incident Response Improvement System (IRIS).

There are specific state laws governing the reporting of abuse, neglect or exploitation of individuals. It is important that the Provider’s procedures include all of these requirements. If a report alleges the involvement of a Provider’s staff in an incident of abuse, neglect or exploitation, the Provider must ensure that Individuals are protected from involvement with that staff person until the allegation is proved or disproved. The agency must take action to correct the situation if the report of abuse, neglect or exploitation is substantiated.

Alliance Incident Review Process

Alliance is required to monitor certain types of incidents that occur with Network Providers, as well as Providers who are not in the Network but operate services in the Alliance catchment area. Alliance is also required to monitor the State IRIS system.
Upon receipt, the Alliance Quality Management Department reviews all incidents for completeness, appropriateness of interventions and achievement of short and long-term follow up both for the individual as well as the Provider’s service system. If questions or concerns are noted when reviewing the incident report the Quality Management staff will work with the Provider to resolve these.

If concerns are raised related to an individual’s care, services, or the Provider’s response to an incident, an onsite review of the Provider may be arranged. If deficiencies are found during the review process, the Provider will be required to submit and implement a plan of correction. Alliance will provide technical assistance as needed and appropriate to assist the Provider to address the areas of deficiency and implement the plan.

**Monitoring to Ensure Quality of Care**

Alliance is charged with conducting compliance reviews and audits of medical records, administrative files, physical environment, and other areas of service including cultural competency reviews. Alliance is also charged with reviewing critical incidents, death reports, and restrictive interventions to assure the protection of rights and the health and safety of individuals.

Alliance will review the incidents reported and determine whether any follow up is needed and may conduct investigations of incidents reported directly by Providers on Incident Reports, as well as reports provided by individuals, families and the community.
SECTION IX: DISPUTE RESOLUTION PROCESS FOR PROVIDERS

For the purposes of this section, Provider is used in reference to a Network Provider or a licensed practitioner that has been appropriately credentialed by the Alliance Provider Network Credentialing Committee and is enrolled with Alliance through a Network Provider.

Alliance follows a fair, consistent, respectful, timely and impartial dispute resolution process for Providers regarding contract disputes, Provider Actions, and credentialing decisions. Provider dispute mechanisms only apply to Providers as described in the opening statement. Alliance does not offer dispute resolution to Applicants who are denied participation in the Closed Network. Not all disputes are subject to the dispute process.

Providers may not appeal a decision by Alliance not to renew or extend a Network Contract beyond its original term, and may not appeal contract termination, credentialing denial or suspension based on the following: notification to Alliance of exclusion from participation in federally funded health care programs by the U.S. HHS Office of Inspector General, Immediate Jeopardy finding issued by the Centers for Medicare and Medicaid Services, action taken by the NC Department of Health and Human Services or any of its Divisions, loss of required facility or professional licensure, accreditation or certification, Provider is excluded from participation in any other North Carolina State health care program, such as Health Choice or another LME-MCO, or Federal, State or local funds allocated to Alliance are revoked or terminated in a manner beyond the control of Alliance for any part of the Contract period.

There are two tracks for Provider dispute resolution. One track is for disputes of Provider Actions involving professional competence or conduct that result in a change in the Provider’s status in the Closed Network. The other track is for disputes of any other Provider Actions.

Alliance provides written notification to the Provider of all Provider Actions and Reconsideration Outcomes. All notifications are sent via email. If the Provider does not signify acceptance of the email within one (1) business day, the notification is sent via trackable mail, unless the Provider responds before a trackable mail is sent. The trackable mail receipt will be maintained as part of the file. The timeframe for requesting reconsideration begins upon the Provider’s acknowledgement of email receipt or first attempted mail delivery. All timelines in this process refer to calendar days unless otherwise noted. “Working day” or “business day” means a day on which Alliance is officially open to conduct its affairs.

Requesting Reconsideration

The Alliance appeal process is available to any Provider who wishes to initiate it in response to an Alliance notification of Provider Action. Any notification of Provider Action
to a Provider will include the basis for the Alliance decision, an explanation of how to request reconsideration and how to submit additional information, and the timelines for doing so. A Reconsideration Request Form is available on the Alliance website.

A Provider has twenty-one (21) days to request reconsideration from receipt or attempted first delivery of the Alliance notification of Provider Action.

Providers must submit a formal written request via certified mail, return receipt requested, using the Reconsideration Request Form, signed by the sole practitioner or an Owner/Operator/Managing Employee of a Provider organized as a corporation, partnership or limited liability company. Formal Requests must be sent to:

Alliance Health
ATTN: COMPLIANCE – PROVIDER RECONSIDERATIONS
5200 W. Paramount Parkway, Suite 200
Morrisville, NC 27560

The Alliance decision shall be considered final if a reconsideration request is not received within twenty-one (21) days from the receipt or first attempted delivery of the notification of Provider Action. The Provider must provide any additional information on four (4) duplicated paper copies at the time the Request for Reconsideration is filed via USPS certified mail.

Reimbursement may continue during the Reconsideration Process except in the following circumstances:

- The Provider is cited for gross negligence or serious quality of care concerns, or
- The Provider is suspected of committing fraud or abuse, or
- Alliance believes continued reimbursement is likely to increase any overpayment amount due.

**Reconsideration Process for Disputes of Provider Actions Related to the Provider’s Professional Competence or Conduct that Result in a Change in Provider Status**

1. Upon receipt of a timely request for reconsideration of a Provider Action related to the Provider’s Professional Competence or Conduct that results in a change in provider status, Alliance will convene a First Level Panel. If the Provider does not request a reconsideration review within twenty-one (21) days from receipt of the Notice of Provider Action, the decision shall become final.

A first level panel meeting will be scheduled at the Alliance Headquarters no later than fourteen (14) days from the receipt of the request for reconsideration. The meeting may occur at a later date, but the meeting date must be decided upon no later than fourteen (14) days from the receipt of the request for reconsideration. Alliance must make good faith efforts to hold the reconsideration meeting within thirty (30) days of receipt of the request. If the thirty (30) day timeframe is not met, the Office of Compliance must document a reason and efforts made. The Compliance Committee designee will provide each panel member with a summary of the dispute/problem; identification of panel members, including indication of which
member of the panel is the clinical peer of the Provider who is the subject of the dispute; and the supporting documentation submitted by the Provider.

2. The Provider is informed of the date, time and place of the meeting at least three (3) days in advance and invited to appear in person or by telephone and to present arguments and documentation to the first level panel. The Provider must notify Alliance in advance if they intend to bring legal counsel to the panel meeting. The Provider must provide any additional written documentation to be considered during the Reconsideration Process at the time the Request for Reconsideration is filed.

3. The first level panel will notify the Office of Compliance of their decision no later than seven (7) days following the panel meeting. The Office of Compliance will issue a written decision to the Provider no later than seven (7) days following the panel decision.

4. If not satisfied with the first level panel decision, the Provider may request reconsideration by a Second Level Panel within seven (7) days from receipt or attempted first delivery of the first level panel decision as set forth in 2, above. If the Provider does not request a second level panel review within seven (7) days from receipt of the first level panel decision, the decision shall become final.

5. The second level panel will conduct a Desk Review of the first level panel decision within fourteen (14) days of receipt of the request for a second level review, and may consider any additional documentation submitted by the Provider along with the second request for reconsideration. If the second level panel does not conduct the review within fourteen (14) days of receipt of the request, the Office of Compliance must document a reason and efforts made to meet the deadline.

6. The second level panel will notify the Office of Compliance of their decision no later than seven (7) days from completion of the Desk Review. The Office of Compliance will issue a final written decision to the Provider no later than seven (7) days following the panel decision. The second level panel decision is final and there is no right to appeal beyond the second level panel.

Reconsideration Process for Disputes of Any Other Provider Actions

1. Upon receipt of a request for timely reconsideration of a Provider Action, Alliance will convene a reconsideration panel consisting of three Alliance employees who were not involved in the original decision. If the Provider does not request a reconsideration review within twenty-one (21) days from receipt or attempted delivery of the Alliance Notice of Action, the decision shall become final.

2. Alliance must make good faith efforts to convene the reconsideration meeting within thirty (30) days of receipt of the request. If the thirty (30) day timeframe is not met, the Office of Compliance must document a reason and efforts made. The Compliance Committee designee will provide each panel member with a summary of the dispute/problem and the supporting documentation submitted by the Provider.
3. The reconsideration panel will notify the Office of Compliance of their decision no later than seven (7) days following the panel meeting. The Office of Compliance will issue a final written decision to the Provider no later than seven (7) days following the panel decision. This decision is final and there is no right to appeal beyond the reconsideration panel.

Reconsideration Process for Claims Denials

Requests for reconsideration of a claim denial must be submitted within twenty-one (21) days of the date the Remittance Advice was posted in the AlphaMCS Provider Portal, and shall be considered by the Alliance Chief Financial Officer (CFO) or designee. The CFO or designee will notify the Network Provider of the final decision within thirty (30) days of receipt of the request for reconsideration. There is no right to appeal denials of claims based on not meeting timely filing requirements.
SECTION X: RESOURCES FOR PROVIDERS

A. Training and Technical Assistance

B. Web-Based Provider Resources

A. TRAINING AND TECHNICAL ASSISTANCE

Alliance provides timely and reasonable training and technical assistance to Providers on a regular basis in the areas of State mandates and initiatives, or as a result of monitoring activities related to services for which the Provider has a contract with Alliance. Requests for training and technical assistance from individual Providers will be fulfilled as time permits. Contact Provider Networks to discuss training needs.

Training Calendar

A calendar of training events for Providers and other stakeholders is available on the Alliance website at https://www.alliancehealthplan.org/calendar/

Contracted Providers must keep abreast of rule changes at the state and local levels, attend training to maintain clinical skills and licensure, be knowledgeable regarding evidence-based or emerging best practices, and be current on coding and reimbursement requirements. Alliance provides a number of resources to assist Providers in meeting these requirements. We communicate information regarding workshops, trainings, and conferences and offer trainings and technical assistance as needed. Alliance maintains a calendar that lists all trainings offered by internal departments (as well as some external training opportunities).

Web Reference:

https://www.alliancehealthplan.org/calendar/

B. WEB-BASED PROVIDER RESOURCES

A wide variety of links to web-based resources of potential interest to the Provider Network can be found on the Alliance website under the “For Providers” tab. The list is not represented as being comprehensive and Alliance does not necessarily endorse any of the programs or information contained in the websites accessed through the provided links.
APPENDIX A: GLOSSARY OF TERMS

**Ability-to-Pay Determination**: The amount an individual is obligated to pay for services. The ability to pay is calculated based on the individual’s income, and number of dependents. The Federal Government Poverty Guidelines are used to determine the individual’s payment amount.


**Access and Information Center**: The toll-free call system established by Alliance to receive all inquiries, respond to crisis situations, and provide quick linkages to qualified Providers in the Network. This will include information, access to care, emergency and Network Provider assistance. The 1-800 call system will rely on information systems management software to assist in tracking and responding to calls.

**Adjudicate**: A determination to pay or reject a claim.

**Administrative Review**: A review of documentation to determine whether Alliance procedures were followed, and if any additional information provided warrants a change in a previous determination.

**ANSI**: American National Standards Institute

**Advanced Directive**: A communication given by a competent adult which gives directions or appoints another individual to make decisions concerning an individual’s care, custody or medical treatment in the event that the individual is unable to participate in medical treatment decisions.

**Appeal**: A request for review of an as Adverse Benefit Determination

**Appellant**: An individual filing an appeal.

**Assessment**: A procedure for determining the nature and extent of need for which the individual is seeking services,

**Authorized Service**: Medically necessary services pre-approved by the LME/MCO.

An individual requiring enhanced benefit is in need of more than the basic benefit visits in order to maintain or improve his/her level of functioning. An authorization for the services available in this level will need to be requested through the LME/MCO’s Utilization Management Department. Authorization is based on the individual’s need and medical necessity criteria for the services requested.

**Basic Benefit Plan**: The Basic Benefit package includes those services that will be made available to Medicaid-entitled individuals and, to the extent resources are available, to non-Medicaid individuals according to local business plans. These services are intended to provide brief interventions for individuals with acute needs. The Basic Benefit package is
accessed through a simple referral from the Local Management Entity, through its screening, triage and referral system. Once the referral is made, there are no prior authorization requirements for these services. Referred individuals can access up to eight (8) visits for adults ages twenty-one (21) and up and sixteen (16) visits for children and adolescents below age twenty-one (21) from the Basic Benefit package from any Provider enrolled in the LME/MCO’s Provider network.

**Benchmark:** A standard by which something can be measured, judged or compared.

**Best Practices:** Recommended practices, including evidenced-based practices that consist of those clinical and administrative practices that have been proved to consistently produce specific, intended results, as well as emerging practices for which there is preliminary evidence of effectiveness of treatment.

**Business Associate:** A person or organization that performs a function or activity on behalf of a covered entity but is not part of the covered entity’s work force. A business associate can also be a covered entity in its own right *(see the HIPAA definition as it appears in 45 CFR 160.103)*.

**CALOCUS (Child and Adolescent Level of Care Utilization System):** A standardized tool that measures level of care needs for children and adolescents. Note: LOCUS is used to assess adults.

**Care Coordination Department (CCD):** A division of Alliance that provides outreach and Treatment Planning Case Management functions for special, high-impact population of individuals.

**Care Management:** Care Management is non-face-to-face monitoring of an individual’s care and services, including follow-up activities, as well as, assistance to individuals in accessing care on non-plan services, including referrals to Providers and other community agencies.

**Catchment Area:** Geographic Service Area with a defined grouping of counties. Alliance’s catchment area includes Cumberland, Durham, Johnston and Wake counties.

**Clean Claim:** A claim that can be processed without obtaining additional information from the Provider of the services or a third party. It does not include a claim under review for medical necessity, or a claim from a Provider that is under investigation by a governmental agency for fraud or abuse.

**Claim:** A request for reimbursement under a benefit plan for services.

**Client:** As defined in the General Statutes 122C-3 (6).

**CMS:** Centers for Medicare and Medicaid Services
Consumer and Family Advisory Committee (CFAC): A formalized group of individuals and family members appointed in accordance with the requirements of NCGS 122-C-170. The purpose of CFAC is to ensure meaningful participation by individuals and families in shaping the development and delivery of public mental health, developmental disabilities, and substance abuse services in the four-county region serviced by Alliance.

Critical Access Behavioral Healthcare Agency (CABHA) Providers: A Provider who delivers a comprehensive array of mental health and substance abuse services. This does not include intellectual/developmental disability services, although some CABHAs may provide I/DD services. The role of a CABHA is to ensure that critical services are delivered by a clinically-competent organization with appropriate medical oversight and the ability to deliver a robust array of services. CABHAs ensure individual care is based upon a comprehensive clinical assessment and appropriate array of services for the population served. A CABHA is required to offer the following Core Services: Comprehensive Clinical Assessment, Medication Management and Outpatient Therapy.

Concurrent Review: A review conducted by the LME/MCO during a course of treatment to determine whether services continue to meet medical necessity and quality standards and whether services should continue as prescribed or should be terminated, changed or altered.

Consumer: A person that needs services for treatment of a mental health, intellectual and/or developmental disability, or substance use/addiction condition. (Alliance has changed its general reference to “consumer” to “individual.”)

Covered Services: The service which the LME/MCO agrees to provide, or arranges to provide to individuals.

Credentialing: The review process to approve the credentials and/or eligibility of a Provider who has applied to participate in the LME/MCO Network of Providers.

Crisis Intervention: Unscheduled assessment and treatment for the purpose of resolving an urgent/emergent situation requiring immediate attention.

Crisis Plan: An individualized, written plan developed in conjunction with the individual and the treatment team. The Plan contains clear directives information to assist in de-escalating a crisis, for individual supports, as well as crisis response clinicians or others involved. Crisis plans are developed for individuals at-risk for inpatient treatment, incarceration, or out-of-home placement.

Cultural Competency: The understanding of the social, linguistic, ethnic and behavioral characteristics of a community or population and the ability to translate systematically that knowledge into practices in the delivery of behavioral health services. Such understanding may be reflected, for example, in the ability to identify and value differences; acknowledge the interactive dynamics of cultural differences, continuously expand cultural knowledge and resources with regard to populations served, collaborate with the community regarding service provisions and delivery, and commit to cross-cultural training of staff and develop
policies to provide relevant, effective programs for the diversity of people served.

**Days:** Except as otherwise noted, refers to calendar days. *Working day* or *business day* means day on which the LME/MCO is officially open to conduct its affairs.

**De-credentialed:** the process that occurs when a currently credentialed licensed practitioner is no longer providing services billed under their rendering NPI. The LP is eligible to reapply if there is identified Network need.

**Denial of Service:** A determination made by the LME/MCO in response to a Network Provider’s request for approval to provide in-plan services of a specific duration and scope which:

- Disapproves the request completely; or
- Approves provision of the requested service(s), but for a lesser scope or duration than requested by the Provider; (an approval of a requested services which includes a requirement for a concurrent review by the LME/MCO during the authorized period does not constitute a denial); or
- Disapproves provision of the requested service(s), but approves provision of an alternative service(s).

**Dispute Resolution Process:** Alliance process to address administrative actions or sanctions taken against Providers in a consistent manner.

**Enhanced Services:** The Enhanced Benefit package includes those services that will be made available to Medicaid-entitled individuals and, to the extent the resources are available, to non-Medicaid individuals meeting Priority population criteria.

**NC Medicaid:** The State of North Carolina, Division of Health Benefits

**DMH/DD/SAS:** The State of North Carolina, Division of Mental Health, Developmental Disabilities and Substance Abuse Services

**Eligibility:** The determination that an individual meets the requirements to receive services as defined by the payor.

**Emergency Medical Condition:** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.
Emergency Services: Covered inpatient and outpatient emergency services are:
- Furnished by a Provider that is qualified to furnish such services, and
- Needed to evaluate or stabilize an emergency medical condition as defined above.

Emergent Need Mental Health: A life threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking, or reporting hallucinations and delusions that may result in self harm or harm to others, and/or vegetative signs and is unable to care for self.

Emergent Need Substance Abuse: A life threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance abuse or dependence.

Enhanced Benefit Plan: Includes those services, which will be made available to Medicaid-entitled individuals and non-Medicaid individuals meeting priority population criteria. Enhanced Benefit services are accessed through a person-centered planning process. Enhanced Benefit services are intended to provide a range of services and supports, which are more appropriate for individuals seeking to recover from more severe forms of mental illness and substance abuse and with more complex service and support needs as identified in the person-centered planning process.

Enrollment: Action taken by NC Medicaid to add a Medicaid recipient’s name to the monthly enrollment report.

Enrollment Period: The time span during which a recipient is enrolled with the LME/MCO as a Medicaid waiver-eligible recipient.

EPSDT: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is the Federal Medicaid benefit that says Medicaid must provide all necessary health care services to Medicaid eligible children under twenty-one (21) years of age. Even if the service is not covered under the NC Medicaid State Plan, it can be covered for recipients under 21 years of age if the service is listed at 1905 (a) of the Social Security Act and if all EPSDT criteria are met.

Facility: Any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers, and includes:
- Licensed facilities are any 24-hour residential facilities required to be licensed under Chapter 122C of the North Carolina General Statutes, such as Psychiatric Residential Treatment Facilities (PRTFs), Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), Supervised Living Facilities, Residential Treatment/Rehabilitation Facilities for Individuals with Substance Abuse Disorders, Outpatient Opioid Treatment Facilities, 5600 group homes or other licensed MH/IDD/SU facilities. These facilities may require a Certificate of Need or Letter of
Support and must meet all applicable state licensure laws and rules, including but not limited to NCG.S. §122C-3 and Title 10A, Subchapter 27C, 27D, 27E, 27F, 27G, 26B and 26C.

- A State facility, which is a facility that is operated by the Secretary.
- A Veterans Administration facility or part thereof that provides services for the care, treatment, habilitation or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers.

**Fee-For-Service**: A payment methodology that associates a unit of service with a specific reimbursement amount.

**Fidelity**: Adheres to the guidelines as specified in the evidenced based best practice.

**Financial Audit**: Audit generally performed by a Certified Public Accountant (CPA) in accordance with Generally Accepted Accounting Principles to obtain reasonable assurance about whether the general purpose financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. Audits also include assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall general purpose financial statement presentation.

**First level panel** means a panel consisting of at least three individuals who were not involved in the original decision. For reconsideration requests concerning a Provider Action related to the Provider’s professional competence or conduct that results in change in provider status, one of the three panel members must be a Provider who is a clinical peer of the provider that filed the dispute.

**First Responder**: A person or personnel of an agency designated as the primary Provider by the Person-Centered Plan/crisis plan who will have access to the individual’s crisis plan at all times and be knowledgeable of the local crisis response system.

**Fiscal Audit**: Audit performed by the Financial Department of the LME/MCO which includes a review of the contractor’s evaluation of an individual’s income, an individual’s determined ability to pay, third party insurance verification, first and third party billing, receipts and denials. A review of COB information will also be conducted to verify support of claimed amounts submitted to LME/MCO.

**Fiscal Agent**: An agency that processes and audits Provider claims for payment and performs certain other related functions as an agent of DMA and DMH.

**Fraud**: The misrepresentation or concealment of a material fact made by a person that could result in some unauthorized benefit to self, some other person, or organization. It includes any act that constitutes fraud under applicable Federal or State law.

**GAF**: Global Assessment of Functioning.
Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee, and failure to respect the individual’s rights.

Grievance Procedure: The written procedure pursuant to which individuals may express dissatisfaction with the provision of services by Alliance and the methods for resolution of the individual’s grievance by Alliance.


Incident: An unusual occurrence as defined in APSM 30-1. Incidents are reported as Level I, II, or III as defined in APSM 30-1.

Initial Authorization (also called Pre-Authorization): The initial or first approval by Alliance’s Utilization Management Department of a medically necessary service(s) at a given level of care prior to services being rendered.

Intellectual/Developmental Disabilities (IDD): Characterized by the following: Impairment of general intellectual functioning and adaptive behavior that occurs before age twenty-two (22) which:
- Limits one (1) or more major life functions.
- IQ of sixty-nine (69) or below.
- Impairment has continued since its origination or can be expected to continue indefinitely.

Least Restrictive Environment: The least intensive/restrictive setting of care sufficient to effectively treat an individual.

Licensed Independent Practitioner: Medical Doctors (M.D.), Practicing Psychologists (Ph.D.) Psychologist Associates (Master’s Level Psychologist [LPA]), Master’s Level Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Licensed Professional Counselors (LPC), Licensed Clinical Addictions Specialists (LCAS), Advanced Practice Psychiatric Clinical Nurse Specialists, Psychiatric Nurse Practitioners, and Licensed Physician Assistants who are eligible to bill under their own license.

LME (Local Management Entity): A local political subdivision of the state of North Carolina as established under General Statute 122C.

LME-MCO (Local Management Entity-Managed Care Organization): LME that is under contract with the Department to operate the combined Medicaid Waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act.

LOCUS (Level of Care Utilization System): A standardized tool for measuring the level of care needs for adults. CALOCUS is used with children and adolescents.

Managed Benefit: Services that require authorization from Utilization Management.
MCO: Managed Care Organization

Material Change: A material change in any written instrument is one which changes its legal meaning and effect.

Medicaid Identification (MID) Card: The Medical Assistance Eligibility Certification card issued monthly by DMA to Medicaid recipients.

Medicaid for Infants and Children (MIC): A program for medical assistance for children under the age of nineteen (19) whose countable income falls under a specific percentage of the Federal Poverty Limit and who are not already eligible for Medicaid in another category.

Medicaid for Pregnant Women (MPW): A program for medical assistance for pregnant women whose income falls under a specified percentage of the Federal Poverty Limit and who are not already eligible in another category.

Medical Assistance (Medicaid) Program: NC Medicaid's program to provide medical assistance to eligible citizens of the State of North Carolina, established pursuant to Chapter 58, Articles 67 and 68 of the North Carolina General Statutes and Title XIX of the Social Security Act, 42 U.S.C. 1396 et. se.

Medical Record: A single complete record, maintained by the Provider of services, which documents all of the treatment plans developed for and behavioral health services received by the individual.

Medically Necessary Services: A range of procedures or interventions that is appropriate and necessary for the diagnosis, treatment, or support in response to an assessment of an individual's condition or need. Medically necessary means services and supplies that are:

- Provided for the diagnosis, secondary or tertiary prevention, amelioration, intervention, rehabilitation, or care and treatment of a mental health, developmental disability or substance abuse condition, and
- Necessary for and appropriate to the conditions, symptoms, intervention, diagnosis, or treatment of a mental health, developmental disability or substance abuse condition, and
- Within generally accepted standards of medical practice, and
- Not primarily for the convenience of an Consumer, and
- Performed in the least costly setting and manner appropriate to treat the individual's mental health, developmental disability or substance abuse condition.

Mediation: The process of bringing individuals or agencies in conflict together with a neutral third person who assists them in reaching a mutually agreeable solution.

MMIS: Medicaid Management Information System
Natural Resource Linking: Processes that maximize the use of family and community support systems to optimize functioning.

NC Innovations: A 1915(c) Home and Community-Based Waiver for individuals with Intellectual and/or Developmental Disabilities. This is a waiver of institutional level of care. Funds that could be used to serve a person in an Intermediate Care Facility may be used to serve people in the community.

NC MH/DD/SAS Health Plan: A 1915(b) Medicaid Managed Care Waiver for Mental Health and Substance Abuse allowing for a waiver of freedom of choice of Providers so that the LME/MCO can determine the size and scope of the Provider network. This also allows for use of Medicaid funds for alternative services.

NCQA: National Council of Quality Assurance is an independent, 501(c)(3) non-profit organization whose mission is to improve health care quality through accreditation and recognition programs with a rigorous review of key clinical and administrative processes, through the Health Plan Employer Data and Information Set (HEIDS®), a tool used to measure performance in key areas, and through a comprehensive member satisfaction survey.

NC-TOPPS: The NC Treatment Outcomes and Program Performance System is a Division web-based system for gathering outcome and performance data on behalf of individuals with mental health and substance abuse concerns in North Carolina’s public system of services. The NC-TOPPS system provides reliable information that is used to measure the impact of treatment and to improve service and manage quality throughout the service system.


Network Provider: An appropriately-credentialed Provider of MH/IDD/SU services that has entered into a contract for participation in the Alliance Network.

Out-of-Plan Services: Health care services, which the Plan is not required to provide under the terms of this contract. The services are Medicaid covered services reimbursed on a fee-for-service basis.

Out-of-Network Provider: A practice or agency who has been approved as an Out-of-Network Provider and has executed a Single Case Agreement with Alliance. The Out-of-Network Provider is not offered as a choice of referral to individuals served by Alliance.

PIHP: Prepaid Inpatient Health Plan.

Primary Diagnosis: The most important or significant condition of an individual at any time during the course of treatment in terms of its implications for the individual’s health, medical care and need for services.
**Priority Populations:** People with the most severe type of mental illness, severe emotional disturbances, as well as substance abuse disorders with complicating life circumstances conditions, and/or situations which impact the person’s capacity to function, often resulting in high-risk behaviors.

**Protected Health Information (PHI):** Under the U.S. Health Insurance Portability and Accountability Act (HIPAA), any information about health status, provision of healthcare, or payment for healthcare that can be linked to a specific individual.

**Penetration Rate:** The degree to which a defined population is served.

**Person-Centered Planning:** A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honor the individual's preferences, choices and abilities. The person-centered planning process involves families, friends and professionals as the individual desires or requires. The resulting treatment document is the Person-Centered Plan (PCP) or Individual Service Plan (ISP).

**Pre-Authorization (also called Initial Authorization):** The initial or first approval by Alliance’s Utilization Department of a medically necessary service(s) at a given level of care prior to service delivery.

**Primary Clinician:** A professional assigned after the initial intake that is ultimately responsible for implementation/coordination of the Treatment Plan/Person-Centered Plan or treatment plan.

**Prior Authorization:** The act of authorizing specific services before they are rendered.

**Prompt Payment Guidelines:** State-mandated timelines that LME/MCOs must follow when adjudicating and paying claims.

**Provider Network:** The Network of credentialed Providers that have entered into contracts to furnish services to individuals served by Alliance.

**Post-Payment Review (aka Billing Audit):** A review conducted by Alliance to assess the presence of appropriate documentation to support claims submitted for payment by Alliance.

**Qualified Professional:** Any individual with appropriate training or experience as specified by the North Carolina General Statues or by rule of the North Carolina Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services in the field of mental health or intellectual/developmental disabilities, or substance abuse treatments or habilitation, including physicians, psychologists, psychological associates, educators, social workers, registered nurses, certified fee- based practicing pastoral counselors and certified counselors *(NC General Statute 122C-3).*

**Recipient:** A person who is receiving services.
Reconsideration Review: A review of a previous finding or decision by Alliance based on the Provider’s Reconsideration Request and any additional materials presented by the Provider.

Recredentialing: The review process to determine if a Provider continues to meet the criteria for inclusion as a LME/MCO Network Provider.

Routine Need – Mental Health: A condition in which the person describes signs and symptoms which are resulting in impairment and functioning of life tasks; impact the person’s ability to participate in daily living; and/or have markedly decreased the person’s quality of life.

Routine Need – Substance Abuse: A condition in which the person describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a substance use disorder according to the current version of the Diagnostic and Statistical Manual.

Second level panel means a panel consisting of at least three individuals who were not involved in the original decision or first level panel decision, one of which must be a Provider who is a clinical peer of the provider that filed the dispute.

SED (Children with Severe Emotional Disturbances): Describes individuals who:
- Are age seventeen (17) or under
- Have mental, behavioral, or emotional disturbance severe enough to substantially interfere with or limit the minor’s role or function in family, school, or community activities
- Score less than sixty (60) on the Global Assessment of Functioning Scale (GAF).

Service Location: Any location at which an individual may obtain any covered service from a Network Provider.

SMI (Persons with Severe Mental Illness): Describes individuals who:
- Are age eighteen (18) or older
- Have substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or the ability to cope with the ordinary demands of life
- Score less than or equal to fifty (50) on the Global Assessment of Functioning Scale (GAF), or
- Have had one (1) or more psychiatric hospitalizations or crisis home admissions in the last year.

SNAP: Measurement used for level of care for I/DD. This scale will be replaced by the Supports Intensity Scale (SIS).

Special Needs Population: Population cohorts defined by diagnostic, demographic and behavioral characteristics that are identified in a Managed Care Waiver. The managed
care organization responsible for waiver operations must identify and ensure that these individuals receive appropriate assessment and services.

**Spend Down:** Medicaid term used to indicate the dollar amount of charges an individual with Medicaid must incur before Medicaid coverage begins during a specified period of time. These may also be referred to as Medicaid Deductibles.

**SPMI (Persons with Severe and Persistent Mental Illness):** Describes individuals who:
- Are age eighteen (18) or older
- Have a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or the ability to cope with the ordinary demands of life
- Score less than or equal to thirty (30) on the Global Assessment of Functioning Scale (GAF), AND
- Have had three (3) or more psychiatric hospitalizations or crisis home admissions in the last year.
- Includes all persons diagnosed with:
  - Bipolar Disorders 296.00-296.96.
  - Schizophrenia 295.20-295.90.
  - Major Depressive Disorders 296.20-296.36.

**Support Plan:** A component of the Person-Centered Plan that addresses the treatment needs, natural resources, and community resources needed for the individual to achieve personal goals and to live in the least restrictive setting possible.

**The Joint Commission (TJC):** The national accrediting organization that evaluates and certifies hospitals and other healthcare organizations as meeting certain administrative and operational standards.

**Third-Party Billing:** Services billed to an insurance company, Medicare or another agency.

**Treatment Planning Case Management:** A managed care function that ensures that individuals meeting Special Needs Population criteria receive needed assessments and assistance in accessing services. Alliance Care Coordinators carry out this function working with Providers if the individual is already engaged with Providers, or assists in connecting and engaging the individual with Providers that will provide the necessary services to meet his/her needs. Activities may include:
- Referral for assessment of the eligible individual to determine service needs.
- Development of a specific care plan.
- Referral and related activities to help the individual obtain needed services.
- Monitoring and follow-up.

**Unmanaged Benefit:** Services that do not require authorization from Utilization Management (UM).
URAC: The national accrediting body under which Alliance Health is accredited.

Urgent Need Mental Health: A condition in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide but expresses feelings of hopelessness, helplessness or rage, has potential to become actively suicidal or homicidal without immediate intervention, a condition which could rapidly deteriorate without immediate intervention, and/or without diversion and intervention will progress to the need for emergent services and care.

Urgent Need Substance Abuse: A condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of their substance use is in need of prompt assistance to avoid further deterioration in the person’s condition which could require emergency assistance.

Utilization Review: A formal review of the appropriateness and medical necessity of behavioral health services to determine if the service is appropriate, if the goals are being achieved, or if changes need to be made in the Person-Centered Plan or services and supports provided.

Utilization Management Authorization: The process of evaluating the medical necessity, appropriateness and efficiency of behavioral healthcare services against established guidelines and criteria and to ensure that the client receives necessary, appropriate, high-quality care in a cost-effective manner.

Utilization Review Manager: LME/MCO qualified professional who reviews an individual's clinical data to determine the clinical necessity of care and authorizes services associated with the plan of care.

Waste and Abuse: Incidents or practices that are inconsistent with sound fiscal, business or medical practices that could result in unnecessary costs to Alliance, the State or Federal government, or another organization. Waste could also result in reimbursement for services that are not medically necessary, or services that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program.
APPENDIX B: COMMONLY USED ACRONYMS

A
AA  Alcoholics Anonymous
ABD  Aged Blind and Disabled
ACH  Adult Care Home
ACR  Assignment of Care Responsibility (form)
A-CRA Adolescent Community Reinforcement Approach
ACTT  Assertive Community Treatment Team
ADA  Americans with Disabilities Act
ADATC  Alcohol and Drug Abuse Treatment Center
ADD  Attention Deficit Disorder
ADHD  Attention Deficit Hyperactive Disorder
ADL  Activities of Daily Living
ADVP  Adult Developmental Vocational Program
AFL  Alternative Family Living
AMA  American Medical Association
AMH  Adult Mental Health
AMI  Alliance for the Mentally Ill
AOC  Administrative Office of the Courts
AOD  Alcohol and Other Drugs
AP  Associate Professional
APS  Adult Protective Services
ASAM  American Society of Addiction Medicine
ATOD  Alcohol Tobacco and Other Drugs

B
BCBS  Blue Cross/Blue Shield
BD  Behaviorally Disturbed
BEH  Behaviorally/Emotionally Handicapped
BSH  Broughton State Hospital

C
CABHA  Critical Access Behavioral Health Agency
CALOCUS (C & A LOCUS) Child and Adolescent Level of Care Utilization System
CAP  Community Alternative Program
CAP-DA  Community Alternative Program for Disabled Adults
CAP-C  Community Alternative Program for Children
CAP-I/DD  Community Alternative Program for Persons with Intellectual/Developmental Disabilities
CARF  Commission on Accreditation of Rehabilitation Facilities
CASP  Cross Area Service Program
CBT  Cognitive-Behavioral Therapy
CC  Care Coordination
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>CCA</td>
<td>Comprehensive Clinical Assessment</td>
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<tr>
<td>CCS</td>
<td>Certified Clinical Supervisor (NCSAPPB)</td>
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<tr>
<td>CCIS</td>
<td>Care Coordination Information System</td>
</tr>
<tr>
<td>CCNC</td>
<td>Community Care of North Carolina</td>
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<tr>
<td>CDSA</td>
<td>Child Developmental Service Agency</td>
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<tr>
<td>CDW</td>
<td>Client Data Warehouse</td>
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<tr>
<td>CFAC</td>
<td>Consumer and Family Advisory Committee</td>
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<tr>
<td>CFS</td>
<td>Child and Family Services</td>
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<td>CFT</td>
<td>Child and Family Team</td>
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<tr>
<td>CG</td>
<td>Community Guide</td>
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<tr>
<td>CHAMPUS</td>
<td>Civilian Health and Medical Program of the Uniformed Services</td>
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<tr>
<td>CHIP</td>
<td>Children’s Health Insurance Program</td>
</tr>
<tr>
<td>CIT</td>
<td>Crisis Intervention Team (Law Enforcement &amp; Fire/Police)</td>
</tr>
<tr>
<td>CM</td>
<td>Care Management</td>
</tr>
<tr>
<td>CMH</td>
<td>Child Mental Health</td>
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<tr>
<td>CMHREF</td>
<td>Child MH/SA Referral Number (Medicaid clients only)</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid (formerly HCFA)</td>
</tr>
<tr>
<td>CMSED</td>
<td>Child Mental Health Severely Emotionally Disturbed</td>
</tr>
<tr>
<td>COA</td>
<td>Council on Accreditation</td>
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<tr>
<td>COB</td>
<td>Coordination of Benefits</td>
</tr>
<tr>
<td>COBRA</td>
<td>Consolidated Omnibus Budget and Reconciliation Act</td>
</tr>
<tr>
<td>CPS</td>
<td>Child Protective Services</td>
</tr>
<tr>
<td>CPT</td>
<td>Current Procedural Terminology (Reimbursement Codes)</td>
</tr>
<tr>
<td>CQI</td>
<td>Continuous Quality Improvement</td>
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<tr>
<td>CQL</td>
<td>Council on Quality and Leadership</td>
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<tr>
<td>CRA</td>
<td>Community Reinforcement Approach</td>
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<tr>
<td>CRE</td>
<td>Case Responsible Entity</td>
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<tr>
<td>CRH</td>
<td>Central Regional Hospital</td>
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<tr>
<td>CRIPA</td>
<td>Civil Rights of Institutionalized Persons Act</td>
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<tr>
<td>CSA</td>
<td>Child Substance Abuse</td>
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<tr>
<td>CSAP</td>
<td>Center for Substance Abuse Prevention (federal)</td>
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<tr>
<td>CST</td>
<td>Community Support Team</td>
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<tr>
<td>CSU</td>
<td>Crisis Stabilization Unit</td>
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<tr>
<td>CT</td>
<td>Cognitive Therapy</td>
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<tr>
<td>D.A.</td>
<td>Diagnostic Assessment</td>
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<tr>
<td>DBA</td>
<td>Doing Business As</td>
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<tr>
<td>DBT</td>
<td>Dialectical Behavioral Therapy</td>
</tr>
<tr>
<td>DCI</td>
<td>Description of Clinical Issues (form)</td>
</tr>
<tr>
<td>DD</td>
<td>Developmental Disability/Developmentally Delayed</td>
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<tr>
<td>DDE</td>
<td>Direct Data Entry (for claims)</td>
</tr>
<tr>
<td>DDS</td>
<td>Disability Determination Services</td>
</tr>
<tr>
<td>DEC</td>
<td>Developmental Evaluation Center</td>
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<tr>
<td>DENR</td>
<td>Department of Environment and Natural Resources</td>
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<tr>
<td>DHHS</td>
<td>Department of Health and Human Services</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>DHSR</td>
<td>Division of Health Services Regulation</td>
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<td>DJJ</td>
<td>Division of Juvenile Justice</td>
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<tr>
<td>DHB</td>
<td>Division of Health Benefits</td>
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<tr>
<td>DME</td>
<td>Durable Medical Equipment</td>
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<tr>
<td>DMH/DD/SAS</td>
<td>Division of Mental Health/Developmental Disabilities/Substance Abuse Services</td>
</tr>
<tr>
<td>DOB</td>
<td>Date of Birth</td>
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<tr>
<td>DOC</td>
<td>Department of Corrections</td>
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<tr>
<td>DOE</td>
<td>Department of Education</td>
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<tr>
<td>DOJ</td>
<td>Department of Justice</td>
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<tr>
<td>DOS</td>
<td>Date of Service</td>
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<tr>
<td>DPI</td>
<td>Department of Public Instruction</td>
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<tr>
<td>DPS</td>
<td>Department of Public Safety</td>
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<tr>
<td>DSB</td>
<td>Division of Services for the Blind</td>
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<tr>
<td>DSDBHH</td>
<td>Division of Services for the Deaf and Hard of Hearing</td>
</tr>
<tr>
<td>DSM-V</td>
<td>Diagnostic and Statistical Manual of Mental Disorders</td>
</tr>
<tr>
<td>DSS</td>
<td>(County) Department of Social Services</td>
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<tr>
<td>DWI</td>
<td>Driving While Impaired</td>
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<tr>
<td>Dx</td>
<td>Diagnosis</td>
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<tr>
<td>EBD</td>
<td>Emotionally/Behaviorally Disturbed</td>
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<tr>
<td>EBP</td>
<td>Evidence-Based Practice</td>
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<tr>
<td>ECAC</td>
<td>Exceptional Children’s Assistance Center</td>
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<tr>
<td>ECI</td>
<td>Early Childhood Intervention</td>
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<tr>
<td>ECS</td>
<td>Electronic Claims Submission</td>
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<tr>
<td>ED</td>
<td>Emergency Department</td>
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<td>EDI</td>
<td>Electronic Data Interchange</td>
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<tr>
<td>EHA</td>
<td>Education for All Handicapped Children Act</td>
</tr>
<tr>
<td>ELP</td>
<td>Essential Lifestyle Plan</td>
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<tr>
<td>ELT</td>
<td>Executive Leadership Team</td>
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<tr>
<td>EMR</td>
<td>Electronic Medical Record</td>
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<tr>
<td>EMATLA</td>
<td>Emergency Medical Treatment Active Labor Act</td>
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<tr>
<td>EOB</td>
<td>Explanation of Benefits</td>
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<td>EPSDT</td>
<td>Early and Periodic Screening, Diagnosis and Treatment</td>
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<td>ES</td>
<td>Emergency Services</td>
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<tr>
<td>FASD</td>
<td>Fetal Alcohol Spectrum Disorder</td>
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<tr>
<td>F&amp;CS</td>
<td>Family and Children's Services</td>
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<tr>
<td>FC</td>
<td>Foster Care</td>
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<td>FCH</td>
<td>Foster Care Home</td>
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<td>FDA</td>
<td>Food and Drug Administration</td>
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<tr>
<td>FEM</td>
<td>Frequency and Extent of Monitoring</td>
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<tr>
<td>FNS</td>
<td>Food and Nutrition Services</td>
</tr>
<tr>
<td>FPL</td>
<td>Federal Poverty Level</td>
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<td>J/K</td>
<td>Description</td>
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<tr>
<td>JCAHO</td>
<td>The Joint Commission, formerly known as Joint Commission on Accreditation of Health Care Organizations</td>
</tr>
<tr>
<td>JCC</td>
<td>Juvenile Court Counselor</td>
</tr>
<tr>
<td>JCPC</td>
<td>Juvenile Crime Prevention Council</td>
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<tr>
<td>JDC</td>
<td>Juvenile Detention Center</td>
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<tr>
<td>JJSAMHP</td>
<td>Juvenile Justice Substance Abuse/Mental Health Partnership</td>
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<tr>
<td>JOBS</td>
<td>Job Opportunities and Basic Skills Program</td>
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<tr>
<td>JTPA</td>
<td>Job Training Partnership Act</td>
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<tr>
<th>L</th>
<th>Description</th>
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<tbody>
<tr>
<td>LCAS</td>
<td>Licensed Clinical Addictions Specialist</td>
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<td>LCSW</td>
<td>Licensed Clinical Social Worker</td>
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<td>LEA</td>
<td>Local Education Agency</td>
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<td>LIAD</td>
<td>LME Individual Admission and Discharge (form)</td>
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<td>LME</td>
<td>Local Management Entity</td>
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<td>LMFT</td>
<td>Licensed Marriage and Family Therapist</td>
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<tr>
<td>LOC</td>
<td>Level of Care</td>
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<tr>
<td>LOCUS</td>
<td>Level of Care Utilization System for Psychiatric Services</td>
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<tr>
<td>LON</td>
<td>Letter of Notification</td>
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<td>LP</td>
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<tr>
<td>LPA</td>
<td>Licensed Professional Associate</td>
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<td>LPC</td>
<td>Licensed Professional Counselor</td>
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<th>M</th>
<th>Description</th>
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<tbody>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
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<tr>
<td>MCM</td>
<td>Mobile Crisis Management</td>
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<td>MFP</td>
<td>Money Follows the Person</td>
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<td>MHBG</td>
<td>Mental Health Block Grant</td>
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<td>MI</td>
<td>Motivational Interviewing</td>
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<td>MOE</td>
<td>Maintenance of Effort</td>
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<td>MST</td>
<td>Multi-systemic Therapy</td>
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<td>MCO</td>
<td>Managed Care Organization</td>
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<td>Mental Health</td>
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<td>MID</td>
<td>Medicaid Identification Number</td>
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<td>MOU</td>
<td>Memorandum of Understanding</td>
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<td>MRA</td>
<td>Maximum Reimbursable Amount</td>
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<td>MRR</td>
<td>Medicaid Reimbursement Rate</td>
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<td>MSW</td>
<td>Master of Social Work</td>
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<tr>
<th>N</th>
<th>Description</th>
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<tbody>
<tr>
<td>NA</td>
<td>Narcotics Anonymous</td>
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<td>NAMI</td>
<td>National Alliance on Mental Illness</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>NCAC</td>
<td>North Carolina Administrative Code</td>
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<tr>
<td>NCBLPC</td>
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<td>TEACCH</td>
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APPENDIX C: EXAMPLE OF MEDICAID CARD
APPENDIX D: NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date of This Notice: September 23, 2013

Alliance Health ("Alliance") is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this Notice or if you want more information about the privacy practices at Alliance Health, please contact the Privacy Officer at (800) 510-9132 or at 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560.

Understanding Your Medical Record/Health Information

Each time you visit a healthcare Provider, a record of your visit is made. Typically, this record contains your symptoms, assessment, diagnosis, treatment plan, and treatment recommendations. These records may also disclose or reveal that you are a recipient of public welfare benefits. This Protected Health Information (PHI), often referred to as your medical record, serves as a basis for planning your treatment, a means to communicate between service Providers involved in your care, as a legal document describing your care and services, and verification for you and/or a third party payer that the services billed were provided to you. It can also be used as a source of data to assure that we are continuously monitoring the quality of services and measuring outcomes. Understanding what is in your medical record and how, when and why we use the information helps you make informed decisions when authorizing disclosure to others. Your health information will not be disclosed without your authorization unless required or allowed by State and Federal laws, rules or regulations.

Our Responsibilities

Alliance must protect and secure health information that we have created or received about your past, present, or future health condition, health care we provide to you, or payment for your health care. We are only allowed to use and disclose protected health information in the manner described in this Notice. This Notice is posted on our website and we will provide you a paper copy of this Notice upon your request.

How Alliance Health May Use or Disclose Your Health Information

The following categories describe ways that Alliance may use or disclose your health information. Any use or disclosure of your health information will be limited to the minimum information necessary to carry out the purpose of the use or disclosure. For each category of uses and disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.
Note that we can only use or disclose alcohol and drug abuse records with your consent or as specifically permitted under federal law. These exceptions are listed on the next page.

**Payment Functions** – We may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care Providers, determine plan responsibility for benefits, and to coordinate benefits. Health information may be shared with other government programs such as Medicare, Medicaid, NC Health Choice, or private insurance to manage your medical necessity of health care services, determine whether a particular treatment is experimental or investigational, or determine whether a treatment is covered under your plan.

**Healthcare Operations** – We may use and disclose health information about you to carry out necessary managed care/insurance-related activities. For example, such activities may include premium rating and other activities relating to plan coverage; conducting quality assessment and improvement activities such as handling and investigating complaints; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration.

**Treatment** – Alliance Health is not a Provider of treatment but some of our functions require that we make a referral for an assessment or perform other activities which include helping formulate a treatment plan, coordinating appropriate and effective care, treatment and services or setting up an appointment with other behavioral health and health care Providers. We may also share your health information with emergency treatment Providers when you need emergency services. We may also communicate and share information with other behavioral health service Providers who have Contracts with Alliance or governmental entities with whom we have Business Associate Agreements. These include hospitals, licensed facilities, licensed practitioners, community-based service Providers, and governmental entities such as local jails and schools. When these services are contracted, we may disclose your health information to our contractors so that they can provide you services and bill you or your third-party payer for services rendered. We require the contractor to appropriately safeguard your information. We are required to give you an opportunity to object before we are allowed to share your PHI with another HIPAA Covered Entity such as your Primary Care Physician or another type of physical health type Provider. If you wish to object to us sharing your PHI with these types of Providers, then there is a form you must sign that will be kept on file and we are required by law to honor your request.

**Required by Law** – Alliance may use and disclose your health information as required by law. Some examples where we are required by law to share limited information include but are not limited to: PHI related to your care/treatment with your next of kin, family member, or another person that is involved in your care; with organizations such as the Red Cross during an emergency; to report certain type of wounds or other physical injuries; and to the extent necessary to fulfill responsibilities when an Individual is examined or committed for inpatient treatment.
**Public Health** – Your health information may be reported to a public health authority or other appropriate government authority authorized by law to collect or receive information for purposes related to: preventing or controlling disease, injury or disability; reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

**Health Oversight Activities** – We may disclose your health information to health, regulatory and/or oversight agencies during the course of audits, investigations, inspections, licensure, and other proceedings related to oversight of the health care system. For example, health information may be reviewed by investigators, auditors, accountants or lawyers who make certain that we comply with various laws; or to audit your file to make sure that no information about you was given to someone in a way that violated this Notice.

**Judicial and Administrative Proceedings** – We may disclose your health information in response to a subpoena or court order in the course of any administrative or judicial proceeding, in the course of any administrative or judicial proceeding required by law (such as a licensure action), for payment purposes (such as a collection action), or for purposes of litigation that relates to health care operations where Alliance is a party to the proceeding.

**Public Safety/Law Enforcement** – We may disclose your health information to appropriate persons in order to prevent or lessen a serious or imminent danger or threat to the health or safety of a particular person or the general public or when there is likelihood of the commission of a felony or violent misdemeanor.

**National Security** – We may disclose your health information for military, prisoner, and national security.

**Worker’s Compensation** – We may disclose your health information as necessary to comply with worker’s compensation or similar laws.

**Marketing** – We may contact you to give you information about health-related benefits and services that may be of interest to you. If we receive compensation from a third party for providing you with the information about other products or services (other than drug refill reminders or generic drug availability), we will obtain your authorization to share information with this third party.

**Disclosures to Plan Sponsors** – We may disclose your health information to the sponsor of your group health plan, for purposes of administering benefits under the plan. If you have a group health plan, your employer is the plan sponsor.

**Research** – Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

**Applicability of More Stringent State Laws** – Some of the uses and disclosures described in this notice may be limited in certain cases by applicable State laws or rules that are more stringent than Federal laws or regulations, including disclosures related to mental health and substance abuse, intellectual/developmental disabilities, alcohol and other drug abuse (AODA), and HIV testing.
Use and Disclosure of Health Information without your Authorization

Federal laws require or allow that we share your health information, including alcohol and drug abuse records, with others in specific situations in which you do not have to give consent, authorize or have the opportunity to agree or object to the use and disclosure. Prior to disclosing your health information under one of these exceptions, we will evaluate each request to ensure that only necessary information will be disclosed. These situations include, but are not limited to the following:

- To a county Department of Social Services or law enforcement to report abuse, neglect or domestic violence; or
- To respond to a court order or subpoena; or
- To qualified personnel for research, audit, and program evaluation; or
- To a health care Provider who is providing emergency medical services; or
- To appropriate authorities if we learn that you might seriously harm another person or property (including Alliance) in the future or that you intend to commit a crime of violence or that you intend to self-harm; or
- For the purpose of internal communications, as outlined above; or
- To qualified service organization agencies when appropriate. (These agencies must agree to abide by the Federal law.)

NC-TOPPS assessments fall under the audit or evaluation exception of federal confidentiality regulations (42 CFR Part 2 and 45 CFR Parts 160 and 164). Individual identifying information obtained via NC-TOPPS may be disclosed without the Individual’s consent to the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and to authorized contractors under the audit and evaluation exception. The DMH/DD/SAS or its authorized contractors may re-disclose any individual -identifying information only to the designated provider facility and to the Individual’s assigned LME/MCO for which this information has been submitted.

When Alliance Health May Not Use or Disclose Your Protected Health Information

Except as described in this Notice, Alliance will not use or disclose your health information without written authorization from you. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose health information about you for the reasons covered by your written authorization, though we will be unable to take back any disclosures we have already made with your permission.

- Your authorization is necessary for most uses and disclosures of psychotherapy notes.
- Your authorization is necessary for any disclosures of health information in which the health plan receives compensation.
• Your authorization is necessary for most uses and disclosures of alcohol and drug abuse records (exceptions are listed above).

Statement of Your Health Information Rights

Although your health information is the physical property of Alliance, the information belongs to you. You have the right to request, in writing, certain uses and disclosures of your health information.

Right to Request Restrictions – You have the right to request a restriction on certain uses and disclosures of your health information. We are not required to agree to the restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing to the Privacy Officer at the address listed below. We will let you know if we can comply with the restriction or not.

Right to Request Confidential Communications – You have the right to receive your health information through a reasonable alternative means or at an alternate location. To request confidential communications, you must submit your request in writing to the Privacy Officer at the address listed below. We are not required to agree to your request.

Right to Inspect and Copy – You have the right to inspect and receive an electronic or paper copy of your health information that may be used to make decisions about your plan benefits. To inspect and copy information, you must submit your request in writing to the Privacy Officer at the address listed below. If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request. There are certain situations where we will be unable to grant your request to review records.

Right to Request Amendment – You have a right to request that we amend your health information that you believe is incorrect or incomplete. We are not required to change your health information and if your request is denied, we will provide you with information about our denial and how you can appeal the denial. To request an amendment, you must make your request in writing to the Privacy Officer at the address listed below. You must also provide a reason for your request.

Right to Accounting of Disclosures – You have the right to receive a list or accounting of disclosures of your health information made by us in the past six years, except that we do not have to account for disclosures made for purposes of payment functions, healthcare operations of treatment, or made by you. To request this accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address listed below. We will provide one list or accounting per 12 month period free of charge; we may charge you for additional lists or accountings. We will inform you of the cost and you may choose to withdraw or modify your request before any costs are incurred. There are certain exceptions that apply.

Right to a Copy – You have a right to receive an electronic copy of this Notice at any time. To obtain a paper copy of this Notice, send your written request to the Privacy Officer at 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560. You may also print a copy of this Notice at

**Right to be Notified of a Breach** – You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact the Privacy Officer at 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560 or by calling (800) 510-9132.

**Changes to this Notice and Distribution**

Alliance Health reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that it maintains. As your health plan, we will provide a copy of our notice upon your enrollment in the plan and will remind you at least every three years where to find our notice and how to obtain a copy of the notice if you would like to receive one. If we have more than one Notice of Privacy Practices, we will provide you with the Notice that pertains to you. The notice is provided and pertains to the named Medicaid beneficiary or other individual enrolled in the plan.

As a health plan that maintains a website describing our customer service and benefits, we also post to our website the most recent Notice of Privacy Practices which will describe how your health information may be used and disclosed as well as the rights you have to your health information. If our Notice has a material change, we will post information regarding this change to the website for you to review. In addition, following the date of the material change, we will include a description of the change that occurred and information on how to obtain a copy of the revised Notice in any annual mailing required by 42 CFR Part 438.

**Complaints**

Complaints about this Notice of Privacy practices or about how we handle your health information should be directed to the Privacy Officer at 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560 or by calling (800) 510-9132. Alliance Health will not retaliate against you in any way for filing a complaint. All complaints to Alliance Health must be submitted in writing. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services at www.hhs.gov/ocr/privacy/hipaa/complaints/ or call (800) 368-1019.

Si necesita información en español, llámenos al (800) 510-9132.
Alliance Health History of Notice of Privacy Practices

Original Approval Date: June 2012
Revised: September 23, 2013 (Removed activities including fundraising, genetic information and underwriting, research; added information to Rights to be Notified of a Breach; changes to NCTOPPS; added use or disclosure of Substance Abuse with consent or as permitted)
Revised: August 15, 2017 (Added the History of changes to the Notice of Privacy Practices)