



Utilization Management Program
Description
2025-2026

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SECTION 1. Alliance Health Utilization Management Plan

Purpose

The Alliance Health (Alliance) Utilization Management (UM) Program facilitates quality, cost-effective and medically necessary services across a continuum of care that integrates a range of services appropriate to meet the individual member need. Alliance Utilization Management plan is designed to meet the following:

- Alliance Operational Policy: *Utilization Management Program*
- 42 CFR Part 438, Subpart D
- 42 CFR Part 456
- NC Medicaid Tailored Plan Contract
- NC Medicaid Direct Contract
- DSOHF Contract
- 2025 National Committee for Quality Assurance (NCQA) Health Plan (HP) Standards

Scope of Utilization Management (UM) Plan

The scope of the Utilization Management Program consists of a range of processes associated with utilization management. These processes include review of relevant UM metrics, data, and actions taken because of the review including development of projects as deemed appropriate. Alliance Health covers behavioral health, medical, and pharmacy services for members with North Carolina Medicaid in designated counties. Behavioral Health, Substance Use, and services for Intellectual and Developmental Disabilities are provided through Medicaid Direct program for those not in Medicaid managed care, and State-funded program for those who are uninsured. Utilization Management activities are designed to assist the practitioner with the organization and delivery of appropriate health care services to members and recipients. Alliance promotes integration of behavioral health, medical, and pharmacy services to provide a holistic approach to meeting members' needs.

SECTION 2. Objectives/Goals

Objectives

Alliance's Utilization Management program is designed to achieve optimal outcomes for members and recipients served while utilizing healthcare resources in a cost-effective manner.

The UM Program objectives are to:

- Ensure the delivery of quality, medically necessary and appropriate health care services including ambulatory care, inpatient care, and alternative care settings, both in-and out-of-network.
- Promote continuity and coordination of care among physical and behavioral healthcare practitioners.

- Promote the delivery of care and services in a culturally competent manner within the context of members' cultural beliefs, behaviors, practices, disabilities and language preferences.
- Maintain compliance with local, state, and federal requirements, as well as accreditation bodies (e.g., NCQA).
- Adopt objective and evidence-based guidelines, protocols, and criteria that support appropriate clinical decision-making.
- Assure clinical quality practices and outcomes are attained.
- Analyze claims and UM data to identify over, under and mis-utilization.
- Enhance member satisfaction with the UM process by ensuring member's continuity of health care services when needed through timely determination of requests received.
- Enhance provider satisfaction by improving the Alliance and practitioner relationships through increased Medical Director or delegate involvement and peer-to-peer conversations.
- Define the program scope and process to determine benefit coverage and medical necessity.
- Protect personal health information of all members and abide by Health Insurance Portability and Accountability Act (HIPAA) regulations.

Goals

Goal 1. Establish and maintain Alliance Health policies and procedures (P&P) in compliance with contractual obligations that govern all aspects of the UM Program. Policies and procedures will meet North Carolina Medicaid Direct, Tailored Plan and NCQA standards.

Goal 2. Maintain consistent and effective clinical review process as evidence of Inter-Rater Reliability testing.

Goal 3. Promote use of appropriate, medically necessary services in the most cost-effective manner necessary to meet the needs of the Members and Recipients served. Ensure services are consistent with the diagnosis, Level of Care needed, and in consideration of comorbidities and the availability of services in network.

SECTION 3. Organizational Structure and Staff Qualifications

The scope of the UM program covers behavioral and physical health clinical aspects of services. As such, multiple departments including Medical Management, Utilization Management and Care Management work together to achieve the objectives and goals of the UM Plan. Below are key staff responsible for leading initiatives and interventions designed to achieve optimal outcomes for the members and recipients we serve.

Although not all staff listed below are within the same organizational unit, all are key personnel responsible for carrying out the Utilization Management Plan. Additional organizational units, such as Provider Network, Quality Management, Care Management, and Finance contribute a great deal to the success of the UM Plan.

Medical Management Team

Chief Medical Officer

The Chief Medical Officer (CMO) reports to the Chief Executive Officer and is responsible for the oversight and supervision of clinical care within the organization. Direct supervisory oversight includes but is not limited to Utilization Management, Medical Management, and Quality Management. Clinical oversight is provided to the Care Management and Member and Recipient Services departments. The CMO approves the Alliance Benefit plan and must approve any changes. The CMO serves as a member of the Utilization Management Committee as well as chair of the Continuous Quality Improvement (CQI) Committee. Final authority to approve all utilization review criteria and Clinical Guidelines that are used for the medical necessity determination process rests with the CMO. In addition to approval of clinical criteria, the CMO ensures the consistent application of these criteria through oversight and leadership of the inter-rater reliability study. The Chief Medical Officer oversees and is responsible for all clinical activities, including but not limited to proper provision of covered services, developing clinical practice standards and clinical policy and procedures. This position requires North Carolina residence, physician licensed to practice in NC and in good standing with a minimum experience of five (5) years in a health clinical setting and five (5) years' experience in managed care.

Deputy Chief Medical Officer

The Deputy Chief Medical Officer (DCMO) reports to the Chief Medical Officer. Generally, the DCMO oversees and is responsible for supporting the CMO in ensuring the proper provision of services and ensuring an integrated approach to the physical and behavioral health of members and recipients, including those with I/DD and TBI needs. The DCMO applies evidence-based criteria in their oversight of physical health UM, CM, Network, and QM staff. In addition, the DCMO provides clinical oversight to the organization, including UM, CM, Access, Care Coordination, Network, and QM staff; oversees the development of evidence-based clinical best practices, policies, and procedures; and provides consultation to management and staff regarding clinical standards, policies, procedures, best practices, recovery, and resiliency. Further, the DCMO provides clinical supervision to clinical staff focusing on medical necessity, appropriate medical practice, etc., including peer review for UM, appeals, and case escalation consultation for CM. Additionally, the DCMO conducts analyses to identify service trends and patterns indicative of inappropriate, unreasonable, or medically unnecessary care and ensures proper provision of covered Medicaid and State-funded services to members and recipients while maintaining efficient operations for quality of care and Alliance's financial goals.

Medical Director – Behavioral Health

The Medical Director Behavioral Health reports to the Deputy Chief Medical Officer (DCMO). Medical Directors- Behavioral Health are required to be licensed by the North Carolina Medical Board and are board-eligible or board certified in adult psychiatry, child psychiatry, or addiction medicine. The AMD possesses at least five (5) years of progressive medical and management experience. Medical Directors are primarily responsible for providing clinical peer reviews for prior authorization requests that cannot be approved by Utilization Management Clinicians and have the authority to clinically deny or reduce services that do not meet medical necessity. Medical Directors also have the authority to approve or deny ICF Level of Care for individuals entering into an ICF IID facility or Medicaid C waiver(s). They also provide clinical support in the form of training, targeted case consultation and case escalation to the UM Clinical Specialists and Care Team members. As licensed psychiatrists, the medical directors offer feedback related to the development of the behavioral health program. In addition, as part of the appeals

process followed by Alliance Health, medical directors are also responsible for completion of review of appeal requests.

I/DD Clinical Director

The I/DD Clinical Director reports to the Deputy Chief Medical Officer (DCMO). This position oversees and is responsible for all I/DD and TBI clinical activities, including but not limited to the proper provision of covered Medicaid, State-funded, and Innovations and TBI waiver services to members and recipients. The I/DD Clinical Director is responsible for developing clinical practice standards, clinical policies and procedures, utilization management, pharmacy, population health, care management, and quality management of I/DD and TBI benefits. Responsibilities also include integration of I/DD and TBI benefits with physical health and behavioral health benefits. The position must be a doctorate-level clinical psychologist, developmental pediatrician, or psychiatrist with appropriate expertise in I/DD and or /TBI and requires a minimum of seven (7) years of utilization review, and/or habilitative and case management experience in I/DD care. Clinical decision-making authority includes peer review level medical necessity determinations. This professional also offers clinical support and guidance in the form of training, consultation, targeted case consultation, and case escalation participation to the UM Clinical Specialists. The I/DD Clinical Director also completes review for I/DD eligibility for Innovations waiver or when the individual's complex needs warrant clinical recommendations.

Senior Psychologist

The Senior Psychologist reports to the I/DD Clinical Director and has the authority to complete peer review medical necessity determinations for services ordered or requested by non-physicians or other licensed prescribers (Nurse Practitioner, Physician Assistant, Osteopathic Doctor). The position requires a doctoral degree in psychology and two (2) years of experience. In addition to peer review activities, the Senior Psychologist provides case consultation to the Alliance Care Teams and case targeted case consultation with UM Clinical Specialists. The Senior Psychologist may also be elisted to consult on I/DD eligibility reviews (third level) by the Clinical Diresctor I/DD/TBI and to provide consultation when the individual's complex needs warrant clinical recommendations. The Senior Psychologist assists in the development and implementation of the Behavioral Health Program, with particular focus on review of I/DD services.

Senior Medical Director-Physical Health

The UM Medical Director-Physical Health reports to the Chief Medical Officer and serves as co-chair and a voting member of the Utilization Management Committee. The UM Medical Director-Physical Health is required to be licensed by the North Carolina Medical Board and is board-eligible or board certified in either adult internal or family medicine. The UM Medical Director-Physical Health possesses at least four (4) years of postgraduate clinical experience and two (2) or more years of managed care and utilization management experience. The UM Medical Director-Physical Health will direct, lead and provide professional oversight for medical management activities related to utilization management, case management, disease management, and quality management activities.

Medical Director – Physical Health

The Physical Health Medical Directors report to the Senior Director Medical Director-Physical Health. They are required to be licensed by the North Carolina Medical Board and are board-eligible or board certified in either adult family/internal/pediatric medicine, or other sub-specialties as needed. The AMD possesses at least four (4) years of postgraduate clinical experience and management experience. The

Associate Medical Directors are primarily responsible for providing clinical peer reviews for prior authorization requests that cannot be approved by Utilization Management Clinical Specialists and have the authority to clinically deny or reduce services that do not meet medical necessity. They also provide clinical support in the form of training colleagues and physical health education.

Pharmacy Director

The Pharmacy Director reports to the Chief Medical Officer and oversees and manages the Tailored Plan pharmacy benefits. The Pharmacy Director develops and implements pharmacy benefit management policies, procedures, and standards. The Pharmacy Director possesses a minimum of three (3) working years of Medicaid pharmacy benefits management experience and must be a North Carolina registered pharmacist with a current NC pharmacist license. Clinical decision-making authority is limited to first level review for Pharmacy services.

Pharmacist

The pharmacist reports to the Pharmacy Director and provides education, consultation, and support to UM Supervisors, UM Clinical Specialists, and Alliance Care teams in regard to pharmacology, psychopharmacology, and complex pharmacy issues. The Pharmacist reviews pharmacy utilization patterns and provides education and outreach to network providers. Through data review, the Pharmacist identifies areas of individual safety and risk resulting from network prescribing patterns and assists in the development of an intervention plan. This includes the use of benzodiazepines and opiates. The Pharmacist provides general pharmacy and state formulary updates and warnings to network providers. The Pharmacist also educates on best practice prescribing and informs Alliance activities in this area as well as overdose prevention. The position requires a Doctor of Pharmacy from an accredited College of Pharmacy, licensure by the North Carolina Board of Pharmacy and two (2) years of experience. Clinical decision-making authority is limited to first level review for Pharmacy services.

Utilization Management Team

Senior Vice President of Utilization Management

The Senior Vice President (SVP) of Utilization Management serves as a non-voting member of the Utilization Management Committee. This position reports to the Chief Medical Officer. In conjunction with the Chief Medical Officer, the Senior Vice President of UM develops and employs strategies to detect and manage under, over and mis-utilization of clinical services. This position requires a master's degree in a human service-related field, full licensure as a clinician by the relevant professional board, and a minimum of five (5) years of demonstrated utilization review and management experience in physical health, behavioral health, and I/DD benefits. Post-degree experience in Utilization Management, including two (2) years in a supervisory or consultative capacity is required. Clinical decision-making authority is limited to oversight of first level review approvals and may not render clinical adverse decisions.

Senior Director of Utilization Management

The Senior Director of UM reports to the Senior Vice President (SVP) of Utilization Management and oversees the Utilization Management department of the BH/IDD Tailored Plan related to service lines

including Physical Health (PH), Behavioral Health (BH), Long -Term Support Services and Supports (LTSS), and Grievance and Appeals. The Senior Director of Utilization Management serves as a voting member of the Utilization Management Committee. The position is responsible for overseeing a core component of the BH/IDD Tailored Plan that ensures that individuals receive the correct level and intensity of services that results in positive outcomes. This role also works to maintain a highly qualified staff, develops BH/PH short and long-term departmental goals, ensures departmental budget and expenses remain within the established annual budget, develops and implements policies and procedures, and communicates with internal and external stakeholders. Clinical decision-making authority is limited to oversight of first level review approvals and may not render clinical adverse decisions.

Utilization Management Director – Physical Health

The Utilization Management Director – Physical Health reports to the Senior Director of Utilization Management and is responsible for the day-to-day management of the UM Department which, in turn, is responsible for medical necessity determinations. The UM Director - PH position requires a master's degree in nursing and five (5) years' experience or a bachelor's in nursing with seven (7) years' experience. At least two (2) years supervisory experience and two (2) years utilization management experience or substantial equivalent. The UM Director – Physical Health ensures the following: a) the UM department functions within all requirements set forth within Alliance policies and procedures and the NC Division of Health Benefits Waiver contract and NCQA UM standards; b) the UM department has systems and processes in place to ensure the effective use of Medicaid, and non-Medicaid service and in collaboration with other clinical department directors; c) effective communication and data sharing strategies are implemented to rapidly identify high risk individuals across the six county region and link with care management; and d) has day-to-day organizational oversight of assigned UM delegates for physical health. The UM Director – Physical Health serves in a consultative role to the appeals process and may complete Office of Administrative Hearings (OAH) level mediations. Clinical decision-making authority is limited to oversight of first level review approvals and may not render clinical adverse decisions.

Utilization Management Supervisor – Physical Health

The UM Supervisor – Physical Health reports to the UM Director – Physical Health. The Utilization Management Supervisor- Physical Health manages and supports the service review process for physical health service delivery through the UM Department. The UM Supervisor position requires an associate degree with five (5) years' experience or a bachelor's degree with three (3) years' experience in Managed Care. The supervisor ensures UM Clinical Specialists are appropriately trained and that UM Clinical Specialists complete medical necessity review within required timeframes and with consistent application of utilization review criteria. The supervisor provides direct supervision of UM Clinical Specialists - PH, staffs complex cases and routinely reviews documentation related to medical necessity determinations. It is the responsibility of the UM Supervisor – Physical Health to consult with MHSUD UM Supervisors to ensure an integrated management of services. UM Supervisor - Physical Health may serve in a consultative role to the appeals process including OAH level mediations. Clinical decision-making authority is limited to oversight of first level review approvals and may not render clinical adverse decisions.

Utilization Management Clinical Specialist – Physical Health

The UM Clinical Specialist - PH reports to the UM Management Supervisor – PH and is primarily responsible for reviewing routine and urgent physical health prior authorization requests and approving services where medical necessity is met. It is the responsibility of the UM Clinical Specialist – PH to

collaborate and consult with other UM clinicians reviewing for behavioral health services to ensure integrated management of services. The position requires an associate or bachelor's degree in nursing. The UM Clinical Specialist – PH review prior authorization requests against approved criteria and Clinical Guidelines and help ensure the effective provision of treatment. UM Clinical Specialist – PH clinicians may administratively deny requests based on benefit limits and when requests do not contain NC Division of Medical Assistance required elements related to prior authorization requests. Clinical decision-making authority is limited to first level review approvals and may not render clinical adverse decisions.

Utilization Management Director - Behavioral Health

The UM Director-Behavioral Health reports to the Senior Director of Utilization Management and is responsible for the day-to-day management of the UM Department which in turn is responsible for medical necessity determinations. The UM Director-Behavioral Health position requires a master's degree in a human service-related field, a license by the relevant professional board (e.g., Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Mental Health Counselor (LCMHC) or Licensed Psychologist (LP)), and a minimum of five (5) years post graduate experience. The UM Director – Behavioral Health ensures the following: a) the UM department functions within all requirements set forth within Alliance policies and procedures and the NC Division of Health Benefits Waiver contract and NCQA UM standards; b) the UM department has systems and processes in place to ensure the effective use of Medicaid and Non-Medicaid service in collaboration with other clinical department directors; and c) effective communication and data sharing strategies are implemented to rapidly identify high risk individuals across the seven county region and link with care management. UM Director – Behavioral Health serves in a consultative role to the appeals process and may complete OAH level mediations. Clinical decision-making authority is limited to oversight of first level review approvals and may not render clinical adverse decisions.

Utilization Management Supervisor- Behavioral Health

The UM Supervisors – Behavioral Health report to the UM Director – Behavioral Health. They manage and support the service review process and care management interventions delivered through the UM department. The UM Supervisor position requires a master's degree in a human service-related field, a license by the relevant professional board (e.g., Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Mental Health Counselor (LCMHC), Licensed Clinical Addiction Specialist (LCAS), Licensed Psychologist (LP), or Licensed Psychological Associate (LPA)), and five (5) years post graduate experience. The supervisors ensure UM Clinical Specialists are appropriately trained in the Alliance care management system and that UM Clinical Specialists complete medical necessity review within required timeframes and with consistent application of utilization review criteria. The supervisors provide direct supervision of UM Clinical Specialists – BH, staff complex cases and routinely review documentation related to medical necessity determinations. It is the responsibility of the UM Supervisor - BH to consult with UM Supervisor- PH to ensure an integrated management of services. UM Supervisor - BH may serve in a consultative role to the appeals process including OAH level mediations. Clinical decision-making authority is limited to oversight of first level review approvals and may not render clinical adverse decisions.

Senior UM Clinical Specialist – Behavioral Health

The Senior UM Clinical Specialist- Behavioral Health reports to the UM Director- Behavioral Health. The Senior UM Clinical Specialist- Behavioral Health manages complex projects requiring short-term clinical oversight. Projects would include, but not limited to, management of consumer transfers when a provider agency is no longer in business, coordinating authorization transfers when a provider changes

sites or is no longer in the network, management and tracking of Out-of-Network requests, Transition of Care, utilization reviews and active care management to ensure economical and clinically effective consumer service delivery by providers. The position will also complete medical necessity reviews as necessary to support the team, ensuring reviews of service plans to ensure that members receive services in the least restrictive, most integrated setting appropriate to the individuals' needs. Position requires a master's degree in a human service-related field and a license by the relevant professional board (e.g., Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Mental Health Counselor (LCMHC), Licensed Clinical Addiction Specialist (LCAS), Licensed Psychologist (LP), or Licensed Psychological Associate (LPA), and five (5) years post graduate experience. The Senior UM Clinical Specialist- Behavioral Health reviews prior authorization requests against approved criteria and Clinical Guidelines and help ensure the effective provision of treatment, and may administratively deny requests when requests do not contain NC Division of Medical Assistance required elements related to prior authorization. Clinical decision-making authority is limited to first level review approvals and may not render clinical adverse decisions.

UM Clinical Specialist – Behavioral Health

The UM Clinical Specialist – Behavioral Health reports to the UM Supervisor – BH and is primarily responsible for reviewing routine and urgent behavioral health and substance use prior authorization requests and approving services where medical necessity is met. Additionally, these positions collaborate and provide care management interventions beyond individual care that they authorize. It is the responsibility of the UM Clinical Specialist – BH to collaborate and consult with UM Clinical Specialist - PH clinicians reviewing for physical health to ensure integrated management of services. The position requires a master's degree in a human service-related field, a license by the relevant professional (e.g., Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Mental Health Counselor (LCMHC), Licensed Clinical Addiction Specialist (LCAS), Licensed Psychologist (LP), Licensed Psychological Associate (LPA), Registered Nurse (RN)), and five (5) years clinical experience. The UM Clinical Specialist – BH review prior authorization requests against approved criteria and Clinical Guidelines and help ensure the effective provision of treatment. UM Clinical Specialist – BH may administratively deny requests when requests do not contain NC Division of Medical Assistance required elements related to prior authorization. Clinical decision-making authority is limited to first level review approvals and may not render clinical adverse decisions.

Utilization Management Supervisor - LTSS

The UM Supervisor - LTSS reports to the UM Director – Behavioral Health and provides direct supervision to UM Clinical Specialist – LTSS. The UM Supervisor - LTSS position requires a bachelor's degree in a Human Services related field and four (4) years of experience. These reviewers are considered Qualified Developmental Disability Professionals (QDDPs). The UM Supervisor - LTSS ensures the service reviews of individuals on the Innovations/Traumatic Brain Injury (TBI) waivers are completed in accordance with federal, NC Division of Health Benefits (DHB) and NCQA standards. He/she reviews initial Individualized Service Plans for individuals new to Innovations and ensure cases are evenly distributed among UM Clinical Specialist - LTSS. This position provides training to new UM Clinical Specialists - LTSS and helps facilitate communications with IDD Care Management. The UM Supervisor - LTSS serves in a consultative role to the appeals process and engages in OAH level mediations for Medicaid C wavier services. Clinical decision-making authority is limited to oversight of first level review for Intermediate Care Facilities (ICF) and Innovations/TBI and Medicaid C waiver approvals and may not render clinical adverse decisions.

Utilization Management Clinical Specialists - LTSS

The UM Clinical Specialists - LTSS report to the UM Supervisor - LTSS and are responsible for the review of annual and updated Individualized Services Plans and service budgets for individuals who have been determined eligible for Innovations or TBI Waiver services. UM Clinical Specialists – LTSS hold a minimum of a bachelor's degree in a human service-related field and four (4) years of experience. UM Clinical Specialists – LTSS do not make Medical Necessity determinations. They review requests to ensure that services are authorized within the parameters and guidelines set forth in the Innovations or TBI Waiver. Any plans submitted which do not meet requirements set forth in the Innovations or TBI Waiver are promoted to peer review. UM Clinical Specialists – LTSS also provide active care management based on their review of service utilization. Clinical decision-making authority is limited to first level review for Medicaid C waiver approvals and may not render clinical adverse decisions.

Director - Utilization Management Program Management

The Director of UM Program Management reports to the Senior Director of UM and oversees the development of internal and external processes, departmental reports and the delivery of data as needed to support and monitor the action plans to accomplish Key Performance Indicators (KPI) and goals of the UM Program Description. The Director of UM Program Management is responsible for providing oversight to the processes of identifying, managing, and tracking UM clinical operations, technology, quality, and regulatory projects that advance the objectives of Alliances strategic goals. This role additionally provides oversight of the clinical education and training programs within UM. The UM Director-Behavioral Health position requires a bachelor's degree in nursing or a master's degree in human services, Public Health, Hospital Administration, or related field and an active clinical license and a minimum of five (7) years of managed care, hospital, or medical group experience, focusing on quality improvement, utilization management, or clinical operations, including five (5) years of consulting, management or leadership experience.

UM Clinical Trainer

The UM Clinical Trainer reports to the Director of UM Program Management and is responsible for delivering comprehensive onboarding and ongoing training and auditing of process for the clinical team. The UM Clinical Trainer will contribute to the development of clinical content, training plans, training program evaluations, and ongoing education materials. The UM Clinical Trainer will work closely with the UM leadership to advise on additional training to help UM staff be successful in their role. The Clinical Trainer's primary objective is to ensure that clinical staff are proficient in utilizing healthcare systems, tools, and procedures to enhance patient care, streamline workflows, and maintain compliance with industry standards. This position requires a bachelor's degree in nursing or master's degree in healthcare administration, Education or related field; and five (5) years' experience in a clinical setting or health plan with a valid NC clinical license.

Clinical Informatics Specialist

The Clinical Informatics Specialist reports to the Director of UM Program Management and plays a crucial role at the intersection of healthcare and information technology. This role will be responsible for bridging the gap between the utilization management staff and information technology. The primary responsibility is to optimize the use of technology and data to enhance workflow efficiency, ensure compliance for both internal and external utilization teams and support clinical decision-making. The role involves analyzing, assisting with the design, implementing, and optimizing health information systems to ensure they meet the clinical and operational needs of the organization. This position requires a bachelor's

degree in nursing or master's degree in medicine, healthcare informatics, or related field; and five (5) years' experience in a healthcare administration, clinical informatics, with a valid NC clinical license.

Supervisor – Administrative Clinical Support

The Supervisor-Administrative Clinical Support reports to the UM Director- Physical Health and provides direct oversight of all Administrative Clinical Support Specialist staff. This role provides management of staff performing non-clinical duties and assists in the development and implementation of workflows, training, and coaching of the administrative team. This position requires sound knowledge of Utilization Management processes from a non-clinical perspective and exceptional leadership abilities. The UM Supervisor - may represent the unit in cross agency collaborative needs.

Administrative Clinical Support Specialist

The Administrative Clinical Support Specialist reports to the Supervisor – Administrative Clinical Support and serves in an administrative function in the coordination of reviews and transfer of clinical information without interpretation of clinical documentation. This role also performs administrative function in the management of the UM committee meetings, minutes, scheduling of meetings, preparation of adverse benefit determination letters, and additional administrative tasks. No clinical decision-making authority is permitted with this position.

Appeals, Grievances and Incidents

Incidents, Grievance and Appeals Director

The Director of Incidents, Grievances and Appeals reports to the Senior Director of Utilization Management. The position oversees all Appeals functions including Behavioral Health and Physical Health appeals. In addition to supervising the Appeals staff, responsibilities of this position include ensuring the Due Process rights of all members are honored during the Appeals resolution process. Additionally, the director collaborates with delegates and vendors to ensure the appeals resolution process is seamless for members. The position requires a master's degree in a human service field and 5 years of administrative or consultative experience in human services programs and five (5) years of management/supervisory experience in Quality Management, Compliance or a comparable field.

Appeals Supervisor

The Appeals Supervisor reports to the Incidents, Grievance and Appeals Director and has direct responsibility for the supervision of Appeals Specialists and daily appeals functions. The position requires a bachelor's degree in a Human Services, Public Health, Healthcare or related field and five (5) years' experience in MH/SUD/IDD service provision or grievance and appeals investigations.

Appeals Analyst – Behavioral Health

The Behavioral Health Appeals Analyst prepares and ensures timely resolution of Behavioral Health appeals. The analyst communicates with appellants to provide information on the Appeals process and to ensure members' Due Process rights are honored throughout the process. The analyst collaborates with the Medical and Legal teams to ensure review materials are formatted and available for prompt review for all 1st (Plan Level) and 2nd (State Fair Hearing) level appeals. The position requires a bachelor's degree with a major in Mental Health, Public Health, Psychology, Sociology, or related field and three (3) years working in in a Human Service/Behavioral Health field.

Appeals Nurse

The Appeals Nurse is responsible for triaging member appeals related to Adverse Benefit Determinations of Physical Health and Pharmacy service requests. The position ensures clinical information related to appeals is directed to the appropriate physician to be reviewed based on medical necessity. The position requires graduation from an accredited nursing school and three (3) years of healthcare experience. The Appeals Nurse must be licensed in North Carolina as a Registered Nurse (RN).

SECTION 4. UM Program Functions

Overview

The Alliance Utilization Management Operating Policies and Procedures serve as the foundation for the operations of the UM department and outline processes, protocols and procedures ranging from receiving requests for services to processing individual appeals. The Alliance UM department actively works to identify service gaps, communicate best practice recommendations and monitor for member-level over, under, and mis-utilization of services. They routinely contact providers to discuss treatment progression and concerns, request additional supporting documentation, consult with the requesting provider, request that providers convene treatment teams, recommend referrals to alternative level of care and follow-up on recommendations, consult with internal medical staff, and use case staffing, targeted case consultation or case escalation when clinical cases of concern are identified.

Key aspects and interfaces of the UM Program include the following:

- Medical Necessity and Non-Medical Necessity Review Decisions
- Prospective, Concurrent, and Retrospective Review Decisions
- Second Medical Option
- UM Timeliness Reports
- Adverse Determinations and Appeals
- Inter-Rater Reliability (IRR) and Performance Monitoring
- Integration and Collaboration with other Operational units
- Delegated UM Services
- Annual Program Evaluation

Delegated UM Services

Alliance delegates specific Utilization Management (UM) program functions to qualified entities that demonstrate compliance with Alliance's established UM delegation standards. These standards are detailed in our formal policies and procedures. Alliance maintains continuous oversight and conducts annual reviews of each delegate's UM Program performance. Delegation decisions are based on the entity's ability to meet these standards consistently.. Alliance conducts ongoing oversight and annual review of each delegate's UM Program. Delegation is dependent upon the following factors:

- Successful completion of a pre-delegation audit to determine the ability to accept delegation.
- Once determined capable of fulfilling the responsibilities of delegation, a delegation agreement is executed with the organization to which the UM activities have been delegated, clarifying the responsibilities of the delegated group and Alliance. The agreement also specifies reporting requirements, and the standards of performance to which the delegated entity has agreed.
- The delegated entity must conform to Alliance's UM standards including timeframes.

- The delegated entity is responsible for providing Alliance with a written UM Program description/plan for annual review and approval.
- The delegated entity is responsible for submitting utilization reports, to include monthly turn-around time reports.

Alliance retains accountability for all UM Program functions and services delegated. Oversight plan for the delegated entities include:

- Annual approval of the delegate's UM program (or portions of the program that are delegated), as well as any significant program changes that occur in between.
- Routine reporting of key performance metrics that are required and/or developed by Alliance's Chief Medical Officer or designee.
- Regular review of delegated performance metrics and outcomes, including review of adverse determination files
- Implementation and monitoring of corrective action processes when necessary
- Evaluation of policy adherence and compliance
- Completion of annual program evaluations
- Assessment of timeliness standards for all UM activities
- Inter-rater reliability (IRR) monitoring for medical necessity decision-makers
- Thorough review of appeals processing and outcomes
- Analysis of grievance handling and resolutions
- Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to Alliance standards and state program requirements based on contract requirements

The following are Alliance's contracted delegates:

Navitus – Navitus Health Solutions, LLC is subcontracted by Alliance Health to provide delegated pharmacy benefit management services for Tailored Plan enrolled Members. Navitus will process claims, render clinical and formulary services, provide pharmacy network management services, arrange for, or provide mail service and specialty pharmacy operations, and provide Health Plan standard management and performance guarantee reports, including reporting on delegated UM functions, and certain other consultative and administrative services. In connection with these services, Navitus will evaluate the status and performance of Alliance Health's pharmacy benefit program and advise the Health Plan on a regular basis of the results of such evaluation. Without limiting the generality of the foregoing, Navitus will perform all services in compliance with applicable law and in accordance with all applicable requirements of the NCDHHS Tailored Plan contract.

WellCare (and its subdelegates) is subcontracted by Alliance to perform specified Utilization Management functions for the following categories of services for Alliance members: Complex Labs, Cardiac Imaging, Radiation Oncology, certain Musculoskeletal and Orthopedics and Imaging Procedures. Utilization Management Functions include Medical Necessity Reviews (Prior Authorization, Concurrent Review and Retrospective Reviews), member and provider notifications, and first level member appeals. Utilization Management functions shall be completed in compliance with standards outlined in the Alliance Tailored Plan contract, state and federal regulations, and NCQA Accreditation standards. WellCare oversees its sub-delegated entities and shall require such entities to comply with all applicable standards and guidelines per the NCDHHS Tailored Plan contract requirements.

ModivCare is subcontracted by Alliance to provide non-emergency medical transportation (NEMT) services. Services include transportation to eligible beneficiaries who lack both means and mode for reaching medical appointments or departing from a hospital stay. Following NCDHHS guidelines, NEMT covers transportation to Medicaid-covered services using the least expensive appropriate option, which may include mileage reimbursement, gas vouchers, or travel-related expenses like food and parking. Services allow attendants (chaperones) for members under 18 or those with special impediments, and requires prior authorization for non-emergency ambulance transportation, rides exceeding 75 miles, out-of-state transport beyond 75 miles, and overnight lodging.

Avesis is subcontracted by Alliance to perform utilization management for vision services. As a utilization management (UM) service provider, Avesis evaluates and determines the medical necessity and appropriateness of vision services. They are responsible for reviewing and processing authorization requests for specific delegated procedure codes to ensure services are medically necessary, cost-effective, and align with established clinical guidelines.

Northwood – Northwood is subcontracted by Alliance as the provider for durable medical equipment, to perform utilization management for durable medical equipment, certain medical supplies, prosthetics and orthotics. Northwood is responsible for reviewing and processing authorization requests for specific delegated procedure codes to ensure services are medically necessary, cost-effective, and align with established clinical guidelines. Services under five hundred dollars do not require prior authorization.

Advanced Medical Review (AMR) Services

AMR, as an independent review organization, will provide independent medical review services as requested by Alliance. AMR will provide Alliance access to Peer Reviewers specializing in various aspects of mental health, substance abuse, pharmacy, and physical health care. Medical review services shall be completed in compliance with standards outlined in the Alliance Medicaid contracts, state and federal regulations, and NCQA Accreditation standards, which include adequate staffing and any licensure or state residency requirement. AMR will assign each review to a reviewer possessing the appropriate knowledge or experience to address the subject matter of the review. AMR shall determine whether a service is medically necessary on a case-by-case basis to approve or deny services. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent medical consultants. As required by 10A NCAC 25A.0201, a medically necessary service may not be experimental in nature. AMR shall ensure medical necessity determinations are rendered by a qualified health professional. For service authorization requests that do not meet medical necessity, Alliance shall issue a Notice of Adverse Benefit Determination (NABD) consistent with 42 CFR § 438.404 and the requirements of the Alliance Tailored Plan Contract. AMR is responsible for providing the language related to the denial reason that should be included in the NABD letter. AMR can also complete Peer-to-Peer Reconsiderations and first level member appeals for adverse decision determinations.

Command Business Products, Inc. DBA Command Direct

Command Direct is a member of the Managed Care Resource Alliance (MRCA) and specializes in health plan communications. Command Direct is subcontracted by Alliance for the printing and mailing of communications for the agency. Alliance is responsible for making timely medical necessity review and appeal decisions. Command Direct provides printing and mailing services of letters that are then mailed to members regarding these determinations. Command Direct also accepts and processes returned mail on behalf of Alliance. Command Direct ensures HIPAA compliance related to all correspondence processes, and ensures compliance with 42 CFR § 438.404.

Targeted Case Consultation and Case Escalation

Clinical Cases of Concern, Targeted Case Consultation and Case Escalation is a mechanism by which individual cases are referred by Utilization Management, Care Management, Provider Networks, and Quality Management for attention by the Medical Management team physicians or specialty team consultation. Targeted Case Consultations and Case Escalations are used when a clinical concern cannot be resolved through the case staffing process and requires a member/members of the Medical Team to review.

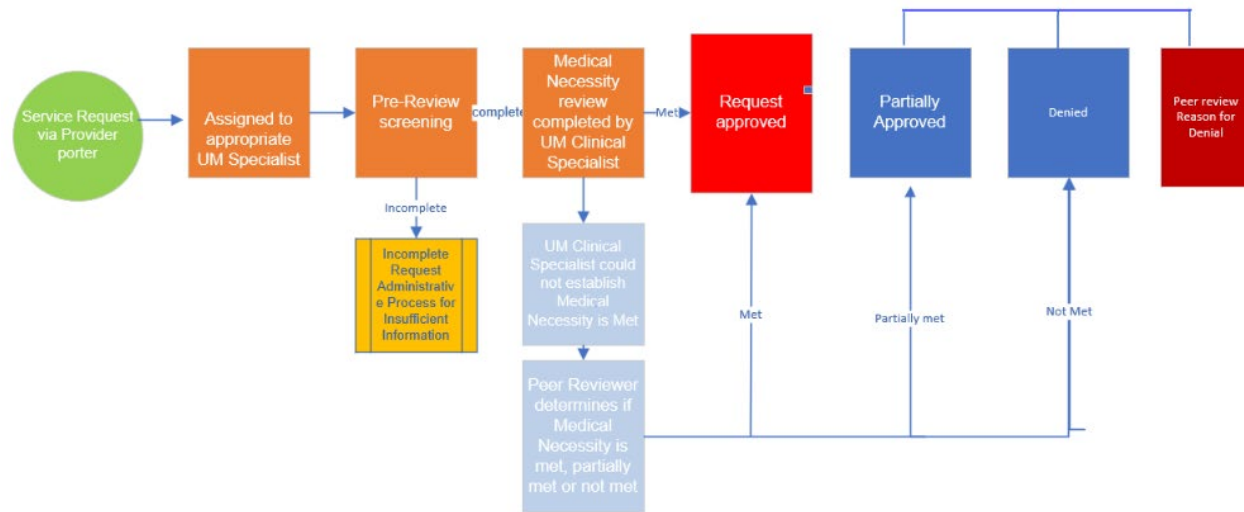
Targeted Consultation: Medical Team Targeted Case Consultation describes a referral of individual cases by Care Management, Utilization Management, Networks and Quality Management Departments for attention by an individual member of the Medical Team; Chief Medical Officer, Deputy Chief Medical Officer, Associate Medical Director, Physical Health UM Medical Director, Pharmacist, Senior Psychologist or Nurse (Subject Matter Experts or SME). Targeted Case Consultation is intended to promote cases deemed by Department Supervisors to require specialty clinical oversight and warrant review by the Medical Team. Targeted Consultation is used to discuss any health and safety concerns that may be identified in proposed treatment, to ensure appropriate member placement or services, further assist with interpretation of clinical information, or for consultation related to best practices for treatment interventions. Targeted Case Consultation also serves as a mechanism in which letters of health and safety considerations may be identified.

Case Escalation: Medical Team Case Escalation describes referral of individual cases by Care Management, Utilization Management, Provider Networks and Quality Management departments for attention by MDs *and* other individual members of the medical team. Subject Matter Experts from other Alliance departments may also attend to provide consultative supports as needed. Case Escalation is intended to escalate cases deemed by Department Directors (or their designees) to require psychiatric or medical oversight. Like Targeted Consultation, cases escalations are used for the purposes of addressing identified concerns with current treatment plans which may have led to a lack of member progress, possible health and safety concerns, and identification of best practice interventions, Case escalation differs from Targeted Case Consultation as a cross-functional SME team is convened to resolve the clinical concern, rather than a single medical team member.

Early Periodic Screening, Diagnostic and Treatment (EPSDT) Services

The EPSDT benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, mental health, developmental, and specialty services. Alliance is required to provide any service that is coverable under the scope of the Tailored Plan and Medicaid Direct contracts, included in the Federal Medicaid program and found to be medically necessary to treat, correct, or reduce illnesses and conditions discovered regardless of whether the service is specifically covered in the Tailored Plan BH/IID Contract, 1915(i) Waiver Authority or NC 1915(b)/(c) Medicaid Waivers. For Medicaid requests for children under 21, UM Clinical Specialists, all clinical peer reviewers, and appeal reviewers must consider EPSDT criteria when making the initial UM decisions, peer clinical review decisions, or appeal decisions. There are no upper limits on the number of hours or units of service or the number of visits to a physician, therapist, or other licensed clinician under EPSDT, nor is there a set list that specifies when or what services or equipment may be covered under EPSD.

Prior Authorization Request Processing



Alliance makes UM decisions in a timely manner to minimize any disruption in the provision of health care. Prior authorization requests for initial and ongoing services must be submitted to Alliance Health or delegated entity. The preferred method of submission is electronically through the provider portal, but providers can submit via fax or email, as needed. Requests for services are reviewed by appropriately licensed or qualified clinicians licensed in the state of North Carolina. Requests for services under the 1915(c) waivers are reviewed by the Utilization Management-LTSS Clinical Specialists, who are considered Qualified Developmental Disability Professionals (QDDPs). Alliance accepts and considers relevant information from any reasonably reliable source when making utilization management determinations.

UM monitors and protects the integrity of UM information throughout the prior authorization review. All documentation associated with a service request are housed in Jiva, and alteration of documents by UM staff is not permissible. Documents cannot be edited in the system. If UM receives notification that documentation was submitted in error or needs to be removed, UM staff must reach out to the Alliance medical records team. In addition to not allowing alteration of existing documentation, UM staff are not allowed to create new documents for a member and are restricted to entering of medical necessity determinations only.

The UM has identified staff that can review service lines based on education and experience and are grouped by specialty, physical health, behavioral health and LTSS. Only appropriated licensed or credentialed individuals based on review type are allowed to complete medical necessity reviews. Jiva tracks the actions taken on any request for service, noting name, date and time for each change, which ensures that actions are connected with the UM staff or medical team member who completed any step in the review process. In addition, this tracking helps ensure that unauthorized individuals do not update or add any information during the course of the review process.

Authorization requests received via the provider portal are date/time stamped by the system in reportable fields that are used to calculate turn-around times (TAT) for decision-making. The system-stamped date/time confirmation is considered the request receipt date. For emergent situations only, if the request is received via telephone, fax or email, the received date is considered to be the date/time the telephone

call, fax or email is received. UM staff are not authorized to modify dates of receipt, and Jiva ensures that all actions taken on a request are time stamped to demonstrate accountability to TAT. All dates and times related to the review are non-alterable, as Jiva will enter a date and time stamp for all notes, changes in status, UM decisions, and denial notice printing.

When non-urgent care information is incomplete, reasonable efforts are made to obtain relevant information and documented in the member's electronic record. Non-clinical administrative staff, who may assist with the pre-review screening of requests, help ensure that all necessary documents have been received, have required signatures, are legible if handwritten, and have no required fields blank. Non-clinical administrative staff contact the provider as soon as possible in order to request the missing information. If a separate pre-screening is not completed by administrative staff, UM Clinical Specialists will complete screening and reach out for additional information as necessary for completion of the review. If the request is urgent, it is immediately forwarded to a qualified Utilization Management (UM) Clinical Specialist bypassing the pre-review screening process. Clinical Specialists can determine if there is sufficient information to review the request, and will make reasonable efforts to obtain relevant information for review if needed.

For all prior authorization requests, the UM Clinical Specialist reviews the clinical information against the appropriate medical necessity criteria utilizing the approved evidence-based decision support guideline, such as MCG, the State Clinical Coverage Policies, Alliance Clinical Coverage Policy, or the Clinical Practice Guidelines, which details evidence-based, best practice standards of care. When indicated, UM Clinical Specialists work with providers to obtain clinical information in order to make a determination of the authorization of services requested and the date of the next review. Only relevant clinical information necessary to make a sound clinical authorization decision is requested from providers, and Alliance does not request information that is not necessary in making the UM determination. During prior authorization reviews, Alliance considers the comprehensive range of the member's physical health, LTSS, BH, I/DD, and TBI needs and may document recommendations for alternative treatments or supports that may be appropriate for a member's complete clinical and other support needs.

If a UM Clinical Specialist finds the request meets medical necessity criteria, an approval that documents the clinical rationale and the clinical information reviewed are documented in Jiva, the Alliance electronic information system. In the event that medical necessity cannot be established, or the request cannot be fully approved by the initial reviewer, the request is promoted to peer review for a determination by a peer reviewer with at least the same level of professional degree (e.g., a psychologist cannot peer review for a physician's service order). Peer reviewers possess unrestricted North Carolina licenses with board certification in at least one of the following: Psychiatry, Child and Adolescent Psychiatry, Addiction Psychiatry, Family Medicine, Internal Medicine, or are doctoral level psychologists. All denials or partial approvals for inpatient care must be made by a qualified physician peer reviewer.

Alliance procedures are followed for applying criteria based on individual members' medical necessity and community standards of care. Alliance seeks to minimize administrative barriers for physicians and other providers while promoting appropriate care. The provider network is educated on covered benefits and services. Alliance continuously evaluates the services requiring prior approval. Covered services and prior approval requirements are published in the benefit plan located on our website.

UM decision-making is based on medical necessity and evidence-based guidelines, appropriateness of care and service and existence of benefit coverage. Alliance does not provide incentives for individual or entity conducting utilization reviews to deny (reduce, terminate, or suspend), limit, or discontinue medically necessary services. Alliance does not discourage, coerce, materially misinform, or intimidate

providers or members, request for covered services, continuation of covered services, or the filing of OAH appeals.

Notifications and Timeframes

Members and recipients are notified via trackable mail for all requests that are denied or not approved in their entirety. Timeframes for expedited, standard and retrospective reviews, inclusive of notification timeframes, are listed in the table below:

Type of Request	Timeframes
Routine (Standard) Reviews	As expeditiously as the member or recipient's condition requires that may not exceed 14 calendar days from receipt of a request
Retrospective Reviews	Not to exceed 30 calendar days unless a more restrictive timeframe is required by the State.
Expedited Initial Reviews	As expeditiously as the member or recipient's condition requires that may not exceed 72 hours from receipt of a request
Expedited Concurrent Request	As expeditiously as the member or recipient's condition requires that may not exceed 72 hours from receipt of a request.
Notice of Extension	Alliance may extend time review period for routine requests up to 14 additional calendar days if: 1. The member, or the provider, requests extension or 2. Alliance justifies (to the State upon request) a need for additional information and how the extension is in the member's interest. Alliance may extend time review period for expedited requests up to 14 additional calendar days if: 1. The member requests an extension or 2. Alliance justifies (to the State upon request) a need for additional information and how the extension is in the member's interest
Mailing of adverse decision letters must be completed within the total allowable timeframes noted above.	

The timeframe for making the determination and issuing notification begins when the request is received by Alliance. When the request is approved, written notification is provided to the attending physician or other ordering provider, or the facility rendering service, via secure electronic means within the timeframes noted above. The written notification will include the specific reason, evidence guidelines, and benefit provisions. During the process of an initial prospective or retrospective clinical review, if the UM Clinical Specialist is unable to approve the request for certification, the case is promoted to the peer clinical review process.

Authorization Requirements for Covered Services

NC Medicaid covers most health services covering a wide range of medical, dental, behavioral health services, as well as long-term care services. Covered services are medically necessary and include items such as doctor visits, check-ups, emergency care, dental care, vision and hearing services, prescription drugs, maternity and postpartum care, case management, hospital services, behavioral health, preventive and wellness services, and durable medical devices. Alliance provides all services in alignment with State standards. Each case is reviewed individually, given the individual member's circumstances and in

accordance with the State defined scope of services: Providers and members will not be asked to withdraw or modify a request for prior approval of a covered service in order to accept a lesser number of hours, or less intensive type of service, or to modify a score or other clinical assessment.

Alliance accommodates a range of services to ensure members receive care timely delivered via telehealth, virtual communication, and remote patient monitoring. Unless otherwise required for a specific service, prior approval is not required for telehealth, virtual communication, and remote monitoring. Services provided via telehealth, virtual patient communication and remote monitoring are provided in the same amount, duration, and scope as services delivered in-person.

Authorization Process

Services that require prior approval are listed in the published Medicaid benefit plan. Alliance informs providers about the procedures and services that require prior authorization, including the timeframes necessary to obtain prior authorization, through the provider manual and the provider portal. The Utilization Management department reviews the services requiring prior authorization regularly, in conjunction with Alliance's CMO/DCMO, to determine if any services should be added or removed from the list, primarily driven by instructions from the State. Requests for prior authorization may include but are not limited to, elective inpatient hospitalizations, outpatient procedures, major organ transplant, diagnostic procedures, therapy services, all out of network referrals and durable medical equipment requests. Such decisions are based on Alliance's program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur.

The prior authorization process involves reviewing clinical information and requests to determine medical necessity prior to the rendering of services. Prior authorization requires the provider or practitioner to make a formal request for service approval utilizing a standardized prior authorization request form developed by Alliance. The request must be submitted to Alliance prior to the service being rendered. For ongoing services, providers must submit concurrent requests which include the clinical status of the member, including any changes in diagnoses and treatment planning information, with justification of extension of services. Upon receipt, the prior authorization requests are screened for eligibility and benefit coverage. Requests are then assessed for medical necessity and appropriateness of the health services requested, including the setting in which the proposed care will take place. Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. The frequency of reviews is based on the severity/complexity of the member's condition and/or necessary treatment and discharge planning activity and are not routinely conducted on a daily basis. If, at any time, services cease to meet inpatient or ambulatory criteria, discharge criteria are met and/or alternative care options exist, the UM Clinical Specialist contacts the facility and obtains additional information to justify the continuation of services. When the medical necessity for the case cannot be determined, the case is referred to the appropriate medical or behavioral health professional for review.

The retrospective authorization process is the process of determining coverage after treatment has been rendered. Alliance will complete a retrospective medical necessity review, when an individual/ member obtains retroactive eligibility, a provider is contracted for a service retrospectively, a primary insurance denies payment for reasons other than lack of medical necessity, coverage is not available, or incorrect, or there is a delay in timely submission beyond the provider's control. As with the prior authorization process, providers are required to submit the section(s) of the medical record necessary to certify medical

necessity or appropriateness of the admission, length of stay, and frequency or duration of the requested service. Retrospective requests based on retrospective Medicaid eligibility must be submitted by the provider within ninety (90) days of the eligibility determination date for outpatient services and 365 days for inpatient hospital services. In addition, Alliance accepts retrospective requests for authorization of outpatient procedures in instances where, in accordance with generally accepted North Carolina Standard, an authorized outpatient procedure was modified or supplemented as a result of clinical findings or outcomes arising during the authorized outpatient procedure. In such instances, the provider shall submit such retroactive requests for authorization within sixty (60) calendar days of concluding the authorized outpatient procedure. Retrospective requests are “non-urgent” requests, since the individual is not awaiting an authorization before receiving treatment. Alliance will review and finalize a decision within 30 calendar days. Members may file an appeal if they disagree with the retrospective determination.

For any service for which a request for authorization has been received, a medical necessity review is completed based on available information to determine the appropriateness of the service/level of care recommended or delivered. Clinical Specialists may reach out to providers or Care Managers as needed to obtain additional information during the medical necessity review. When the medical necessity for the case cannot be determined, the case is referred to the appropriate medical or behavioral health professional for review.

Emergency Services/Urgent Care Services

Prior authorization is never required for emergency services or urgent care services. An emergency is generally defined as a situation where a prudent layperson, possessing an average knowledge of health and medicine, would believe that immediate medical attention is necessary to prevent serious harm or death. Therefore, Alliance shall not retract a prior authorization for emergency services after the services have been provided, except as provided in N.C.G.S. § 58-3-190(c).

Physical Health (medical/surgical) Services

Services that require prior approval are listed in the published Medicaid benefit plan. Not all physical health services require prior approval. The provider retains documentation that the service is medically necessary in the member’s treatment file. For physical health services that do require prior approval, the first level review is completed by an UM Clinical Specialist - PH, UM Supervisor - PH or UM Director – Physical Health. These qualified licensed health professionals will review clinical information submitted with a request to make an appropriate medical necessity determination. The clinicians completing these reviews have medical expertise based on their education and experience, and receive the necessary supervision, both individual and group, as well as training to support their work. They are also able to utilize our medical team, as well as behavioral health team, for consultation purposes to ensure that the services received by a member can meet their holistic long-term needs, as they complete reviews of services for which prior authorization is required.

Prior approval or referrals are not required for:

- Emergency services
- Family planning services including women’s routine and preventive health care services, obstetrical ultrasound
- Children’s screening services
- Transplants

Alliance limits its requests for information during the prior authorization and certification process to only what is minimally necessary. When requesting documentation for utilization management decisions, Alliance complies with the Minimum Necessary Standard. When disclosing or using protected health information (PHI), Alliance makes reasonable efforts to limit requests to the minimum information necessary to accomplish the review. The authorization process is designed to avoid placing undue burden on members, practitioners, their staff, or healthcare facility personnel. Alliance collects only the specific information required to certify admissions, procedures, treatments, length of stay, or the frequency and duration of services. Communication with requesting providers or members (including telephone and email) is limited strictly to obtaining necessary service request information and providing education about covered services. Information needed to perform the review may include, as applicable, but is not limited to, the following information:

- Office and hospital records
- A history of the presenting problem
- Clinical or mental status exam notes
- Diagnostic testing results
- Treatment plans and progress notes
- Patient psychosocial history or assessments
- Information on consultations with the treating practitioner
- Evaluations from other healthcare practitioners and providers
- Photographs
- Operative and pathological reports
- Rehabilitation evaluations
- Printed copy of criteria related to the request
- Information regarding benefits for service or procedure
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members
- Applicable level of care assessments
- Physical or behavioral health screenings and results

Clinical information received, as well as rationale for the medical necessity determination and/or leveling of care is documented and maintained in Jiva, the clinical documentation system. Documentation and requests submitted outside of the Jiva Provider Portal (e.g. received via fax or email) are uploaded and maintained in Jiva and reviewed in the same manner as those submitted directly into Jiva.

Pharmacy Services

Alliance maintains a pharmacy benefit to ensure and provide members' access to therapeutically needed medications that provide the best overall value to members, providers, and the State. Alliance Health has contracted with Navitus, a pharmacy benefits manager (PBM) to administer the pharmacy benefit. Navitus follows the existing NC Medicaid Direct Fee-for-Service Preferred Drug List (PDL), clinical coverage policies, and follows the NC Medicaid prior authorization (PA) criteria. UM functions delegated to Navitus includes but not limited to processing of PA requests for non-preferred drugs and others with specific coverage criteria, supporting the PHP Lock-In Program as defined in the Opioid Misuse Prevention and Treatment Program, and implementing point of sale edits to prevent overprescribing and inappropriate prescribing of antipsychotics to members under the age of eighteen (18).

Navitus maintains web-based PA processes, which provide an electronic review system accessible to providers. They also utilize common PA request form(s), developed by the State, and accept PA requests via electronic submission, via phone, via fax, or via U.S. mail.

Navitus' pharmacy automated claim processing system integrates member pharmacy claims and diagnosis history to ensure adjudicated pharmacy claims that require PA are based on criteria from existing diagnosis or prior pharmacy claims history. Pharmacy electronic PA requests and notifications are processed within twenty-four (24) hours from when the request is received, unless it is necessary for the PA request to be pended to obtain additional information. The PBM shall ensure that if a pharmacist cannot fill a prescription when presented due to a PA requirement in an emergency, the PBM must cover a seventy-two (72)-hour emergency supply of the prescription. Navitus honors existing and active pharmacy services prior authorizations on file with the North Carolina Medicaid program, Standard Plan, or Tailored Plan through the expiration date of the active service authorization.

Behavioral Health Benefit Services

The behavioral health team, which is comprised of licensed clinicians and Qualified Developmental Disability Professionals, works to ensure that quality behavioral health services are delivered to our members through the review of prior authorization requests. These professionals also make treatment recommendations based on best practice guidelines to promote treatment outcomes for our members. Alliance supports a continuum of services that are offered both in inpatient and residential settings, as well as in the community. The behavioral health team works to ensure that members are placed in the most appropriate level of care to meet their needs with consideration of available services within the service array.

Basic Benefit Services

In cases where the appropriate care are Basic benefit services, which are delivered in a community-based setting, include family, individual and group therapy with a qualified licensed practitioner, psychological testing, assessments, and evaluation and medication management services with a psychiatrist or physician extender. For these services, the provider establishes initial medical necessity for the service, not Alliance. The provider must follow the admission and continued stay criteria for the service. In all cases, the member is not required to obtain a referral to a behavioral health service provider. Medicaid basic benefit services do not require prior authorization. Non-Medicaid basic benefit services have an assigned unmanaged benefit, which the member can utilize without seeking prior authorization. Continuation of services beyond the unmanaged benefit require prior authorization.

Enhanced Benefit Services

Enhanced Behavioral Health, Residential, and Long-Term Support Services (LTSS) are designed to meet members' needs within a higher level of care service array. These are services that tend to be higher in cost and aimed at the more high-risk clinical populations. Where specified in NC Medicaid Clinical Coverage Policy, unmanaged or pass-through units are applied to individual services. If prior authorization is required based on Clinical Coverage Policy/Service Definitions, the provider submits assessment findings, a person-centered plan and other clinical information, as applicable, along with the service recommended through the Provider Portal on a Prior Authorization Request form. Alliance Health makes BH, I/DD and TBI services available to members without Medicaid coverage who meet financial eligibility requirements as required by the Department. Service availability is subject to available funding. Prior authorization parameters and limitations are outlined in the Non-Medicaid Benefit Plan.

Utilization Management Clinical Specialists - BH focus clinical expertise on these services that require a higher level of care management due to the complex needs of the individual. Utilization Management Clinical Specialists-BH compare the submitted clinical information, including an individual's diagnosis(es), clinical presentation, and identified needs and goals to the medical necessity criteria identified for admission, continued stay or discharge for the service requested. These staff members determine whether the service is medically necessary based on the established criteria and issue an authorization where appropriate. Alliance UM Clinical Specialists use approved Clinical Guidelines to help determine if the treatment requested is based on sound clinical practice and evidence-based models of care, however, this is not used in the determination of medical necessity, but rather to offer treatment recommendations to further support member outcomes. Alliance approved Clinical Guidelines are located on the [Alliance website](#).

In instances where the available clinical information does not fully support the established criteria for a service, UM Clinical Specialists-BH may seek supervision or consultation, as appropriate from the Utilization Management Supervisors, Directors, and medical management team prior to consideration of the need for a clinical peer review for denial or reduction. If medical necessity does not appear to be met based on comparison of the clinical information to established criteria, the UM Clinical Specialist-BH will promote the case to a second level review with a medical team member with the appropriate license and experience. Only qualified MDs and PhD psychologists can deny, reduce, or terminate services.

Innovations Waiver and TBI Services

Innovations and TBI waiver services are offered to members who meet applicable level of care and slot allocation from the Department. The NC Innovations level of care assessment tool is used to determine whether a member meets the level of care required by the Innovations waiver. Similarly, the TBI waiver level of care tool is used to determine whether a member meets the level of care required for the TBI waiver. Innovations and TBI waiver services are administered consistent with Home & Community Based Services waiver program as defined in 1915(c) Medicaid waiver and any forthcoming 1915(i) Authority. Prior approval is required for Innovations and TBI waiver services. For services covered by the 1915(c) waivers including Traumatic Brain Injury and Innovations, the assigned Care Manager submits the prior authorization request form, in-lieu-of the direct care provider, along with applicable assessments, Individual Service Plan (ISP), budget and forms required by clinical coverage policy. Utilization Management Clinical Specialists- LTSS, who are Qualified Developmental Disability Professionals, compare the needs and goals identified in the ISP against the established waiver guidelines. Authorization of services must be consistent with and incorporate the desires of the Innovations waiver or TBI waiver member's Individual Service Plan (ISP), including the desired type, amount, and duration of services. In instances where the UM Clinical Specialists-LTSS feels that the requested services are not the most appropriate services or supports to meet the member's needs, they may seek supervision or consultation, as appropriate, from the Utilization Management Supervisors, Directors, and the medical management team. Only qualified MDs and PhD psychologists can deny, reduce, or terminate services, and in instances where medical necessity does not appear to be met, the UM Clinical Specialist can promote the case to a licensed medical team member for review.

Behavioral Health Crisis Services and Inpatient Services

The Alliance Crisis Continuum of Care is designed to provide timely and effective support for individuals experiencing a behavioral health crisis and contains a broad range of crisis services. To reduce barriers to

access and encourage the use of medically appropriate alternatives to inpatient and emergency department care, several crisis services have no prior authorization requirements. These services include Behavioral Health Urgent Care, Facility Based Crisis Services, Mobile Crisis Management Services, and Non-Hospital Medical Detoxification Services. Providers of these services may treat members without submitting prior authorization requests to the UM department, thereby expediting treatment initiation. Additionally, to ensure individuals have timely access to inpatient psychiatric services, inpatient facilities have 72 business hours from the time of admission to request initial prior authorization. This unmanaged time frame allows the inpatient psychiatric provider to assess the member and provide initial stabilization services without seeking prior authorization.

If a member requires ongoing services after the initial unmanaged period, a provider can submit a prior authorization request to Alliance. These requests for continued inpatient psychiatric services are then reviewed by Utilization Management Clinical Specialists-BH following established procedures for review against medical necessity criteria, and promotion to peer review in instances where the medical necessity criteria do not appear to be met. At any time during the review process, UM Clinical Specialists-BH may seek consultation from supervisors, directors, and medical team members to ensure that services are tailored to meet the member's immediate needs for crisis stabilization, and consideration of aftercare recommendations.

Alliance will cover emergency medical services consistent with the prudent lay-person standard, as referenced in the NC Medicaid Division of Health Benefits contract and in the Emergency Medical Treatment and Labor Act (EMTALA) of 1986, as amended by the Balanced Budget Act of 1997. Services may be provided any time, without regard to prior authorization and regardless of the emergency care provider's contractual relationship with Alliance. Furthermore, Alliance does not limit what constitutes an emergency medical condition according to diagnosis or symptom lists.

Mental Health Parity

Alliance Health complies with the Mental Health Parity and Addiction Equality Act (MHPAEA) federal law that prohibits health plans from imposing greater restrictions on MH/SUD benefits than on M/S benefits, including financial requirements (copays, deductibles) and treatment limitations (visit limits, prior authorization) (42 C.F.R. §§ 438.3(e)(1)(ii) and 438.910(b)-(d)).

Members are not required to obtain a referral or prior authorization for an initial mental health assessment performed by a network mental health provider. Standards for reviewing medical necessity for medical/surgical procedures are consistent with those used for Mental Health and Substance Use Disorder treatment include the application of Clinical Coverage Policy and applicable level of care guideline (ASAM, CANS, SIS, NC SNAP, MCG®). Title 42, CFR, §438.910(b) state that treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. Alliance ensures quantitative treatment limits (QTL) on services for both mental health and substance use are not more restrictive than medical/surgical procedures in the following essential health benefits (EHB) covered categories:

1. Ambulatory patient services (outpatient services);
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services (Services that help patients acquire, maintain, or improve necessary skills for daily functioning) and devices;

8. Laboratory services;
9. Preventive and wellness services and chronic disease management;
10. Pediatric services, including oral and vision care.

SECTION 5. Utilization Management Clinical Review Criteria

The UM Department utilize applicable North Carolina Division of Health Benefits Clinical Coverage Policies (and subsequent approved waiver amendments), MCG and Alliance Clinical Coverage Policies as the foundation for making medical necessity determinations. The NC Division of Health Benefits Clinical Coverage Policies contain the criteria used for determining medical necessity for some services. Approved Clinical Coverage Policies are located on our website at [Clinical Coverage Policy Reference Tool](#).

Where medical necessity criteria is not specific or defined in the NC DHHS Clinical Coverage Policies, or where NCDHHS does not have a policy, Alliance utilizes MCG or Clinical Coverage Policies approved by Alliance, as permitted by NCDHHS. Alliance policies are reviewed annually. Alliance uses patient records, practitioner calls and other means to collect information to make utilization decisions. As part of our attempt to collect this information, Alliance will collect only the minimum necessary information to make decisions. Alliance considers at least the following characteristics when applying criteria to everyone; age, comorbidities, complications, progress of treatment, psychosocial situations, home environment, when applicable. UM considers the local delivery system when making UM decisions to meet member's specific health care needs.

Annual Evaluation of Clinical Coverage Policies

As part of the process to review the clinical review criteria and decision support tools with relevance and accuracy, the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services ensures that a continuous annual review is in place, with workgroups/teams (which include representatives from Alliance) meeting on an ongoing basis to interpret feedback received from various entities and forums occurring throughout the state and to consider revisions. The state's process for developing and revising service policies involves collaboration among representatives from the North Carolina Council, the Division of MH/DD/SA, physician groups, hospitals, and Managed Care Organizations to provide additional input into the relevance and accuracy of clinical decision support tools. The Managed Care Organizations utilize this collaboration to examine clinical review criteria from a quality improvement perspective.

Alliance also reviews all relevant benefit and coverage, updates and changes from NC DHHS and other benefit/coverage sources as necessary.

Additional Avenues for Continuous Clinical Coverage Policy Review Medical Policy Committee

With a broad inter-departmental representation, Alliance's Medical Policy Committee (MPC) formulates, proposes changes, reviews, implements, and disseminates clinical protocols and evidence-based practice guidelines. This ensures that internal and external staff have the direction necessary to deliver the most appropriate care for our members and that members have access to cost-effective, quality behavioral and physical health services.

Co-chaired by the PH UM Medical Director and the Clinical Planning and Policy Director, the MPC aims to:

- Assure that all medical policies and procedures are scientifically sound, industry standard, evidence-based, and as much as possible, peer-reviewed
- Evaluate and address the inclusion of new technology and new applications of existing technology in the plan's benefits for physical health, behavioral health, pharmaceuticals and devices.
- Assure that all the UM decisions are based on appropriateness of care, availability of services and the member's coverage
- Implement best practice policies and procedures
- Assure standardized review, approval and adoption of medical policies and procedures by a wide audience
- Facilitate communication so that Alliance staff and providers requesting services on behalf of members will be aware of and understand the policies

UM Assessment and Decision Support Tools

The following standardized assessment and decision support tools have been approved for use as part of the medical necessity determination process or best practice standards of care.

Decision Support Tool	Description of use/source
State of North Carolina MH/DD/SAS service definitions	Service definitions that define and outline clinical criteria for services paid for utilizing non-Medicaid state funds allocated by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) https://www.ncdhhs.gov/divisions/mhddsas/servicedefinitions
American Society of Addiction Medicine (ASAM) Criteria	The ASAM is a widely referenced and comprehensive guideline and level of care tool used for Individuals experiencing substance use disorder and co-occurring conditions. The ASAM is used for populations except children ages zero (0) through six (6) https://www.asam.org/asam-criteria/about-the-asam-criteria
Alliance Clinical Practice Guidelines	Evidence-based internal Clinical practice guidelines developed to be utilized by health plans and providers in the clinical decision-making process.
NC Medicaid Clinical Coverage Policies and approved in lieu of service definitions	Medical necessity criteria established by NC Medicaid Division of Health Benefits for covered services under the state plan. https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies
MCG Guidelines	Nationally recognized care guidelines grounded on evidence-based medicine developed by MCG Health to guide clinical decision making. These guidelines help providers and health plans drive informed care, provide fast access to evidence-based best practices and care-planning tools across the entire care continuum, supporting clinical decision-making and documentation as well as enabling efficient transitions between care settings.
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	Comprehensive and preventive health care service provided to children under the age of 21 who are enrolled in Medicaid. The EPSDT benefit is designed to ensure that children receive appropriate preventive, mental health, dental, developmental, and specialty services.
Child and Adolescent Needs and Strengths (CANS)	Information tool for children ages 0-6 years used to communicate a shared vision of the child, youth and families at all levels of care. The assessments include strengths, educational needs, student needs, life domain needs and caregiver needs and strengths. https://praedfoundation.org/tcom/tcom-tools/the-child-and-adolescent-needs-and-strengths-cans/
Supports Intensity Scale (SIS)	Tool utilized to measure individual's support needs in personal, work-related, and social activities that best describes the type and intensity of supports an individual requires. A

	SIS is completed for every member on the Innovations Waiver.
NC SNAP	The NC SNAP is administered for Individuals requesting I/DD state funded services and are not on the Innovations waiver. https://www.ncdhhs.gov/providers/provider-info/mental-health/nc-support-needs-assessment-profile
Intermediate Care Facilities, Innovations and TBI Level of Care	Level of care tool as defined by NC Medicaid to determine if individuals meet ICF-IID level of care for Intermediate Care Facilities, Innovations Waiver or TBI waiver.
State and Federal Rules	Applicable state and federal regulations governing the service delivery under the managed care system.
Alliance Medical Policies	Clinical protocols and evidence-based practice guidelines developed and reviewed internally that guides clinical staff on the direction needed to deliver the most appropriate care for our members and to assure that members have access to cost-effective, quality behavioral and physical health services applicable to the state issued clinical coverage policies.

SECTION 6. Oversight of Program and Indicators of Program Successes and Opportunities

Utilization Indicators

Alliance monitors key performance indicators and goals at the department, unit, and agency level. Several key indicators are monitored via department dashboards and through our Continuous Quality Improvement (CQI) Committee structure. Clinical leadership and the committee structure use data analytics to ensure compliance with contract-based performance indicators, track trends and establish new targets and baselines as needed. Alliance has formal procedures to track over, under and mis-utilization, and observations related to service utilization trends are addressed through a variety of means, including plans of action through UM Committee. The UM Committee reports these action plans to the CQI Committee. In addition to the data related to the listed indicators, the Utilization Management Committee has access to financial reports, ED reports and reports generated through the Quality Management department and Medical Economics department that help evaluate the effectiveness of clinical practices and adjust practices accordingly. UM Committee is the primary forum to regularly monitor service utilization and continuously strive to identify metrics that will better indicate over, under and mis-utilization.

Service over, under and mis-utilization may indicate poor quality and potentially inefficient care. To ensure the appropriate provision of services, Alliance implements a program that monitors a broad range of data to determine variations in the use of service across providers and levels of care. The UM Committee and Clinical Performance Committee are responsible for detecting over, under and mis-utilization and analyzing claims (encounter) data and authorization data to determine utilization patterns. Data analysis will identify the potential need for further review.

If data analyses identify questionable patterns, Alliance may contact providers to review their medical records to identify the reasons particular practice patterns are different from expected. Although this could be a function of the provider's case mix severity, it could also indicate potential problems that need to be resolved. Clinical Operations may refer service or provider quality concerns to QM as well as to

Network Evaluation for a focused review. Suspected incidences regarding compliance violations are referred to the Office of Compliance and Risk Management for further review.

Responses to validated utilization issues include training and technical assistance, increased monitoring or referral to the Special Investigations unit if the over-utilization appears to be driven by wasteful practice or fraudulent billing. Alliance also may initiate internal action plans to ensure more appropriate service management by the clinical operations department if utilization issues are related to poor oversight and care coordination.

UM Committee Oversight

In line with the Continuous Quality Improvement (CQI) Committee's overarching goal of monitoring and improving quality across the organization and improving access to and quality of mental health and physical health services for the individuals we serve, the Utilization Management (UM) Committee's purpose is to monitor service utilization indicators, service benefits and medical necessity criteria, UM Appeals and UM performance metrics. The UM Committee monitors these functions to detect risk to both the individuals we serve and our partner service/support organization, and to work with CQI and its other subcommittees to determine the most appropriate way to address the risk. Committee membership is comprised of cross functional representation to achieve the goal of monitoring and improving quality. The UM Committee reviews data to ensure that individuals are receiving the right level of services; that service utilization and projected utilization are within expected ranges; those trends, issues and utilization drivers are identified; and that Alliance responses to utilization issues are implemented and effectively measured.

Responsibilities

The UM Committee is responsible for monitoring service utilization-related clinical risk indicators to the organization and to the individuals we serve. The committee considers data in the context of expected levels of utilization indicating good clinical care, considering both initiatives focused on improving care and new services that are expected to result in a change in utilization patterns. The committee does this by evaluating data and reports from the following areas:

- **Clinical and administrative performance metrics** related to the functions of the UM department are reviewed to identify opportunities for improved administrative functioning supporting more appropriate service utilization in the community (timely care, right level of service, etc.).
- **UM** reviews prior authorization processing volume with percentages of those denied or partially denied; Key performance indicator for Turn-Around Time (TAT), service under/over utilization trends and review inter-rater reliability results to determine next steps if needed (once per year).
- **Appeals statistics** are reviewed to identify any trends in appeals that could indicate unexpected trends in utilization, dissatisfaction with services, or the process of obtaining services by providers or the individuals and families we serve (quarterly). Appeal statistics are also used as an early indicator of compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA).
- **UM Delegation oversight** performance measures outlined in applicable Scopes of Work are reported to the UM Committee to determine next steps if needed to correct identified deficiencies.
- **Budget and Finance** reports are referred to UM Committee and indicate over- or under-expenditures on clinical services – UM Committee may recommend a clinical review of utilization patterns that may underlie the aberrant expenditure trends.

- **Utilization Management Program Description** is reviewed annually to ensure that the plan is consistent with the goals of the organization and connected to what is being monitored in UM Committee (annually). The Senior Vice President of Utilization Management is responsible for the annual review which is completed through collaboration and consultation with cross-functional departments. The Chief Medical Officer approves the UM Plan and annual plan evaluation. In addition to UM Committee, the plan is reviewed by CQI Committee. Should revisions be needed between annual reviews, the SVP of UM completes the revision and follows the same CMO, UM Committee and CQI approval process for the revision.
- **Medical Necessity Criteria and Covered Services Benefit Plan** is reviewed and approved by the Clinical Performance Committee. This review and approval process is accomplished within the Committee to ensure that the criteria and benefit plan are clinically appropriate and consistent with contractual expectations and reviewed at least annually, and as changes are required. Changes to the benefit plan are reviewed and approved by the Medical Policy Committee with final sign-off authority by the CMO (or designee in his/her absence).
- **Advisory Committee of Assigned Quality Improvement Projects** – Monitors the progress and addresses barriers to meeting the goals outlined in the Quality Improvement Projects(s).

The UM Committee develops and drives the types of reports that allow the committee to evaluate and propose a response to concerning trends in over- or under-utilization of services and works with other CQI subcommittees to determine the best committee to respond to the issues. For issues assigned to UM Committee, the committee develops and implements clinical and/or administrative action plans to decrease risk. Workgroups may be formed to collaborate on interventions needed to decrease the risk and report-out to the UM Committee. Monitoring and evaluation of interventions is completed in conjunction with Quality Management.

UM Committee Membership

- The Utilization Management Committee is chaired by the Senior Medical Director – Physical Health.
- Membership is inclusive of a cross-departmental representation and divided between voting members. Alliance departments that are not voting members are encouraged and invited to attend as subject matter experts. A quorum is defined as 50%+1 of voting members.

Consistency of Utilization Management Decision-Making

The Inter-rater reliability (IRR) testing is administered once per year to UM Clinical Specialists, Physician Reviewers, Senior Psychologist, Utilization Management Medical Director, Associate Medical Directors and senior clinical staff that complete peer reviews or complete medical necessity determinations. Individuals not receiving a passing score on the IRR will receive additional education, supervision and training relevant to any missed items. Results of this testing are shared with the Chief Medical Officer and formally reviewed in the UM Committee. The goal is to identify variation amongst decision makers in regard to implementation of policy and approved criteria and guidelines. Results of the testing are used to identify areas for improvement which include focused training and increased supervision, clarification and improvement to written processes and protocols and/or development of additional support tools. Medical staff complete training and education on a variety of topics to support reliability of decision making.

Beyond the IRR testing, the UM Supervisors complete monthly sample record reviews to ensure consistent application of clinical coverage policies with applying medical necessity decision process.

SECTION 7. UM Decision Appeals Process

In handling appeals, Alliance must provide members/recipients with reasonable assistance in completing forms and taking other procedural steps, including providing interpreter services and toll-free numbers that have adequate teletypewriter/ telecommunications devices for the deaf (TTY/TDD) and interpreter capability. Reasonable assistance includes explaining how to fill out the form, how and when to file an appeal, options for submitting the appeal (fax, email, in person), providing duplicate appeal forms when necessary, etc. All the timeframes in this policy refer to calendar days unless otherwise specified.

Medicaid Appeals

Alliance has an established and impartial process for resolving disputes and responding to requests to reconsider a decision found to be unacceptable to care and services. An *appeal* is a request for review of an adverse benefit determination or “action”. Alliance members or their legal guardians have the right to request an appeal of any “action,” which is specifically defined at 42 C.F.R. § 438.400(b) to include the following:

- Denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial of payment for a service;
- Failure to provide services in a timely manner; and
- Failure by Alliance to meet required grievance or appeal timeframes.

Under North Carolina Medicaid, all Medicaid members requesting an appeal must first go through a local reconsideration process at Alliance before filing a request for a State Fair Hearing.

Additionally, individuals with Medicaid who are found not to meet Intellectual/Developmental Disabilities (or “I/DD”) eligibility and therefore cannot be placed on the Registry of Unmet Needs, a waiting list for Innovation waiver slots, are given appeal rights.

The Medicaid Appeals Process

Alliance participates in the thorough, appropriate, and timely resolution of clinical appeals. Medical Reviewers not involved in the prior adverse decision review the appeal. The assigned medical reviewer must be neither the individual who made the adverse determination that is the subject of the appeal nor a subordinate of the original reviewing physician.

- Alliance will provide notification when making a decision to deny, reduce, suspend, or terminate Medicaid-funded services.
- The member or legal guardian can request an Internal Plan Appeal in which Alliance will review the decision – there are timeframes specified in the letter that outline when Alliance must receive the request for an Internal Plan Appeal.
- If the member or legal guardian feels the appeal review is urgent, they can request an expedited review. Alliance will make a decision about whether or not to process the appeal in an expedited timeframe and inform the member or legal guardian of the decision.
- Alliance will acknowledge the receipt of the appeal, review the decision, and inform the member or legal guardian of the decision. Appeal determinations are made by specialists with the same or similar experience/education using approved clinical criteria, records, etc. If Alliance feels that

extending the timeframe would be in the best interest of the member, Alliance may do so and will provide notification to the member or legal guardian. The member or legal guardian may also request an extension.

- If the member or legal guardian disagrees with Alliance's decision, they will have the option to follow instructions in the notification letter to request a State Fair Hearing. The Office of Administrative Hearings will offer the appellant the opportunity to engage in mediation to attempt to resolve the disagreement. However, the appellant may choose to move forward with a State Fair Hearing without participating in mediation.
- During the appeal process, Alliance will continue all benefits under most circumstances.

Non-Medicaid Appeals

Individuals receiving State-funded services may also appeal an Alliance decision to deny, reduce, suspend, or terminate a State-funded service authorization in accordance with 10A NCAC 27G .7004. There is no entitlement to non-Medicaid funded services.

Non-Medicaid Appeals Process

The overview provided below is meant to provide a brief summary of the process. For important details about the process please reference the [Provider Operations Handbook](#) or [Recipient Handbook](#) for specific information about this process.

- Alliance will provide notification when making a decision to deny, reduce, suspend, or terminate State-funded services.
- The recipient or legal guardian can request a local appeal in which Alliance will review the decision – there are timeframes specified in the letter that outline when Alliance must receive the request for a local appeal.
- Alliance will acknowledge the receipt of the appeal, review the decision, and inform the recipient or legal guardian of the decision.
- If the recipient or legal guardian disagrees with Alliance's decision, they will have the option to follow instructions in the notification letter to request a review by the State Non-Medicaid Appeals Panel with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS).

SECTION 8. UM Staff Availability

Alliance ensures that Utilization Management (UM) personnel are available during regular business hours to receive calls from providers, consumers, and other stakeholders in order to conduct communication functions necessary to expedite access to supports and services. These communication functions include:

- Receiving administrative communications from providers, members, and recipients, and other stakeholders;
- Responding to administrative communications; and
- Conducting outgoing administrative communications related to UM during providers' reasonable and normal business hours, unless otherwise mutually agreed upon.

UM staff are available to receive communications during business hours from 8:30am-5:15pm Monday through Friday. UM staff identify themselves by name and title at the beginning of all calls. All emails

include signature lines with the UM staff's name, title, and phone number. Calls received after normal business hours are returned the next business day.

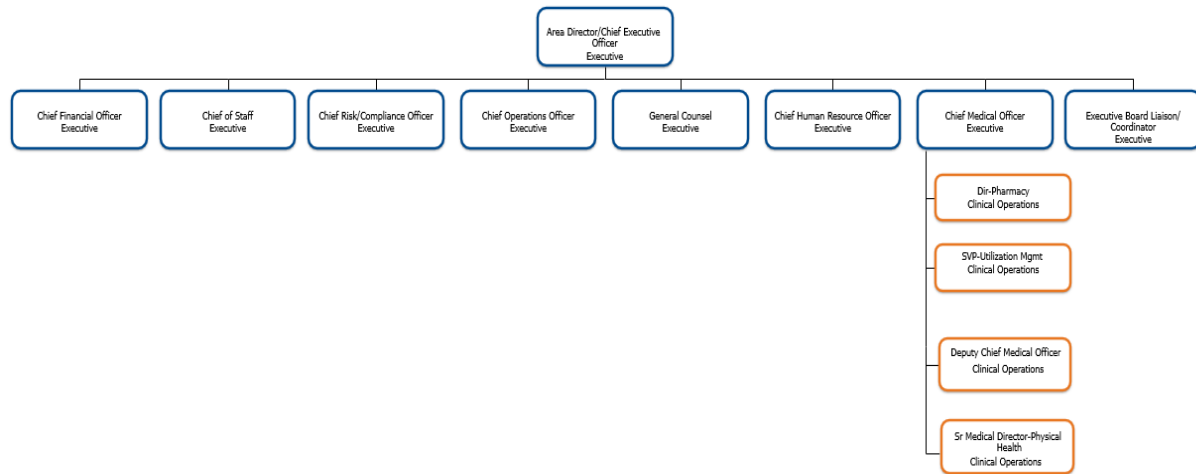
Member and Recipient Services and the Provider Support Line are available to receive communication from members/guardians and providers, respectively, Monday through Saturday 7 a.m. to 6 p.m. Licensed clinicians are available in the Member and Recipient Services department 24/7 should an emergent issue arise that require staff attention or resolution after Alliance business hours.

SECTION 9. Definitions

- A. **Peer Review:** The process by which the Utilization Management Medical Director, Associate Medical Directors, Senior Psychologist, or Peer Review delegate determines if medical necessity is met upon review of clinical records when a UM Clinical Specialist is unable to approve a valid request in full.
- B. **Utilization Management Program Description:** The organizational plan that includes essential requirements for the establishment and implementation of a utilization management process to ensure the quality, appropriateness, and efficacy of care.
- C. **Utilization Management Committee:** A cross functional team designed to ensure that key departments are brought together to communicate, address problems and to conduct overall management and monitoring functions for clinical and care management activities.
- D. **Utilization Management:** The process of evaluating the necessity, appropriateness, and efficiency of healthcare services against established guidelines and criteria.
- E. **Medical Necessity:** Medically necessary treatment shall be defined as those procedures, products, and services that are provided to consumers and are:
 - 1. Necessary and appropriate for the prevention; diagnosis; or palliative, curative, or restorative treatment of a mental health or substance abuse condition;
 - 2. Consistent with Medicaid policies and national or evidence-based standards, Department of Health and Human Services defined standards, or verified by independent clinical experts at the time the procedures, products, and services are provided;
 - 3. Provided in the most cost effective, least restrictive environment that is consistent with clinical standards of care;
 - 4. Not provided solely for the convenience of the recipient, recipient's family, custodian or provider;
 - 5. Not for experimental, investigational, unproven, or solely cosmetic purposes;
 - 6. Furnished by or under the supervision of a practitioner licensed (as relevant) under State law in the specialty for which they are providing service and in accordance with 42 CFR, the Medicaid State Plan, the North Carolina Administrative Code, Medicaid Clinical Coverage policies, and other applicable Federal and State directives;
 - 7. Sufficient in amount, duration, and scope to reasonably achieve their purpose; and
 - 8. Reasonably related to the diagnosis for which they are prescribed regarding type, intensity, duration of service and setting of treatment.

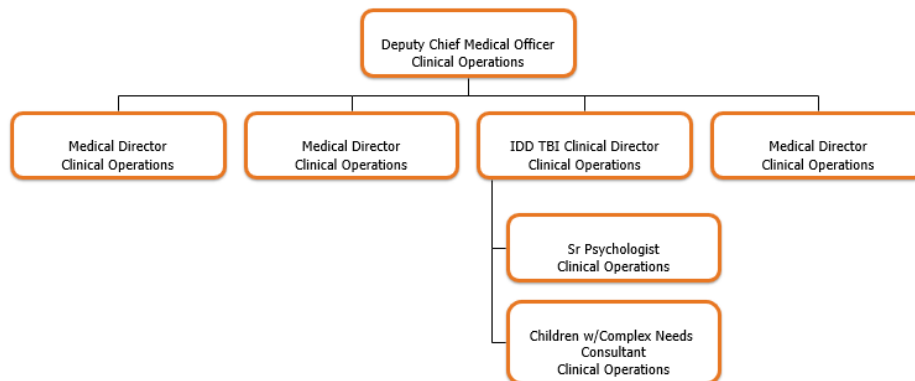
SECTION 10. Alliance Health Utilization Management Organizational Chart

Executive Leadership

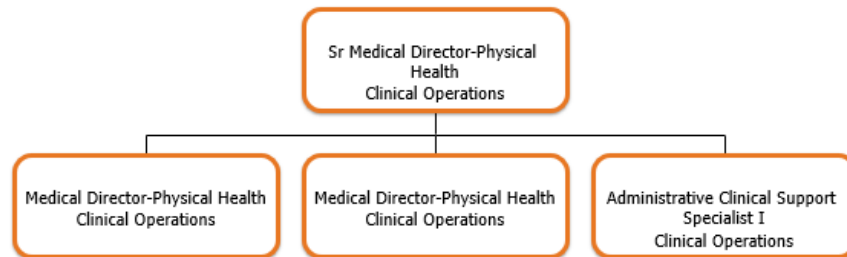


Medical Management Team

Behavioral Health



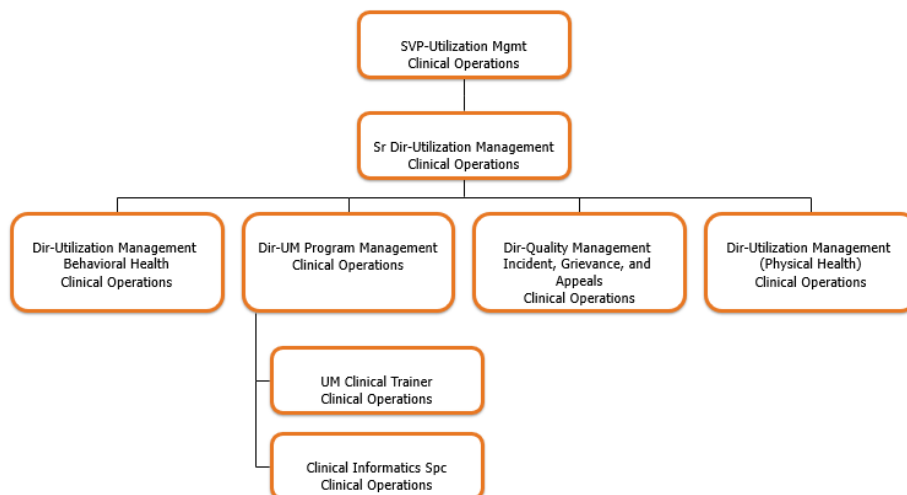
Physical Health



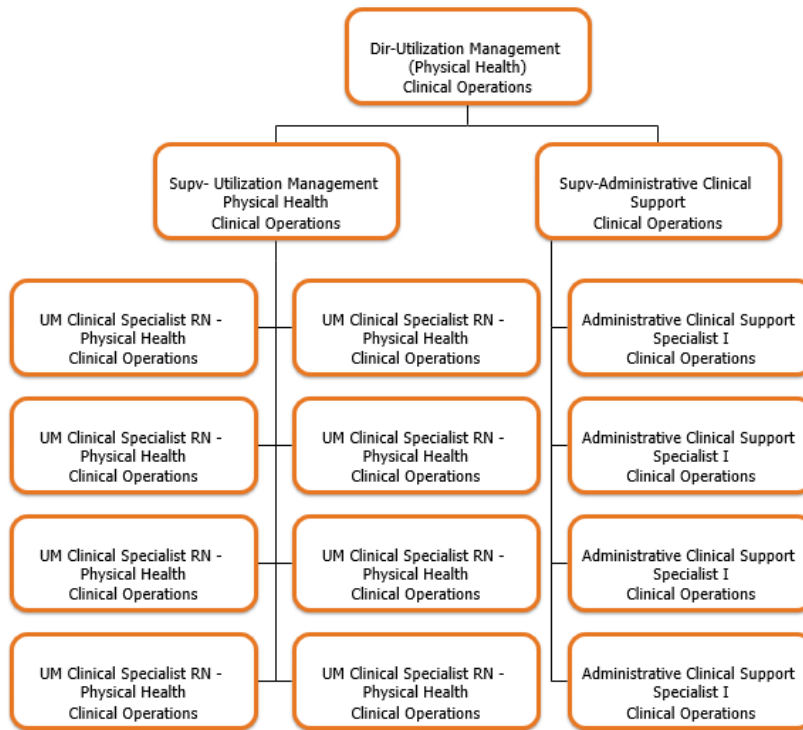
Pharmacy Services



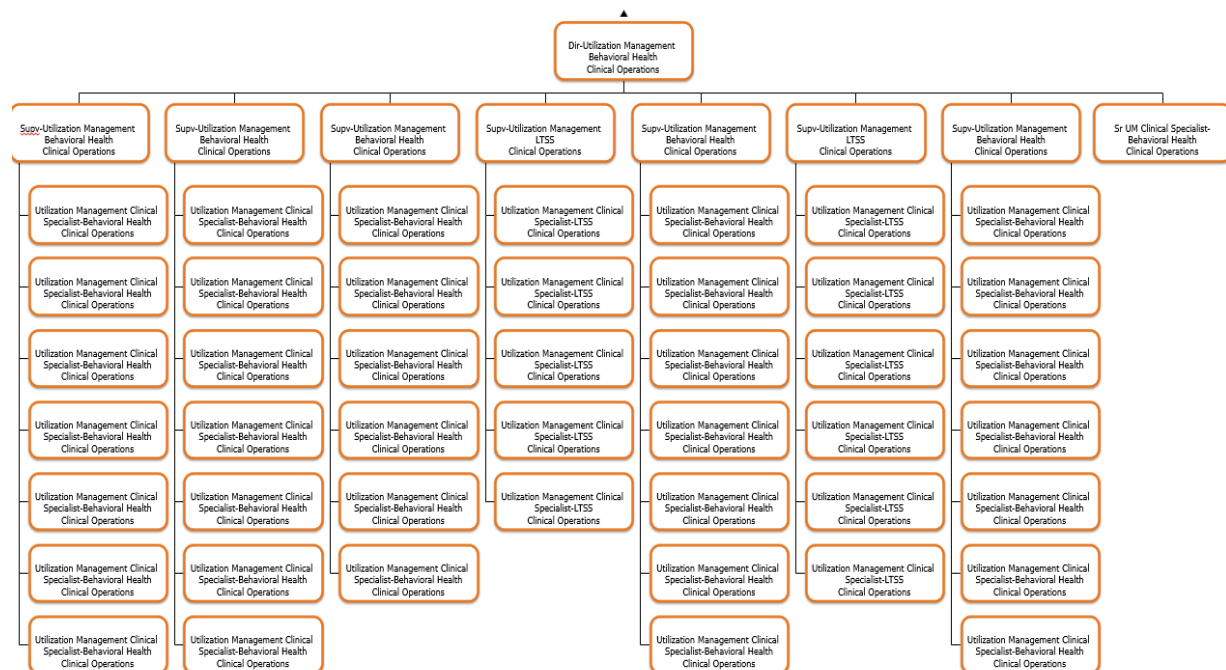
Utilization Management Organizational Chart



Utilization Management- Physical Health



Utilization Management- Behavioral Health



Appeals, Grievances and Incidents

