AmeriHealth Caritas North Carolina Inc.

Utilization Management Program Description 2021

Contents

Background and History

AmeriHealth Caritas North Carolina (ACNC) provides coverage for physical health, behavioral health and pharmacy services as a prepaid health plan in the North Carolina Medicaid Managed Care program. ACNC will administer health care benefits for identified NC Medicaid and NC Health Choice populations.

Introduction

Utilization Management involves the planning, organizing, directing and monitoring of delegated and non-delegated health care services. These activities are undertaken to help ensure the provision of appropriate, affordable, high quality care, contributing to the overall goal of Member wellness and are one mechanism by which ACNC seeks to reduce inappropriate and duplicative use of health care services. Utilization management activities and results are reported to the Quality Assessment and Performance Improvement Committee (QAPIC) and reflect monitoring activities stated in the Quality Assessment Performance Improvement (QAPI) Program. UM Program policies and procedures are designed to meet NCQA standards and are reviewed and updated annually and more frequently as needed.

ACNC Utilization Management Program is designed to uphold and mirror AmeriHealth Caritas Family of Company corporate values while administering contracted benefits and services. The values that are innate to our operations are:

Advocacy, Competence, Dignity, Stewardship,
Care for the Poor,
Hospitality, Compassion, Diversity

The Utilization Management Program documented here concentrates on both the physical and behavioral health medical necessity and the outcome of treatment, emphasizing prospective and concurrent utilization management services.

Membership and Demographics

ACNC analyzes its Member population and subpopulations in order to assist Members with multiple and complex conditions access the appropriate level of care and services and to aid the organization in defining its program structure and identify necessary resources. ACNC will serve the following categories of Medicaid beneficiaries:

- ABD: aged blind, disabled
- TANF and Other related children/adults including: Aid to Families with Dependent Children (AFDC), other children, pregnant women, infants and children, breast and cervical cancer (BCC), legal aliens (full Medicaid), NC Health Choice, Medicaid CHIP.

Utilization Management Objectives

The primary goal of utilization management functions is to collaborate with providers, Members and

others involved in healthcare delivery, in order to provide quality, cost effective healthcare in the most appropriate setting for the intensity of services required.

The Utilization Management Program objectives listed below pertain to physical health, behavioral health and pharmacy services.

- To facilitate the reduction of inappropriate and duplicative healthcare services.
- To promote collaborative practice among all disciplines to assure continuity of care and high quality services over the course of illness and recovery.
- Fully integrate physical and behavioral health services so as to minimize fragmentation in delivery andservice.
- Help ensure medically necessary care and services are provided in the most appropriate clinical setting, intensity and duration, consistent with the Member's condition(s) and co-morbidities.
- To use evidence based clinical guidelines to promote improved outcomes for Members and priority populations.
- To promote appropriate interventions, alternatives, and population health supports as health care services are rendered.
- To facilitate the identification and management of high risk cases, with appropriate referral of high risk management cases for additional care management services.
- To review and evaluate Member and provider satisfaction with the ACNC utilization management program and develop strategies for improvement based on feedback.
- To assess utilization practices and patterns in order to identify over- or under-utilization of services by providers and Members and review of outliers.
- To review and render determinations for provider and Member appeals of Medical Necessity determinations.
- To administer the provision of medically necessary services to all ACNC Members under the age of twenty-one (21) beginning at birth, which are necessary to treat or ameliorate defects, physical or behavioral health, and conditions identified by an EPSDT screen, considering the medical necessity criteria specific to EPSDT and the needs of the child.

Utilization Management Scope

The ACNC Utilization Management Program establishes a process for implementing and maintaining an effective, efficient utilization management system. ACNC covers services in the North Carolina Medicaid and Health Choices State Plans with the exception of services carved out of Medicaid Managed Care and as otherwise noted in ACNC's contract with NC DHHS.

Utilization management activities are designed to assist the practitioner with the organization and delivery of appropriate health care services to Members within the structure of their benefit plan. ACNC promotes integration of behavioral health, medical, and pharmacy services, with a focus on healthy opportunities to provide holistic approach to meeting the Member's needs. Integration is accomplished through communication between involved providers, as well as a collaborative approach to managing the Member's overall care. ACNC Utilization Management and Population Health Management staff work together to facilitate communication of the Member's status and needs and to coordinate care between all of the stakeholders involved in the Member's care. ACNC supports open communication between members and providers regarding available services. Members will not be discouraged or influenced regarding amount of services they may request in their plans of care or their right to appeal the denial or reduction or termination of service.

ACNC's Utilization Management plan applies to:

- Medical, behavioral health (mental health and substance use disorder care), long term services and supports and pharmacy services.
- Member populations, age groups, disease categories and special risk groups enrolled in ACNC, regardless of eligibility category.
- Covered services provided to Members through contracted or non-contracted practitioners and providers.
- Processes, activities, components, and information sources used to manage and/or make determinations for benefit coverage and medical appropriateness including:
    - Utilization Management processes and functions: prior authorization, concurrent review, discharge planning, and transitional care management.
    - Utilization monitoring processes (e.g. over/under utilization of services, drug utilization reviews, review of activities delegated to other entities).
    - Performance monitoring process (e.g. inter-rater reliability, telephone answer time, abandonment rate, productivity, prior authorization turnaround time determinations).
    - Evaluation of outcome data.
    - Monitoring of UM activities delegated to other entities.

Accountability and Reporting

Operational responsibility for the development, implementation, monitoring, and evaluation of the UM Program are the responsibility of the ACNC Chief Medical Officer, a licensed physician in the State of North Carolina. The ACNC Chief Medical Officer (CMO) or the CMO's designee is available to discuss and report on the Utilization Management Program. Operational responsibility for the development, implementation, monitoring, and evaluation of the behavioral aspects of the UM Program are the responsibility of ACNC Behavioral Health Director, a psychologist or psychiatrist licensed and residing in the State of North Carolina. The AmeriHealth Caritas UM Director along with the ACNC UM Manager and Supervisors have responsibility for the managerial oversight of all aspects (behavioral and medical) of the UM Program and for helping to ensure that the basic components of utilization management are established and effectively operating.

Mental Health Parity

Medical management standards are applied equally with respect to mental health and substance use disorder benefits and medical/surgical benefits. Application of standards includes medical necessity criteria, admission standards for provider networks, provider reimbursement rates, restrictions based on location, facility, type or provider specialty, fail-first policies or step therapy protocols and exclusions based on failure to complete course of treatment.

The UM department periodically assesses its medical management standards against those applied by its behavioral health subcontractor to ensure that the non-quantitative treatment limits (NQTLs) applied to mental health/substance use disorder (MH/SUD) benefits, as written and in operation, are comparable to and applied no more stringently than those used in applying the same NQTLs to medical/surgical (M/S) benefits.

The UM department conducts these periodic assessments by reviewing relevant Policies and Procedures at least annually and as needed based on contract, benefit, or prior authorization changes.

Transition (Continuity) of Care

Member transitions into ACNC

As outlined in policy *UM.706NC Member Transition of Care*, ACNC provides continuing coverage of care from a non-participating provider for new Members transitioning to ACNC from another Pre-paid Health Plan (PHP) or from a Managed Care Organization/Local Management Entity (MCO/LME) or Medicaid Fee-For-Service (FFS) to help ensure continuity of care for each Member and minimize the burden on providers during the transition.

After the Crossover period, new Members enrolling with ACNC who are engaged in an active course of treatment will have their services covered for the shorter of the duration of the existing authorization with the following exceptions related to ongoing special conditions:

- Members who are scheduled for a surgery or inpatient stay who were scheduled prior to the ACNC effective date-through the date of discharge after completion of the surgery or inpatient stay and through post-discharge follow up care occurring within 90 days after the discharge that is related to that surgery or inpatient stay.
- Members who are on the schedule or on a waiting list for an organ transplant who were scheduled or placed on the waiting list prior to the ACNC effective date-through the date of discharge after the completion of the transplant and through post-discharge follow up care related to the transplant occurring within 90 days after the date of discharge.
- New Members who are pregnant in the first trimester at the time of their enrollment with ACNC-through the end of the first trimester.
- New Members who are pregnant in the second or third trimester-for the duration of their pregnancy and post-partum care period.
- In addition, for pregnant Members, coverage for behavioral health care from non-participating providers for the duration of the pregnancy.

For Members transitioning to ACNC from another PHP, MCO/LME, or the FFS program, ACNC makes best efforts to obtain pertinent Member information, including medical records, care management records, open services authorizations, prescheduled appointments (including NEMT), and any other relevant information as expediently as possible. Consistent with the contract requirements, ACNC will outreach to the Member transitioning to ACNC from another PHP, MCO/LME, or FFS program within give (5) business days from the date of the Department's notification to ACNC of the Member's enrollment date.

Members joining the ACNC will be held harmless for the cost of medically necessary covered services with the exception of applicable cost sharing. ACNC will provide coverage for medically necessary inpatient care through the date of discharge from the facility for Members who are admitted to the facility while an ACNC Member.

Member transitions out of ACNC

For Members transferring to another PHP, MCO/LME, or the FFS program, ACNC will make best efforts to provide pertinent Member information to the other PHP, LME/MCO or Fee-for-Service program upon notification that the Member is transitioning from ACNC. Information provided may include but is not limited to: medical records, care management records, open service authorizations, and prescheduled appointments (including Non-Emergent Medical Transportation).

Member Transition of Care with Change of Providers

As outlined in policy UM.707NC *Member Transition of Care with Change of Providers*, ACNC provides continuing coverage of care for Members when a provider is terminated from the ACNC network due to expiration or non-renewal of the contract.

In situations where the provider termination is related to quality of care or program integrity, ACNC Care Management staff assists the Member to identify and transition to a new provider.

Members transferring to another provider will be held harmless for the cost of transitioning from one provider to another, including copying of relevant Member information, such as medical records, care management records, open series authorizations, prescheduled appointments (including NEMT), and any other relevant materials.

Discharge Planning/Transitional Care

ACNC nurses/ licensed BH clinicians work collaboratively with staff from Population Health Management to provide appropriate access to non-hospital based healthcare in an effort to prevent unplanned or unnecessary readmissions, reduce emergency department utilization and avoid adverse Member outcomes. The Utilization Management (UM) staff work with the facility discharge planners to review and update the discharge plan, and take proactive actions to plan for discharge. Discharge planning begins upon admission to the facility. Reviewers follow the transitional care process to alert the appropriate team for outreach evaluation and intervention as appropriate. Information on discharge needs is documented in the electronic care management system. The hospital is prompted to establish aftercare services and appointments for the Member as well as identify and resolve barriers to full participation in aftercare services. Additionally, an appointment with a licensed mental health provider is expected to be scheduled by the hospital, to occur within seven (7) calendar days from a discharge for all behavioral health inpatient admissions. ACNC Population Health Management provides support to the Member post discharge by actively participating in the coordination of needed services. Oversight and monitoring of the transition/ discharge planning process is done by medical management leadership through weekly reports that show completion of the assessment and referral to the appropriate team and random case audit.

ACNC provides real time support to difficult discharge planning issues, with the goals of reducing length of stay and improving Member outcomes. From the point of admission, the concurrent review nurses and licensed behavioral health clinicians work collaboratively with the facility staff performing care coordination to provide appropriate access to non-facility based health care. The UM Clinicians work with the facility discharge planners to review and update the discharge plan, and proactively plan for the discharge, including coordination of Skilled Nursing Facility and Rehabilitation Hospital care and authorization of step-down services and discharge medications. The clinicians work closely with ACNC

medical directors and care managers to address the needs of the Member and bridge gaps in care including, long term services and support (LTSS) services, based on the Member's current needs assessment and consistent with the person centered service plan.

Members in need of long-term services and supports (LTSS) will be supported by a Care Manager. ACNC UM staff will coordinate closely with the LTSS Care Manager to help ensure that all needed services, including LTSS-specific services, are provided timely and that the care planning and authorization processes do not delay their provision. LTSS services are approved based on the Member's assessment findings and consistent with the Member's person-centered Care Plan. Transitional care management for Members with LTSS from a nursing facility or other institution includes outreach to a Member's prior care managers, Member's PCP and other health care providers and community organizations involved in the Member's care. Transition out of an institution is defined as change in Member circumstance and cause for re-assessment by the LTSS Care Manager. The housing specialist will help ensure that Members using LTSS who are transitioning from nursing facilities to the community are connected to appropriate housing options as needed.

The ACNC UM team meets weekly with representatives from Population Health Management, Provider Network Management, Pharmacy representative and a Medical Director to discuss and assist with complex discharge planning and/or barriers to care for our Members.

Population Health Management

ACNC Population Health Management strategy uses a population health framework to match Medicaid Members to the level of support they need to address their medical, behavioral health and social needs. The PHM strategy utilizes a person-centered approach that listens to and respects Member and family choices, including cultural, spiritual, and linguistic preferences. It provides customized, integrated, person-centered care to best address all aspects of Member wellness. The strategy delivers and coordinates services in a way that blends advanced data-driven stratification and analyses with appropriate levels of individual engagement such as advocacy, communication, problem-solving, collaboration, and empowerment. This coordination results in effectively and efficiently connecting Members to the right care at the right time.

The Population Health Management team includes nurses, behavioral health clinicians, non-clinical care connectors and community health navigators, clinical pharmacists, ACNC medical and behavioral health directors, primary care physicians (PCPs), Advanced Medical Homes, Local Health Departments, specialists, and community agencies. This multi-disciplinary approach supports Members, caregivers, and parents/guardians to meet our Members' needs at all levels in a proactive manner; a process designed to maximize health outcomes and quality of life.

The Population Health Management strategy consists of core components that are focused on the Member's level of need, including: Complex Care Management (CCM), Care Coordination, Bright Start Maternity Management, Pediatric/Adolescent Preventive Health Care, Disease Management, and Health and Wellness activities. Each component is designed around a holistic approach that addresses physical health, behavioral health and social determinants of health.

The guiding principles of the strategy are: person-centered care, minimally disruptive medicine, trauma-informed care, cultural humility and team-based care, with an emphasis on addressing healthy opportunities. The Population Health Management approach uses data analytics to define Member cohorts, stratify Members by their risk of experiencing certain events, deliver care targeted to the individual needs of those Members and report on individual and group outcomes to help ensure quality

and accountability. It addresses Member needs across the continuum from healthy to high-severity, chronically ill populations, including optimizing wellness (keeping Members healthy), short-term stabilization (managing Members with emerging risk), and ongoing care management (managing multiple chronic illnesses and/or disabilities). Member safety activities cross all levels of the continuum.

Delivery of Utilization Management Services

Utilization Management (UM) is an interactive process designed to provide services to Members to assist them in obtaining covered benefits that are medically necessary. UM staff is available by a toll-free telephone number/TDD/TTY during ACNC business hours, Monday through Friday from 8:00 AM to 5:00 PM EST. Providers can obtain assistance with service authorizations and/or coverage determinations after hours and on weekends (24/7) by calling the provider/member service line and being connected to a registered nurse, licensed Clinician or medical director.

Authorization

ACNC utilizes an authorization process to evaluate clinical necessity and appropriateness of select covered services for Members that are sufficient in amount and duration or to reasonably achieve the purpose for which the services are furnished. ACNC performs standard and expedited prior (pre-service) authorization review and review of ongoing services (concurrent review) for select healthcare services to determine medical necessity and eligibility for coverage under the Member's benefit package. At certain times, when information is not available to make a prior or concurrent determination and services have already been provided, Member records are reviewed retrospectively to determine benefit coverage and/or medical necessity.

The utilization management process is not used to improperly influence, change or prevent request for a prior approval. ACNC prohibits the provision of material misinformation to providers or Members or intimidation of providers or Members that has the foreseeable effect of significantly discouraging request for covered services, continuation of covered services, or the filing or prosecution of Office of Administrative Hearing (OAH) appeals. Additionally, the ACNC care management process is not be used to improperly influence, change or prevent a request for a prior approval. ACNC encourages clinical and treatment discussions between the Member and provider.

The information collected for the authorization process includes, but is not limited to the Member's name, ID number and date of birth; the practitioner's name; the planned date of service; plan of care, clinical information related to the initial service and any continued service, the dates of the planned procedure (if applicable); and clinical information to support the need for the service or admission. Only the minimum needed information for determining medical necessity and transitional care management are requested by ACNC.

Authorization requests may be submitted by the practitioner, provider and/or Member. ACNC will intervene on behalf of the Member to collect and process the clinical information needed for the authorization process if the Members requesting a service that the practitioner/provider has not requested timely or is refusing to request. ACNC may request the Member to see another provider to facilitate the clinical evaluation necessary to process the service request. Licensed utilization staff may approve services based on application of ACNC medical necessity criteria.

ACNC furnishes covered benefits/services in an amount, duration and scope no less than the amount,

duration and scope for the same services under Fee-for-Service. ACNC will not arbitrarily deny or reduce the amount, duration or scope of a required service because of the diagnosis, type of illness or condition of the Member. Determinations are made and communicated in accordance with Policy UM.010NC *Decision Response Time*. Both telephonic and written communications contain the process for appealing any adverse determination that is made.

EPSDT related requests

ACNC covers services, products, or procedures for an ACNC Member less than 21 years of age if medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. ACNC covers EPSDT services in an amount, duration and scope no less than the amount, duration and scope for the same services under Fee-for-Service and as defined in North Carolina DHHS EPSDT policies. ACNC does not make an adverse benefit determination on a service request for a child until the request is reviewed per EPSDT criteria.

ACNC covers medically necessary services within the categories of mandatory and optional services, regardless of whether such services are covered under the NC Medicaid State Plan and shall refer to and arrange any services not included within the scope of the contract. When reviewing a service authorization for members under twenty-one (21) years of age, ACNC shall determine whether a service is medically necessary on a case by case basis, taking into account the medical necessity criteria specific to EPSDT defined in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62 and the particular needs of the child, including the application of medical necessity criteria by an appropriately licensed medical professional to the documented, individual clinical condition of the member.

While an EPSDT request is under review, ACNC may suggest alternative services that may be better suited to meet the child's needs, engage in clinical or educational discussions with participants or providers, or engage in informal attempts to resolve participant concerns as long as it is clear that the Member has the right to request authorization of services. ACNC provides referral assistance for non-medical treatment not covered by the plan but found to be needed because of conditions disclosed during screenings and diagnosis.

The PHP shall comply with the Department's standards for the timely provision of EPSDT services. For purposes of this Contract, the "timely provision of EPSDT services" shall mean that a Member shall have a scheduled appointment for an EPSDT service no more than six (6) calendar weeks form the date of the request for an appointment.

Referrals

Referrals are not required for a Member to access care with network providers, including but not limited to participating specialists, or ancillary providers. Additionally, referrals are not required to access family planning services and supplies, reproductive health services and supplies, school based clinic services, emergency and post stabilization services from in-network or out-of-network providers. Tribal Members do not need a referral to receive care from Indian Health Care Providers, whether or not the Indian Health Care Provider participates with the ACNC network.

Members are encouraged to work through their PCP for coordination of healthcare needs including use of specialists and ancillary services. Members can seek care from participating specialists without direction from their PCP; ancillary services require a physician's prescription/order.

Members may access behavioral health services directly without contacting ACNC or their PCP for referral. ACNC has established standards to help ensure timely Member access to behavioral health services based on level of need. Providers will triage Members and help ensure they access services within the established access standards.

Occasionally, a Member may be referred to an out-of-network practitioner or provider because of the special needs and qualifications of the out-of-network practitioner/provider. ACNC makes such decisions on a case-by-case basis in consultation with an ACNC Medical Director. ACNC will cover and pay for care that it has pre-authorized to be provided out of its established network.

Referral to the Population Health Care Management Programs: Any ACNC practitioner, provider, Member, or staff person can refer a Member to one of the ACNC Population Health programs. Specific programs exist for Members with complex care needs or chronic conditions, and for Members of priority populations including Members who are pregnant.

Emergency Room and Post Stabilization Services

ACNC does not require a referral or prior authorization for an emergency medical service or treatment from an in-network provider or out-of-network provider that may be required to stabilize the identified condition, including transfer to another facility. Emergency room claims and payments are automatically paid and will not be denied regardless of diagnosis, provided that the diagnosis is not a benefit exclusion (e.g. fora medical legal purpose). Emergency room claims will not pend for medical necessity review.

In accordance with 42 C.F.R. § 438.114(e), ACNC will cover post-stabilization services from in-network providers and from out-of-network providers and will limit charges to a Member to an amount no greater than what would be charged if he or she had obtained the services through the network. This includes all medical and behavioral health services that may be necessary to assure that no material deterioration of the Member condition is likely to result from, or occur during, discharge of the Member or transfer of the Member to another facility.

Requests for post-stabilization authorization that are not responded to within one (1) hour from initial request, or if ACNC staff was not available at the time of initial request, will be covered without the requirement of prior authorization regardless of provider's contract status. If the treating physician and ACNC representative cannot reach an agreement concerning the Member's care and a participating provider is not available for consultation, ACNC will give the treating physician the opportunity to consult with a participating provider and the treating physician may continue to care for the patient. ACNC financial responsibility for Post Stabilization service shall end when:

- a participating provider with privileges at the treating hospital assumes responsibility for the Member's care;
- a participating provider assumes responsibility for the Member's care through transfer;
- a representative from ACNC and the treating physician reach an agreement concerning the Member's care;or
- The Member is discharged.

Medical Necessity Decision Making

Medical Necessity is determined by generally accepted North Carolina community practice standards

as verified by independent Medicaid consultants. As required by 10A NCAC 25A.0201, a medically necessary service may not be experimental in nature.

To make clinical decisions, ACNC uses nationally recognized, evidence-based criteria, which are applied, based on the needs of the individual Member, characteristics of the local delivery system and applicable contract language concerning benefits and exclusions. Service authorization staff that make medical necessity determinations is trained on the established and approved criteria.

ACNC uses nationally recognized and/or community developed evidence-based criteria for issuing coverage determinations related to medical services. For services covered by mandated NC DHHS Clinical Coverage polices, clinical criteria application is performed using the DHHS Clinical Coverage policy. Criteria are reviewed annually for appropriateness to the ACNC's population needs and updates as applicable when nationally or community-based clinical practice guidelines are updated.
The annual review process involves appropriate practitioners in developing, adopting and reviewing criteria. The criteria are consistently applied in consultation with requesting providers/practitioners when appropriate.

Any request that is not addressed by, ordos not meet, medical necessity guidelines is referred to the Medical Director or designee for a decision. Any decision to deny, alter or limit coverage for an admission, service, procedure or extension of stay, based on medical necessity, or to approve a service in an amount, duration or scope that is less than requested is made by the ACNC Medical Director/Behavioral Health Medical Director or designee with expertise in addressing the Member's medical, behavioral health or LTSS needs. The Medical Directors and their designee(s) have no history of disciplinary action or sanctions taken or pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.

Medical necessity decisions made by the ACNC Medical Director, Behavioral Health Medical Director or designee are based on the North Carolina definition of Medically Necessary Services in conjunction with the Member's benefits and medical/behavioral expertise. At the discretion of the Behavioral Health Medical Director, Medical Director or designee, participating board-certified physicians from an appropriate specialty, other qualified healthcare professionals or the requesting practitioner/provider may provide input to the decision. If a decision requires specialized judgment, ACNC contracts with external Independent Review Organizations (IRO) with sub-specialist physicians available to participate in utilization review. The ACNC Medical Director, Behavioral Health Medical Director or designee makes the final decision. Only medical director may issue an adverse benefit determination of medical or behavioral health services based on medical necessity.

In accordance with Policy UM.008NC *Clinical Criteria*, ACNC uses the following criteria for medical necessity decision-making:

1. North Carolina DHHS Clinical Coverage Policies including but not limited to:
    a. 8A: Enhanced Mental Health and Substance Abuse Services
    b. 8A-2: Facility-based Crisis Services for Children and Adolescents
    c. 8B: Inpatient Behavioral Health Services
    d. 8C: Outpatient Behavioral Health Services Provided by Direct-enrolled Providers
    e. 8Q: Research-based Intensive Behavioral Health Treatment for Autism Spectrum Disorder

f. 1E-7: Family Planning Services
g. 1A-5: Child Medical Evaluation and Medical Team Conference for Child Maltreatment
h. 1A-23: Physician Fluoride Varnish Services
i. 1A-36: Implantable Bone Conduction Hearing Aids (BAHA)
j. 1A-39: Routine Costs in Clinical Trial Services for Life Threatening Conditions
k. 13A: Cochlear and Auditory Brainstem Implant External Parts replacement and Repair
l. 13b: Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement and Repair

2. InterQual® Adult Criteria (Condition Specific- Responder, Partial Responder, Non-responder)
3. InterQual® Pediatric Criteria (Condition Specific- Responder, Partial Responder, Non-responder)
4. InterQual® Outpatient Rehabilitation and Chiropractic Criteria
5. InterQual® Home Care Criteria
6. InterQual® Procedures Criteria
7. InterQual® DME Criteria
8. InterQual® Criteria for Behavioral Health Adult and Geriatric Psychiatry Criteria
9. InterQual® Criteria for Behavioral Health Child and Adolescent Psychiatry Criteria
10. InterQual® Criteria for Behavioral Health Residential and Community Based Treatment
11. American Society of Addiction Medicine (ASAM) Patient Placement (except for members aged 0 through 6; EPSDT criteria will be used for members in this age range)
12. Behavioral Health Screening Tools:
    a. Level of Care Utilization System (LOCUS) for members aged 18 and older
    b. Child and Adolescent Level of Care Utilization System (CALOCUS) for members aged 6 through 17
    c. Early Childhood Services Intensity Instrument (ECSII) or Child and Adolescents Needs and Strengths (CANS) for infant, toddler and preschool aged members (ages 0 through 5)
    d. Supports Intensity Scale (SIS) for I/DD services for members aged 5 and older(SIS Children version required for members between the ages of 5 through 16 and the SIS Adult version required for members aged 17 and older)
13. North Carolina Administrative Code& Rules
14. NIA Radiology Guidelines
15. AmeriHealth Caritas Corporate Clinical Policies

ACNC adopts preventive and clinical practice guidelines from nationally established sources that develop clinical practice guidelines with a sound scientific basis. Guidelines are based on documented scientific evidence, professional standards, and consensus of expert opinion. Potential topic areas and guideline sources for preventive health and clinical practice guidelines are based on member need, common health conditions, and concerns of the ACNC population. Guidelines are reviewed by board certified practitioners who review the guidelines against clinical evidence at least every two years, or more frequently if guidelines change within the two-year period. The ACNC QAPI Committee, including

contracted network health professionals, makes the final decision on adoption of the clinical practice guidelines. ACNC clinical practice guidelines meet the clinical practice guidelines required for Health Plan Accreditation set forth by the National Committee for Quality Assurance (NCQA).

Corporate Clinical Policies and Clinical Practice Guidelines are made available to Members and practitioners/providers on the ACNC website. Members/Practitioners may request copies of guidelines used for a medical necessity determination at any time by contacting the plan.

Prior authorization is not a guarantee of payment for the service authorized. ACNC reserves the right to adjust any payment made following a review of the medical record or other documentation and/or determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member's eligibility changes between when the authorization was issued and the service was provided.

Consistency in Criteria Application

The Utilization Management staff involved in medical necessity decisions is assessed for consistent application of review criteria a minimum of two times a year as outlined in Policy UM.708NC *Inter-rater Reliability Testing for Utilization Management Staff*. An action plan is created and implemented for any variances among staff outside of the specified range. Clinical and non- clinical staff are audited for adherence to policies and procedures.

Staff Roles and Responsibilities

Within Utilization Management, the role of each staff member is clearly defined and operationalized to help ensure all aspects of the UM process exemplify care coordination efforts for quality administration of health care benefits, in accordance with North Carolina requirements, state and federal laws and regulations, and accreditation guidelines. At any time there is a difference between the standards, the more restrictive standard is applied to the ACNC UM Program. Utilization Management staff involved in medical necessity review determinations has the knowledge and skills to evaluate clinical information used to support medical necessity decisions. Written job descriptions outline the qualifications applicable for each level of medical necessity decision making. Documentation of current licensure for nurses, physicians (practitioner), and behavioral health professionals, is maintained in the individual's personnel or credentials file.

Current licensed nurse reviewers and licensed behavioral health clinicians, whose education and experience meet the job qualifications, perform the initial review of the clinical information against criteria. Qualifications for physician/practitioners who review requests for care based on medical necessity include education, training or professional experience in medical or clinical practice and current U.S. license to practice without restriction.

Requests for benefit coverage or medical necessity determinations are made through staff supervised by a Registered Nurse and/or Licensed Behavioral Health Clinician. Decisions to approve coverage for care may be made by Utilization Management staff when falling within AmeriHealth Caritas North Carolina's written guidelines. Certain services may be authorized by clinical (licensed nurse or licensed behavioral health clinician) or non-clinical staff if the request is supported by ACNC approved review criteria.

The ACNC Chief Medical Officer is supported by other licensed physicians, behavioral health clinicians and healthcare professionals. Together, they provide clinical review of medical information and/or peer-

to-peer contact with attending/treating physician and/or other healthcare practitioners when there is conflicting medical information or there are questions on application of medical necessity guidelines. Any decision to deny, alter or approve coverage for an admission, service, procedure or extension of stay in an amount, duration or scope that is less than requested is made by the ACNC Behavioral Health Medical Director, Medical Director or designee. Only medical director may issue an adverse benefit determination.

Prior Authorization

Decisions to require prior authorization for certain services are based on data, such as utilization data that indicate services that are likely to be over utilized, costly or may potentially signal conditions that might require extensive clinical or care management interventions. ACNC performs non-urgent and urgent prior (pre-service) authorization review of select health services to determine medical necessity and eligibility for coverage under the Member's benefit package.

Concurrent Review

ACNC performs concurrent review of inpatient hospitalizations, to assess the inpatient stay based on clinical information related to the Member's care, evaluate appropriate utilization of inpatient services, and promote delivery of quality care on a timely basis. In addition, concurrent review provides information to facilitate the discharge plan and allows for peer consultation between the attending facility physician and the ACNC's Medical Director as needed. Concurrent Review also identifies and facilitates engagement of the transitional care manager and workflows.

Retrospective Review

At times, when information is not available to make a prior or concurrent determination and services have already been provided, Member records are reviewed retrospectively to determine benefit coverage and/or medical necessity. In these instances, the record is reviewed and a decision is reached within 30 calendar days of receiving the necessary information. In the case of an adverse determination, the attending or treating health care professional, institutional provider and/or Member are notified of the decision and the reason for the decision.

The following tables reflect the timeframes for delivery of UM Services:

Table B: Utilization Management Decision Timeframes for Covered Services

Review Type	Review Timeframe	Extension
Preservice Non-urgent	14 calendar days from receipt of request.	14 calendar days (if requested by Member or provider/practitioner; or if ACNC justifies (to the State upon request) that it is in the best interest of the Member.
Preservice Urgent	No later than 72 hours after receipt of request	14 calendar days (if requested by Member or provider/practitioner; or if ACNC justifies (to the State upon request) that it is in the best interest of the Member.

Urgent / Concurrent	72 hours	May extend the time frames by up to 14 calendar days if it needs additional information but must notify the Member and the Member's authorized representative of its decision as expeditiously as the Member's health condition requires, but no later than the expiration of the extension
Post Service	30 calendar days	NA

Table C: UM Notification Time Frames for Covered Health Services

Decision	Notification Timeframe	Notification to	Notification Method
Pre-service Non Urgent	Based on Member's need but no more than 14 calendar days from the receipt of the request unless extension requested/given	Member Practitioner/provider	Electronic/written
Pre-service Urgent	72 hours from receipt of request unless extension requested/given	Member Practitioner/provider	Electronic/written

Decision	Notification Timeframe	Notification to	Notification Method
Urgent/concurrent	72 hours from receipt of request unless extension requested/given	Practitioner/provider	Oral, Electronic/written,
Post Service	30 calendar days from receipt of request	Member(if at financial risk) Practitioner/provider	Electronic/written

Determinations to Deny Coverage

Prior to any determination to deny coverage or authorization for health care services, it is the policy of ACNC to make reasonable efforts to contact the requesting provider to bridge any gap in information, clarify medical needs, and reach agreement on a plan of care that will meet the Member's needs. 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 SNAP (score for neonatal acute physiology) for neonatal acute physiology) score or other clinical assessment.. Prior to the decision on a request for prior approval, ACNC will limit contacts with the requesting provider or Member to those needed to obtain more information about the service

request and/or provide education about covered services.

At the time of the fax/verbal notification of a determination to deny or limit coverage or authorization, the healthcare practitioner/provider is informed of the availability to discuss the determination with ACNC Medical Director and/or designee who made the determination. Through this reconsideration (Peer-to-Peer) process, practitioners/providers are given an opportunity to discuss a determination to deny or limit coverage with the ACNC Medical Director and/or Designee.

The Member and requesting health care practitioner/provider receive a written notice of any decision to limit or deny coverage or authorization (the Adverse Benefit Determination). The Adverse Benefit Determination contains the reason for the decision and the process to appeal the decision, in accordance with Policy UM.017NC - *Notice of Adverse Benefit Determinations.*

Member Appeals

ACNC appeal policies and procedures are based on federal, state and accreditation requirements as well as state regulations and contractual requirements. The ACNC Member Handbook, Provider Manual, and policies and procedures describe how a Member, practitioner or provider acting on the Member's behalf who is dissatisfied with an adverse benefit determination can file an appeal. Changes in the appeals process are published in member and provider newsletters or other applicable documents such as the Member Handbook.

Members are provided information about the grievance, appeal and State Fair Hearing process in the Member Handbook and in the adverse benefit determination letters that are issued in conjunction with the utilization review process.

The Provider Network department gives each practitioner information about the member appeal and State Fair Hearing process at the time they enter a contract with ACNC as well as through a variety of other sources, including the provider manual, provider newsletters, and the Plan website.

The Appeals Coordinator, in collaboration with the Member Services department and Provider Services department, is responsible for informing and educating members and practitioners about a member's right to file a grievance or appeal or request a State Fair Hearing and for assisting members in filing a grievance or appeal or requesting a Fair Hearing.

The Appeals Coordinator completes a full investigation of the substance of the appeal including any aspect of clinical care and actions taken. The member is given the opportunity to submit written comments, documents or other information related to the appeal. Upon request and free of charge, members are given reasonable access to and copies of all documents relevant to the appeal. Authorized representatives are permitted to act on a member's behalf. Information concerning the appeal process and notices are provided to members in a culturally and linguistically appropriate manner. Members may request continued coverage pending the outcome of the appeal; however, if an appeal decision is adverse to the member, ACNC may seek reimbursement for services provided during the appeal.

The member or member's representative may file or request an appeal within 60 calendar days of the Notice of Adverse Benefit Determination. ACNC will resolve standard appeals as expeditiously as the member's health conditions require but no more than 30 calendar days of receipt. For expedited appeal requests, ACNC will resolve the appeal as expeditiously as the member's health conditions

require but no more than 72 hours from receipt of the request. When an authorization decision is overturned on appeal, ACNC will provide authorization for the services within 72 hours.

All appeals of medical necessity decisions require are view from a same-or-similar specialist. A Medical Director with clinical expertise treating the Member's condition or disease and who was not involved in the initial determination and who is not a subordinate of any person involved in the initial determination will render the determination.

The appeal decision will be communicated to the member in easy to understand language. The written communication will contain the credentials, title, qualifications and specialty of each reviewer who participated in the appeal. For appeals not resolved wholly in favor of the member, the written notice shall include the right to file a State Fair Hearing, including the procedures to do so and the right to request continuation of benefits while the hearing is pending, including the instructions on how to make the request. The written notice shall also include notice that the member may be held liable for the cost of those benefits if the hearing upholds ACNC's action.

Member request for appeals are documented in the UM authorization system for tracking and trending. Member appeals are tracked, trended and reviewed by the Quality Assessment Performance Improvement Committee.

UM Information System

The ACNC UM information system generates and stores an authorization number and the effective dates of the authorization along with the servicing and requesting practitioners/providers, regardless of contracted status. The system stores and reports service authorization requests, authorization decisions, clinical data to support the decision and the timeframes in which the practitioners/providers and/or members were notified of the decision.

Staff members document certain required information pertaining to the authorization request, including diagnosis, requested service, Member information, primary care provider or treating practitioner and other involved providers/practitioners along with their contact information, the reason for the request, clinical information applicable to the request and any information that supports the decision for medical necessity. The Medical Director is responsible for documenting the actions taken for these medical review requests and confirming that the date(s), final decision, reason for the decision, and criteria used is captured within the documentation.

Quality Assessment Performance Improvement Committee

The Quality Assessment Performance Improvement Committee (QAPIC) provides monitoring, oversight and direction for the UM Program. Committee responsibilities related to the UM Program includes:

- Reviewing and approving medical necessity criteria and clinical and preventive practice guidelines used by ACNC.
- Monitoring and evaluating utilization of health services (including over- and under-utilization and outliers) and the effectiveness of utilization management activities.
- Monitoring and reviewing provider performance with respect to quality and utilization outcomes and application of clinical practice guidelines.
- Reviewing and approving program policies and procedures related to the UM process.
- Monitoring and evaluating performance related to appeal processing and service indicators.

- Reviewing results of program clinical outcome collection, clinical practice guideline adherence, medical record review outcomes and utilization results to identify opportunities for improvement and overseeing related improvement plans.
- Monitoring and evaluating consistent application of medical necessity criteria and overseeing related improvement plans.
- Reviewing results of Member and provider satisfaction and appeal data to identify opportunities for improvement.
- Reviewing and approving the UM Program description, UM Program evaluation and UM policies and procedures.
- Monitoring performance of program delegates and vendors and recommending interventions, as appropriate.

Quality Improvement

The UM Program is one component of ACNC's quality infrastructure and set of business processes that allow the achievement of high quality outcomes and service and is an integral part of the way ACNC does business. In addition to providing an interface to the ACNC Quality Assessment/Performance Improvement Program, the UM Program employs systemic monitoring and evaluation of utilization management processes and services against objective criteria and tools. Utilization Management activities are monitored on the individual, team and program level.

Data on Member and provider satisfaction with utilization management processes, including the grievance and appeal systems, are collected through the Quality Assessment Performance Improvement program activities and used to evaluate opportunities for improvement. Additional data used for quality monitoring includes, but is not limited to: Average Speed of Answer, call volume, abandonment rate, Inter-rater Reliability review outcomes and functional process audit results, including:

- Intake/Triage.
- Prior Authorization.
- Concurrent Review.
- Discharge Planning.
- Medical Review.
- Provider Medical Grievances, Member Grievances and Appeals.
- Decision Timeliness.

Action plans are developed to address identified variances. Performance results and action plan results are communicated to staff via individual sessions, team meetings and department communications and reported to the QAPIC.

In addition, the UM Program serves as a window into the quality of care and services received by the individual Member and the population as a whole. Data collected through the performance of UM activities is used in the following manner:

- Referral of potential quality-of-care issues on an individual Member basis.
- Identification of access issues and gaps in health care service availability.
- Aggregation of data related to provider practice patterns.
- Identification of areas for medical policy development and/or revision.
- Identification of opportunities to improve processes to enhance provider and Member experience with utilization management activities.

Potential quality-of-care issues are investigated by the ACNC Quality Management staff to address access issues, gaps in health care service availability and medical policy changes. Data on provider practice patterns are reviewed by the ACNC leadership, with action taken under the direction of the ACNC Quality Program. Opportunities to improve Member and provider satisfaction are reviewed by the UM Program medical leadership at least annually.

Fraud, Waste, and Abuse

Incidents of alleged provider or Member fraud and abuse received from Members, employees, and providers are sent to the ACNC Chief Compliance Officer and/or the ACNC SIU Lead. A review is then conducted by Special Investigations Unit (SIU) personnel who will evaluate the referral results for validity and obtain the documentation to support the investigation. The ACNC Chief Compliance Officer is responsible for making the decision on which fraud, waste, and abuse cases to refer to the North Carolina Department of Health and Human Services (the "Department"). All cases involving a credible allegation of fraud will be referred to the Department within 5 days of making a credibility determination as to the allegation.

Over and Underutilization

ACNC has internal monitoring processes to continuously evaluate the activities of providers, Members, and employees to proactively reduce the financial and negative impact of potentially fraudulent activity to ACNC and the State of North Carolina. ACNC assesses utilization practices and patterns to identify over- or under-utilization through monitoring of monthly and quarterly key indicator reports, analyzing utilization trends of membership and the annual program evaluation and makes program adjustments as needed.

Delegated Activities

For potential delegates, ACNC conducts a pre-delegation audit to help ensure they have the capability to perform and are adequately performing the function. Results of the pre-delegation audit are reported to QAPIC.

Delegation arrangements are governed by agreements that outline the scope of activities, performance expectations, reporting responsibilities and consequences for failure to meet the contract requirements. Delegates are expected to follow all ACNC contract requirements which are outlined in each delegation agreement. Reports from delegated entities are routinely reviewed by management and appropriate committees within ACNC's quality structure and more frequently if necessary. ACNC may investigate/audit delegate performance at any time. Results of annual oversight audit and any additional investigations/audits are presented to the QAPIC, which approves the on- going delegation arrangements for these entities. ACNC maintains responsibility and accountability for delegated functions.

ACNC delegates pre- and post-service review, including medical necessity determinations and notification of adverse determination, for the below services to National Imaging Associates:

- Nuclear cardiology.
- Computed tomography angiography (CTA).
- Coronary computed tomography angiography (CCTA).
- Computed tomography (CT).

- Magnetic resonance angiography (MRA).
- Magnetic resonance imaging (MRI).
- Myocardial perfusion imaging (MPI).
- Positron emission tomography (PET).

Performance reports are received and reviewed monthly, and include the timeliness of medical necessity determinations and the timeliness of notification of the determination. Performance results are reported to the QAPIC and appropriate action is taken if performance metrics are not being met.

Prohibition of Incentives

ACNC professional staff does not receive incentives directly or indirectly related to utilization management determinations. Professional knowledge, the appropriate application of standardized resource information, adherence to regulatory and credentialing standards, and following plan policies and procedures are the requirements and accountability professional staff must adhere to.

The ACNC Code of Conduct and Ethics (the "Code") includes a section on "Ensuring Appropriate Services for Members," which affirms ACNC's requirements that: Utilization management (UM) decisions are based only on appropriateness of care and service and existence of coverage; providers, associates or other individuals conducting utilization review are not rewarded by ACNC for issuing denials of coverage or service; and financial incentives for UM decision makers do not encourage decisions that result in under-utilization.

All ACNC employees are required to adhere to the Code. The Code is distributed or made available electronically and reviewed with staff upon hire and annually thereafter. Specifically, all employees are required to attest that they have read and agree to abide by the Code upon hire and annually thereafter.

Confidentiality

The Utilization Management process deals with sensitive Member and provider information. Documents that are created and reviewed as a part of the Utilization Management process are confidential and are maintained in compliance with appropriate federal and state privacy laws and regulations and other regulatory requirements.

All employees, participating providers and consultants must maintain confidentiality standards required by the Code regarding both patient information and proprietary information. All employees are required to sign a Confidentiality, Privacy and Security Agreement as a condition of their employment.

Evaluation and Annual Update

The UM Program is reviewed, evaluated and updated annually by the ACNC Utilization Management Director, Behavioral Health Director and ACNC Corporate Chief Medical Officer. The updated Program is then presented to the QAPIC for approval. Recommendations are made to improve the effectiveness of the Program and the Program's ability to reach established goals and objectives.

ACNH will revise the UM Program Description based on changes requested by DHHS and submit to DHHS in writing any changes to the UM Program no less than sixty (60) calendar days before the changes go into effect. ACNC will education and provide training for providers and prescribers on any

changes to the UM Program prior to the effective date of the change.

Utilization Management Approval Page

Disposition	**Printed Name**	**Signature/Initials**	
Approved			
Approved			

Revisions

Date	Description of Changes
11/3/2020	Updated formatting, updated effective dates
4/1/2021	Added verbiage to bottom of the Evaluation and Annual Update section.