Alliance
BEHAVIORAL HEALTHCARE

# Provider Operations Manual

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# SECTION I: INTRODUCTION AND OVERVIEW



## A. WELCOME TO ALLIANCE BEHAVIORAL HEALTHCARE

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

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

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

All timelines in this document refer to calendar days unless otherwise specified. A "business" or "working" day refers to a day on which Alliance is officially open for business.

We thank you for your participation in our Network, and look forward to a long and rewarding partnership as we work together to provide quality treatment to the individuals we all serve.

## B. MESSAGE FROM THE ALLIANCE CHIEF EXECUTIVE OFFICER

Dear Providers,

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

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

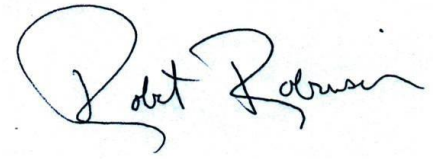
It is Alliance's goal to manage a comprehensive Provider Network that is integrated and responsive. We seek to maintain an environment in which providers can be successful both clinically and financially. Alliance Network Providers must be mission-driven, willing to work cooperatively on behalf of consumers and their family members, and be active participants within Alliance's System of Care. Medicaid is the payor of last resort, and Alliance Network Providers are expected to maximize other sources of funding and to extend public funding as far as possible.

Alliance recognizes that a comprehensive, community-wide System of Care requires multiple providers working together in collaborative relationships to serve consumers in the most effective and efficient manner possible. While these relationships sometimes prove challenging, they are the foundation on which we create and maintain the System of Care our consumers and our community deserve. Alliance is interested in your perception of our operations as well. To evaluate performance, we will measure the satisfaction of your experience with Alliance as well as your experiences with other providers. We believe this information is important and will lead to continuous improvement in both quality and efficiency.

As the system evolves, Alliance will use performance indicators, outcome measures and other factors to determine selection and retention of providers in our closed Network, but consumer access to care will remain the primary determining factor. Alliance will always strive to maintain an appropriate balance between consumer choice and our responsibility to effectively and efficiently manage publicly-funded MH/IDD/SA services.

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

Sincerely,



Rob Robinson
Chief Executive Officer
Alliance Behavioral Healthcare

## C. WHO WE ARE

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

As an LME/MCO, Alliance is responsible for authorizing, managing, coordinating, facilitating and monitoring the provision of State, Federal and Medicaid-funded MH/IDD/SA services in Cumberland, Durham, Johnston and Wake Counties. The LME/MCO model developed by the State utilizes a funding strategy that includes single management of all public funding resources through a local public system manager. Under this model, Alliance receives funding from multiple Federal, State and County sources. The financing provides for coordination and blending of funding resources, collaboration with out-of-system resources, appropriate and accountable distribution of resources, and allocation of the most resources to the people with the greatest

disabilities. Re-engineering the system away from unnecessary high-cost and institutional use to a community-based system requires that a single entity has the authority to manage the full continuum of care.

## D. ALLIANCE MISSION, VISION AND VALUES Our Mission

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

### Our Vision

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

### Our Values

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

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

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

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

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

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

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

paid resources with natural supports and other community partners to address the holistic needs of individuals served through Alliance.

Assessment, person centered planning, active care management and care coordination are essential elements of the clinical model. Comprehensive assessment of consumer needs beyond behavioral healthcare is an essential first step for positive treatment outcomes. Assessment examines a consumer's need for behavioral health services, physical health, housing, education and or vocational needs, barriers and general support needs to enhance symptom reduction, recovery and the ability for one to live as independently as possible.

Person-centered and individualized service plans are developed to address the needs highlighted through the comprehensive assessment. Alliance Care Managers play an active role to ensure that the needs identified through the assessment and person-centered planning processes are being actively addressed by the treating providers. Care management includes review of requests for service, follow-up contact with providers and consumers, review of services provided, identification of both individual and systemic service over- and under-utilization and provider consultation and technical assistance. Alliance also provides care coordination to individuals deemed high-risk and who have special healthcare needs that requires a high level of coordinated care and monitoring to ensure that services are addressing multiple needs, safely, and at the least restrictive level of care possible.

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

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

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

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

- Day Treatment.
- Psychosocial Rehabilitation.

- Twenty-four (24) hour residential and treatment providers.

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

- Conduct a Comprehensive Clinical Assessment.
- Develop the Person-Centered Plan (PCP), treatment plan, and/or individual service plan (ISP) as well as a crisis plan that address the consumer as a whole person.
- Coordinate service provision for the consumer, including monitoring of those services which includes managing and taking responsibility for a team approach to treatment and service provision.
- Make revisions to the PCP/treatment plan when the consumer's needs indicate a change of service or provider.
- Submit the necessary registration and authorization request paperwork to Alliance.
- Crisis response services as required by the applicable service definition.
- Upon discharge from a behavioral health home provider and no other service provider remains in place, the behavioral health home provider will retain crisis response duties for 60 days post discharge.

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

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

## F. MEDICAID WAIVERS: WHAT IS THE NC MH/DD/SAS HEALTH PLAN?

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

Through the 1915(b) and 1915(c) sections of the Social Security Act, states are permitted to submit a request to waive some Medicaid requirements in order to provide

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

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

## G. ABOUT THE NC INNOVATIONS WAIVER

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

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

In Provider-Directed Supports, services are delivered in a traditional manner with staff in the employment of an agency. Participants and their families have the opportunity to choose their NC Innovations service providers and are included in support planning.

The service provider is fully responsible for the employment of individuals who work with the participant.

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

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

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

www.AllianceBHC.org/consumers-families/idd-resources/nc-innovations-1915-c-waiver
www.ncdhhs.gov/dma/lme/Innovations.html

## H. OTHER PUBLICLY-FUNDED SERVICES

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

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

Alliance manages a variety of County-funded programs, including but not limited to crisis and assessment centers and outpatient walk-in clinics, and is also responsible for the nationally award-winning BECOMING (Building Every Chance of Making It Now and Grown up) is program funded by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). It targets high-risk 16-21 year olds in Durham County who

have mental health challenges and have become disconnected from services and supports that would normally assist them in transitioning to adulthood.

Through partnerships within the community, BECOMING connects these youth with literacy support services, coordination of clinical care, employment services, positive recreational opportunities and leadership training, with a goal of helping make these transitions more successful.

www.AllianceBHC.org/consumers-families/getting-started/non-medicaid-services
www.AllianceBHC.org/consumers-families/crisis-and-access
www.AllianceBHC.org/consumers-families/system-of-care/becoming

# SECTION II: PROVIDER RESPONSIBILITIES AND INVOLVEMENT

A. Provider Responsibilities
B. Provider Involvement

## A. PROVIDER RESPONSIBILITIES

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

Providers must be knowledgeable and compliant with all applicable requirements of State and Federal law, rules and regulations governing the provision of MH/IDD/SA services, DMA Clinical Coverage Policies, DMH Manuals including Confidentiality APSM 45-1 (1/05), Client Rights Rules in Community Mental Health, Developmental Disabilities & Substance Abuse Services APSM 95-2 (7/03), Records Management and Documentation Manual APSM 45-2 (3/3/09) (Effective April 1, 2009), DHHS Medicaid Bulletins, DMH/DD/SAS Communication Bulletins and Joint Implementation Updates, this Manual and any applicable supplements or revisions, the Alliance Weekly Update and other official Alliance or DHHS communications, and the terms and conditions in Provider's contract(s) with Alliance.

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

**Alliance Network Providers are required to stay updated about current information affecting our consumers:**

- Provide medically necessary services according to the most recent State standards and/or waiver service definitions.
- Participate and assist with utilization/care management, quality management, evaluation and monitoring activities, peer review, credentialing, recredentialing and appeals and grievances.
- Attend and participate in Provider Meetings.
- Adhere to this Manual and review the Alliance website for updates on a regular basis: www.AllianceBHC.org.

- Review State and Federal websites for the most up-to-date information on a regular basis:
  www.ncdhhs.gov/mhddsas/
  www.ncdhhs.gov/dma/
  www.cms.gov/
- Keep all relevant staff in your agency informed of new and/or changing information as it relates to their function within the agency.
- Work in conjunction with the appropriate department at Alliance for technical assistance when needed.

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

- Timely respond to requests for information from Alliance.
- Timely submit credentialing and re-credentialing information.
- Collaborate with monitoring and evaluation activities.
- Cooperate and comply with Plans of Corrections or other compliance activity.
- Timely submit all notice of change forms.

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

- Let Community Relations know about events in your county for consumers.
- Participate in the education of stakeholders and consumers on system access, services and supports available, appeals and grievances, Advanced Directives and the Provider Network.
- Actively participate in community collaborative efforts to develop prevention, education and outreach programs.
- Work in collaboration with other providers, consumers and families.
- Assist in the development of educational materials and brochures on mental illness, developmental disabilities and substance abuse to educate the community about the needs of people with disabilities.
- Be responsive to the cultural and linguistic needs of the consumers your agency serves.
- Pursue the acquisition of knowledge relative to cultural competence and the provision of services in a culturally competent manner. Provide culturally competent services and ensure the cultural sensitivity of staff members. Develop a Cultural Competency Plan and comply with cultural competency requirements.
- Demonstrate consumer friendly services and attitudes. The Network Provider must have a system to ensure good communication with consumers and families.
- Participate in quality improvement activities including consumer satisfaction surveys, provider satisfaction surveys, clinical studies, incident reporting, performance improvement projects and outcomes requirements.
- Participate in the coordination of care among different providers including other MH/IDD/SA providers as well as physical health care providers.

**Alliance Network Providers must comply with all billing and claims processing requirements:**

- Obtain authorizations as required for contracted services.
- Provide services only at credentialed site locations identified in your contract(s).
- Provide only those services for which your agency is credentialed and approved by Alliance.
- Verify consumer insurance coverage at the time of referral, admission, each appointment, and on a quarterly basis.
- Bill all first and third party payers prior to submitting claims to Alliance.
- Report all first party required fees and third party payments and denials on the claim you submit to Alliance.
- Timely submit Clean Claims electronically as stated in your contract.
- Ensure that your agency is monitoring your account receivable balance so that claims continue to be submitted in a timely manner.
- Submit all documentation which is required for Federal, State, or grant reporting requirements. This includes, but is not limited to, required consumer enrollment demographics that must be reported to the State of North Carolina by Alliance.
- Never submit claims for payment with the intention or understanding that it will be used for any purpose other than that described in the supporting documentation for the payment as it is against the law to knowingly submit false, fraudulent or misleading claims, including claims for services not rendered, or claims which do not otherwise comply with applicable program contractual requirements.
- Comply with NCTracks enrollment requirements (change requests, affiliation disclosures, etc.).

**Alliance Network Providers must comply with all Clinical, Utilization Management and Authorization requirements:**

- Ensure that consumers meet medical necessity requirements for all services provided.
- Provide medically necessary covered services to consumers according to your contract and as authorized by Alliance.
- Strive to achieve best practice in every area of service.
- Actively participate with the individual, their families, community resources, and other providers in development of a comprehensive Person-Centered Plan or Individual Service Plan.
- Develop of methodologies for treatment, support, and/or habilitation programs that are in accordance with the Person-Centered Plan or Individual Service Plan.
- Communicate with the Alliance Care Coordinator (when assigned) about the needs of individuals receiving support from your agency.
- Notify the Care Coordinator of any changes, incidents or other information of significance related to the individual supported.

- Implement a clinical back up system to respond to emergencies on weekends and evenings for people you serve, or serve as a first responder as outlined in the applicable service definition and your contract.
- Provide services in accordance with all applicable State and Federal laws and regulations.
- Provide services in accordance with access standards and appointment wait time requirements.
- Maintain a "no–reject" policy for consumers who have been determined to meet medical necessity for the covered services provided.
- Work with Alliance to ensure a smooth transfer for any consumers that desire to change providers, or when you need to discharge a consumer because you cannot meet his/her special needs.

**Alliance Network Providers must comply with documentation requirements and participate in all reviews and audits:**

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

**Alliance Network Providers must have a Business Continuity Plan and participate in community disaster response and recovery efforts:**

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

## B. PROVIDER INVOLVEMENT

Alliance encourages providers to actively participate in the Network. Alliance has a local community site in each county that includes personnel from Community Relations and Care Coordination. Education and training opportunities are offered throughout the year at each of the local sites. See **Web Reference:** www.AllianceBHC.org.

# SECTION III: NETWORK DEVELOPMENT AND EVALUATION



## A. ALLIANCE RESPONSIBILITIES

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

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

## B. SUFFICIENCY OF THE PROVIDER NETWORK

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

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

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

## C. NETWORK PROVIDER TYPES AND SPECIALTIES

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

- **Licensed Practitioners (LP) –** Licensed Practitioners in the areas of Psychiatry, Psychology, Counseling, Addictions and Social Work are enrolled in Alliance's Provider Network. These providers may be Medical Doctors (M.D./D.O.), Practicing Psychologists (Ph.D.), Licensed Psychological Associates (Master's Level Psychologist [LPA]), Master's Level Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Licensed Professional Counselors (LPC), Licensed Clinical Addiction Specialists (LCAS), Advanced Practice Psychiatric Clinical Nurse Specialists, Psychiatric Nurse Practitioners, and Licensed Physician Assistants, and may include Associate-level practitioners as permitted by DMA. Licensed Practitioners provide Outpatient services such as psychiatric care, assessment and outpatient therapy. These services may be provided as a solo practitioner

(outpatient treatment), or in a group practice (outpatient treatment), provider agency (outpatient treatment and enhanced benefit services) or hospital. Licensed Practitioners must meet all Alliance credentialing criteria but are not directly contracted with Alliance unless they are enrolled as a Licensed Independent Practitioner (LIP). Instead, LPs bill through the group practice, provider agency, facility or hospital with which they are affiliated. Every LP enrolled in a group, and the group practice itself, must meet all Alliance credentialing standards.

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

- **Group Practices –** Group Practices consist of two or more individual Licensed Practitioners providing outpatient services who have decided to form a corporate entity for tax, billing or other purposes, and meet credentialing and enrollment requirements for a group practice. Ownership of the corporate entity may be an individual, entity or group of individuals. Group practices may not deliver enhanced benefit services.

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

- **Critical Access Behavioral Healthcare Agency (CABHA) –** A CABHA is a type of provider agency that delivers a comprehensive array of critical mental health and substance abuse services in accordance with Medicaid State Plan requirements and under appropriate medical and clinical oversight that includes a Medical Director, Clinical Director and QM/Training Director. The CABHA's role is to ensure that a robust array of critical services is delivered by a clinically competent organization with appropriate medical oversight. A CABHA is required to offer the following core services: comprehensive clinical assessment, medication management, and outpatient therapy, as well as being enrolled to deliver at least two of the following services in the age and disability-specific continuum served:

- Intensive In-Home (IIH)*.
- Community Support Team (CST)*.
- Day Treatment*.
- Substance Abuse Intensive Outpatient Program (SAIOP).
- Substance Abuse Comprehensive Outpatient Treatment (SACOT).
- Child Residential Level II, III, or IV.
- Psychosocial Rehabilitation (PSR).
- Assertive Community Treatment Team (ACTT).
- Multi-Systemic Therapy (MST).
- Partial Hospitalization (PH).
- Substance Abuse Medically Monitored Community Residential Treatment.
- Substance Abuse Non-Medical Community Residential Treatment.
- Outpatient Opioid Treatment.

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

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

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

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

Practice settings could include federally qualified health centers (FQHC), rural health centers, county health departments, hospital outpatient practices and general primary care practices.

## D. OUT-OF-NETWORK/EMERGENCY SERVICES PROVIDERS

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

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

If an Alliance consumer is receiving services from a provider who is not in the Alliance Provider Network or who has not requested an out-of-Network authorization, Alliance will not pay for the service. As noted above, Alliance *will pay* for acute behavioral emergency care for an Alliance consumer by a non-contracted provider (except that Hospitals remain subject to registration with NC DMA). When a consumer enrolled in the NC MH/IDD/SA Health Plan resides outside of the Alliance region, we will work collaboratively with the consumer and providers in that area to ensure that the consumer has access to needed services.

## E. CULTURAL COMPETENCY

Cultural and linguistic competency and the delivery of such services should be integrated into the overall fabric of service delivery, linked to quality of care and emphasized in policy, practice, procedures, and resources. Alliance recognizes that becoming culturally competent is an ongoing process in which we gain knowledge about

one another and use that knowledge to build trust, break down barriers and improve the quality of care throughout the Network.

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

We encourage our staff and providers to recognize that culture makes us who we are. Culture not only determines how we see the world and each other, but greatly impacts how we experience physical and mental illness. It also shapes the recovery process, affects the types of services that are utilized, impacts diagnosis, influences treatment and the organization and financing of services. We envision that our Network includes providers who recognize that there is variation in behaviors, beliefs and values as they assess an individual's wellness or illness and incorporate that awareness in treatment planning with competence and sensitivity. Alliance facilitates a Cultural Competency Committee that includes consumers, family members, providers, other stakeholders, and Alliance staff as members.

Language interpretation services must be made available by providers by telephone and/or in person as needed. TDD (telecommunication devices for the deaf) must also be made available by providers for persons who have impaired hearing or a communication disorder.

## F. NONDISCRIMINATION AND NO REJECT REQUIREMENTS

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

Likewise, discrimination by any contracted provider (including staff, employees or independent contractors of such provider) against any consumer, employee or other stakeholder due to race, age, religion/spiritual beliefs, sex, national origin, political affiliation, culture, and/or language, ability, handicapping condition, sexual orientation, socioeconomic status, or other personal beliefs is strictly prohibited. Providers must not impose their own personal beliefs on consumers, employees and other stakeholders.

When screening consumers, Alliance staff and contracted providers must also take into account the visual, auditory, linguistic and motor limitations of the consumer. When consumers with special needs are identified in the referral screening process, services will be tailored to meet those needs to the extent that resources are available.

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

## G. AFTER HOURS COVERAGE

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

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

Outpatient and other Contracted Providers who are not required by the applicable service definition to maintain live staff for after-hours coverage are required to either provide or have an agreement with another entity to provide access to 24-hour coverage for behavioral health emergency services and must ensure that instructions and guidance are available after hours to their clients who may call in crisis, for example a voicemail or messaging service that instructs consumers how to call the Alliance Access and Information Center and/or directions and contact information for the nearest local crisis and assessment center.

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

When a consumer presents to a local crisis and assessment center after-hours requesting assistance, the crisis center staff must determine if the individual is enrolled with Alliance and the name of his or her primary provider. Crisis staff will perform an assessment to gather basic presenting information that includes determining the individual's needs and crisis lethality and attempt to contact the primary provider and access the crisis plan to obtain vital information to ensure that a thorough and comprehensive assessment is completed and an appropriate disposition is made. The primary provider will be contacted for assistance, information, and treatment recommendations. After-hours staff from the primary provider agency must respond telephonically to the local crisis and assessment center and have access to the consumer's crisis plans and pertinent clinical information. Specific information regarding demographics, problem summary, diagnosis, substance use history, living situation, supports, health issues, medication regime, safety and security issues, history of suicidal or homicidal ideation/intent, the service delivery plan, and other pertinent details of the Crisis Plan should be provided. If there is no reason to contact the Primary provider after-hours on-call staff, the crisis center staff will contact the Primary provider the next business day to alert them of the contact they had with the consumer. This contact should be documented in the consumer's record. If the crisis center staff is unable to reach the Primary provider's after-hours on-call staff or does not receive a call back within one (1) hour, this will be reported to the Alliance Access and Information Center immediately for follow-up by the Alliance Quality Management and/or Compliance Departments.

If a consumer arrives at a local Emergency Department (ED), and the ED physician needs additional information to assist in the process of evaluating the consumer needs, the ED provider may call the Alliance Access and Information Center. Alliance staff can report whether the consumer is enrolled with Alliance and/or connected with a service provider and the name and contact information for that provider. They may also share information such as current authorization, consumer's guardian, record of previous hospitalizations (local or state) or a record of using crisis services, consumer's crisis plan and/or a known diagnosis, medications being prescribed if any, outpatient commitment or a history of outpatient commitment, and/or the name and contact information for the consumer's assigned Alliance Care Coordinator.

## H. QUALITY OF CARE

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

- Health and safety of consumers.
- Rights protection.
- Protection of health information.
- Provider qualifications.
- Consumer satisfaction.
- Management of complaints.
- Incident investigation and monitoring.
- Assessment of outcomes to determine efficacy of care.
- Management of care for Special Needs Populations.
- Preventive health care initiatives.
- Clinical best practice.
- Recovery focused outcomes.

## I. PROVIDER COMMUNICATION AND TRAINING

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

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

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

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

This Manual, the Alliance website and quarterly “All Provider Meetings” also serve as key components of an orientation for new providers. These resources include key documents and information, such as the Provider Operations Manual, key Alliance contacts in each functional area (e.g. Business Operations, Provider Network Operations, Utilization Management, etc.), as well as contact information for designated Provider Network Development staff available to answer provider questions. Additionally, new Providers will have an opportunity to participate in an orientation on the day of All Provider Meetings.

Additionally, Alliance has established Provider Advisory Councils where clinical as well as administrative items are discussed. Provider Advisory Council members are nominated and elected by their peers, better ensuring a true and representative group inclusive of differing and important perspectives. Provider surveys are conducted on a regular basis and the Provider Advisory Councils review all surveys prior to their dissemination to larger provider community.

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

Lastly, Alliance has a dedicated Provider Network line through its telephonic helpdesk, (919) 651-8500, as well as a dedicated Provider Network email address (ProviderNetwork@AllianceBHC.org). Through the Helpdesk and dedicated email, providers are able to receive real-time assistance during normal business hours, and 24/7/365 assistance is available through Alliance’s Access and Information Center

(Call Center). Providers are also encouraged to review information on the Alliance web site and may request technical assistance through the helpdesk. Access and Information Center staff members are updated on Network activities at regular staff meetings and receive all Weekly Updates and other communications to ensure they are best equipped to answer questions that may be received directly from providers.

### Provider Training Opportunities

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

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

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

Alliance resources for providers and Training Opportunities:
www.AllianceBHC.org/providers/publications-and-resources/newsletter-archives
www.AllianceBHC.org/providers/training

NC Department of Health and Human Services information can be found at the following websites:
www.ncdhhs.gov/mhddsas/implementationupdates/index.htm
www.ncdhhs.gov/mhddsas/communicationbulletins/index.htm
www.ncdhhs.gov/mhddsas/Whatisnew/index.htm
www.ncdhhs.gov/dma/bulletin/index.htm
www.ncdhhs.gov/dma/mp/index.htm

## J. CREDENTIALING AND RECREDENTIALING

Credentialing is the process of determining whether a provider who applies to participate in the Alliance Provider Network meets the minimum criteria established by Alliance for participation. Recredentialing is a process to update and verify the accuracy of a

Network Provider's credentialing. Specific credentialing/recredentialing criteria that comply with federal and state law, rules and regulations as well as national accreditation standards are used in the process of determining initial and ongoing approval for participation. The following minimum criteria must be met in order to be approved for participation or remain enrolled in the Alliance Provider Network:

- **Good Standing –** All applicants for participation in the Alliance Closed Network must be in good standing with all applicable oversight agencies. This means that the provider or applicant has submitted all required documents, payments and fees to the U.S. Internal Revenue Service, the NC Department of Revenue, NC Secretary of State (if organized as a corporation, partnership or limited liability company), the NC Department of Labor, and the NC Department of Health and Human Services, and has not had any sanction issued by those entities, including but not limited to the following:
    - LME-MCO: Contract Termination or Suspension, Referral Freeze, Unresolved Plan of Correction, Outstanding Overpayment, Prepayment Review, Payment Suspension.
    - DMA: Contract Termination or Suspension, Payment Suspension, Prepayment review, Outstanding Final Overpayment.
    - DMH/DD/SAS: Revocation, Unresolved Plan of Correction.
    - DHSR: Unresolved Type A or B penalty under Article 3, Active Suspension of Admissions, Active Summary Suspension, Active Notice of Revocation or Revocation in Effect.
    - U.S. Internal Revenue Service/NC Department of Revenue: Unresolved tax or payroll liabilities.
    - NC Department of Labor: Unresolved payroll liabilities.
    - NC Secretary of State: Administrative Dissolution, Revocation of Authority, Notice of Grounds for other reason, Revenue Suspension. Providers organized as a corporate entity must have a "Current – Active" registration with the NC Secretary of State.
    - Boards of Licensure or Certification for the applicable Scope of Practice.
    - Provider's Selected Accrediting Body.

  Providers are required to disclose any pending or final sanctions under the Medicare or Medicaid programs including paybacks, lawsuits, insurance claims or payouts, and disciplinary actions of the applicable licensure boards or adverse actions by regulatory agencies within the past five years or now pending. For purposes of the credentialing procedure, Alliance considers an action of DHHS to be final upon notification to the provider, unless the provider has requested a reconsideration review with the Department, in which case Alliance considers the action final upon issuance of a decision by the DHHS Hearing Office.

- **Eligibility to Participate in Federal Healthcare Programs –** Alliance is prohibited from contracting with providers who are identified on the List of Excluded Individuals/Entities (LEIE) maintained by the Office of Inspector General (OIG) of

the U.S. Department of Health and Human Services (HHS) or the Excluded Parties List System (EPLS) maintained by the federal System for Award Management.

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

- **Insurance Requirements –** Providers are required to attain and maintain active insurance coverage as required by Provider's contract with Alliance. This includes professional liability, comprehensive general liability, automobile liability, workers' compensation and occupational disease insurance, employer's liability insurance and tail coverage as applicable, with waivers for automobile and workers compensation requirements in limited circumstances.

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

- **General Requirements –** Providers shall submit a completed application with appropriate documentation, disclosures and signatures to join the Network, agreeing: (a) to comply with all Network requirements for reporting, inspections, monitoring, consumer choice requirements; (b) to participate in the corporate compliance process and the Network continuous quality improvement process; (c) to undergo a criminal background check for all individual practitioners, owners and managing employees; and (d) to pass an on-site visit conducted by Provider Network Department prior to initial enrollment in the network, except for Hospitals, DHSR licensed facilities and LPs . The application must include a Signed Attestation Statement indicating application is correct and complete and that the individual submitting the application is authorized to do so. Providers must disclose all required ownership information, affiliations (by contract or otherwise) with any other provider, any and all felony and misdemeanor convictions since the age of 18, and history of sanctions by applicable oversight agencies and accreditation/certification/licensure bodies. Providers are required to meet all other criteria outlined in applicable Federal and State laws, rules, regulations, policies, Manuals, the NC State Plan for Medical Assistance, the NC

Medicaid 1915 (b)/(c) Waivers, Contracts between Alliance and NCDHHS, and the Alliance *Selection and Retention Criteria* Procedure, including but not limited to the following:

  - Providers shall have a “no-reject policy” for referrals within the capacity and the parameters of their competencies. Providers shall agree to accept all referrals meeting criteria for services they provide when there is available capacity.
  - Providers shall be able to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in the Alliance AlphaCM Provider Portal.
  - Providers shall demonstrate consumer friendly services and attitudes. During the application process, providers may be asked to demonstrate how consumers and families are involved in treatment and services. Providers shall have a good system of communication with consumers.
  - Providers shall demonstrate experience and competency. Stability of past operations is important.
  - Providers shall have the capacity to respond to emergencies for assigned consumers according to State availability standards for emergent needs, Section VI C of this Manual, and service definition requirements for First Responder capacity.
  - Providers shall demonstrate that they have in place accounting systems sufficient to ensure fiscal responsibility and integrity.

- Licensed Practitioners are required to register and complete an application with the Council for Affordable Quality Healthcare (CAQH), be licensed and meet all requirements imposed by the applicable North Carolina licensing board. Alliance does not directly contract with associate licensed applicants.
- Applications are not accepted if incomplete. Incomplete applications will be returned to Provider and Provider will be required to return the application within 7 calendar days.
- All applications and credentialing information is required to be submitted to Alliance electronically. Any information submitted by any other format will be returned to Provider.
- Licensed Practitioners working for a Network Provider are required to be credentialed and linked to that provider before delivering services. The provisional effective date is the date that Alliance accepts the Licensed Practitioners application packet. The provider will receive notice of acceptance of the LP and the effective date in writing. Alliance will not accept incomplete application packets for Licensed Practitioners.
- All providers of services that require national accreditation as determined by the Secretary of DHHS must achieve and maintain national accreditation and be in Good Standing with their national accrediting body.

The PNCC meets on a regular basis to review provider applications. Alliance will deny the application or terminate the contract of a provider if any person who has an

ownership or control interest in the provider, or who is an agent or managing employee of the provider, appears on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities or has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, Children's Health Insurance Program (NC Health Choice) or the Title XX Services Block Grants Program.

Alliance specifically reserves the right to deny the application or terminate the contract of any provider for any other reason deemed appropriate by the Credentialing Committee, including but not limited to a finding that any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a felony or misdemeanor or has reprimands or other sanctions imposed by licensing boards, issues related to quality of care, non-response to requests for information regarding credentialing material, or other matters brought to the attention of the Committee. Providing false information or failing to disclose information in response to a question in the application will result in a denial of the Provider's application and may subject the Provider to criminal prosecution by the NC Medicaid Fraud Investigations Unit.

Providers are required to have their credentials reviewed and verified at a minimum of every thirty-six (36) months from the date of the last credentialing review. Alliance may suspend or terminate from the Network any provider that Alliance determines does not meet credentialing criteria or has not returned the completed re-credentialing/application packet within the designated time period. Providers will be notified of the recredentialing process and are required to submit all requested documentation within thirty (30) days.

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

## K. SELECTION (INITIAL PARTICIPATION) CRITERIA

Alliance operates and manages a Provider Closed Network. Annually, Alliance will complete an analysis of the Provider Network needs and gaps. This Needs Assessment will include input from consumers, families, community stakeholders and CFAC as well as other sources of input. Based on the criteria for Network adequacy and access as defined in Alliance procedures, the analysis will result in a Network Development Plan to address any opportunities to strengthen the Provider Network. If the Network Development Plan identifies any service needs or gaps or access to care issues and Network Providers are not available to meet the identified needs, Alliance will seek to add providers through a variety of means, including but not limited to issuing Requests for Proposal or Requests for Information and Requests for Letters of Interest. Network

participation opportunities will be posted on the Alliance website unless it is to meet a consumer or family's unique need or challenging geographic or transportation circumstances.

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

When accepted in the Network, Alliance may execute a contract as required by federal law before any Medicaid services can be authorized or paid. Alliance is also required by state regulation to enter into contracts with providers of State-funded services before any State-funded services can be authorized or paid. Network Providers are required to have a fully-executed Alliance contract which identifies all approved services and sites prior to the delivery of services to an Alliance consumer regardless of the funding source.

## L. RETENTION CRITERIA

In accordance with 42 CFR 438.214 and the terms and conditions of the Alliance contract with the Division of Medical Assistance to operate a Prepaid Inpatient Health Plan, Alliance is required to implement provider selection and retention criteria that does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. Alliance may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. Alliance will not discriminate solely on the basis of the Provider's license.

Alliance has the right not to renew a contract with a Network Provider for any reason, or to reduce or limit the contracted services for a Network Provider in subsequent contract terms, at the sole discretion of Alliance. In general, Alliance will renew a Network Contract unless there is excess service capacity or the Network Provider meets any of the conditions outlined below.

Bases for non-renewal of contract(s) include but are not limited to: Alliance may consider any of the following provider performance or other factors when making a decision about contract renewal:

- Availability of public funds.
- Demonstrated compliance with the terms and conditions of the Alliance Provider Contract (including any applicable Scope of Work), and applicable state and federal laws, rules and regulations.

- Demonstrated compliance with the policies and procedures outlined in the Alliance Provider Operations Manual as amended or supplemented, Alliance provider news feeds, bulletins and manuals issued by the Department.
- Demonstrated ability of provider to ensure that consumers meet medical necessity requirements for all services provided.
- Efforts to achieve evidence-based or best practice in applicable areas of service.
- Efforts to provide culturally competent services and ensure the cultural sensitivity of staff members, including development of a cultural competency plan and compliance with cultural competency requirements.
- Implementation of a clinical back up system to respond to emergencies on weekends and evenings for consumers served by the Provider.
- Demonstrates consumer friendly services and attitude by implementing a system that ensures good communication with consumers and families.
- Provision of services in accordance with all applicable state and federal laws, rules, regulations, the NC State Plan for Medical Assistance, Innovations Waiver, State Service Definitions, and/or Clinical Coverage Policies.
- Meeting DMH/DD/SAS access standards and appointment wait times when a consumer has been accepted by the provider (unless Alliance approves otherwise in writing for state or local-funded services only).
- Implementation of a no-reject policy for consumers who have been determined to meet medical necessity for the services contracted by Provider.
- Cooperation and compliance with discharge and transfer requirements to ensure a smooth transfer for any consumer that desires to change providers, or because the Provider cannot meet his/her special needs.
- Meeting all documentation requirements as set forth in Medicaid Clinical Coverage Policies, State Service Definitions, and/or DMH/DD/SAS Records Management and Documentation Manual.
- Cooperation and participation with all Alliance program integrity activities (including but not limited to investigations and post-payment reviews), utilization review/management, quality management, compliance, and appeal and grievance procedures.
- Provider's demonstrated ability to satisfactorily complete and upload Service Authorization Requests (SARs) that meet Alliance Utilization Management requirements (i.e. provider does not have high percentage of administrative denials proportional to the numbers of consumers served).
- Ability of Provider to meet re-credentialing criteria.
- Participation in consumer satisfaction surveys, provider satisfaction surveys, clinical studies, incident reporting, and outcomes requirements.

Alliance has the right not to renew a contract with a Network Provider for any reason, or to reduce or limit the contracted services for a Network Provider in subsequent contract terms, at the sole discretion of Alliance. In general, Alliance will renew a Network

Contract unless there is excess service capacity or the Network Provider meets any of the conditions outlined below:

- Provider is not in compliance with applicable federal or state laws, rules or regulations, or is in breach of any provision of its current Contract with Alliance, including but not limited to the Scope of Work or requirements concerning clients' rights, confidentiality and records retention, or
- Provider has not billed for services in the sixty (60) days prior to Alliance's review of the contract renewal, or
- Alliance has received notification that the Network Provider is not in good standing with the Department, the U.S. Internal Revenue Service, the NC Department of Revenue, NC Secretary of State (if organized as a corporation, partnership or limited liability company), the NC Department of Labor or other LME/MCOs, or
- Provider has failed to implement a Plan of Correction issued by Alliance and the time for doing so has expired, or
- Alliance has issued two (2) or more sanctions or administrative actions at different times against the Provider in the previous contract period, or
- Provider has failed to remit an identified overpayment to or enter into an approved payment plan with Alliance within the designated timeframe, or
- Alliance has logged quality of care concerns or other serious concerns about the Provider that have not been satisfactorily resolved in required timelines, or
- Provider has had a consistent volume of claim denials despite technical assistance or training offered and/or provided by Alliance, or
- Provider has not responded to requests for data or other information necessary for Alliance to respond to requests from the State, or
- Provider has failed to meet monitoring requirements, or
- Alliance has identified excess capacity for the service(s) delivered by Provider and issued an RFP, RFI or other procurement mechanism for such service(s).

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

## M. APPLYING FOR ADDITIONAL SITES OR SERVICES

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

- A Provider has been awarded the services based on a competitive process,
- The site or service is an -related expansion of a currently provided service

- An emergency need has been identified that can only be filled by a specific provider
- A unique need has been identified that can only be filled by a specific provider, or
- A specific Provider has been designated by the funding source or grantor.

When any one of these requirements is met, providers may submit or be requested to submit an Alliance Additional Services Request with all required elements to ProviderNetwork@AllianceBHC.org. All additional sites or services shall be subject to applicable credentialing requirements.

## N. REPORTING CHANGES AND LEAVE OF ABSENCE

Network Providers are to report all changes as follows:

- Notify the Credentialing Unit in writing within one (1) business day of any changes in credentialed status, including but not limited to, the scope of their license, changes in licensure status, changes in privileged status at other organizations, pending citations or malpractice claims, Secretary of State status, IRS or Department of Labor status, sanctions related to federal programs (Medicaid, Medicare, etc.) and any other major change in status.
- Notify the Credentialing Unit in writing within five (5) business days of personnel changes or information updates which may include, but is not limited to, changes in capacity including inability to accept new referrals, addition of capacity or specialty services, telephone/email/address changes, changes in ownership or managing employees including but not limited to proposed acquisitions or mergers, additions and deletions for the LP roster (for groups and agencies) as well as changes in other required credentialing or enrollment information.

Licensed Independent Practitioners wishing to initiate a leave of absence (LOA) shall notify the Credentialing Unit in writing, no later than sixty (60) days prior to their desired effective date. Unless the leave is a result of disabling illness, a Licensed Independent Practitioner shall not request more than six (6) months in an initial Leave of Absence. An extension to the original leave may be requested if needed. The leave is not to exceed an additional six (6) months and must be submitted no later than sixty (60) days prior to the expiration of the original Leave of Absence. Alliance will respond to the request within ten (10) business days. A contracted LIP will be allowed a total of twelve (12) months LOA over any seven (7) year period and cannot exceed four (4) LOA requests. Failure to comply with LOA process may result in termination of the practitioner's contract.

## O. MONITORING AND EVALUATION

*Note: The Department of Health and Human Services through the NC DHHS-LME/MCO-Provider Collaboration Workgroup is in the process of revising the Provider Monitoring Process and developing advanced placement tools. This section of the Manual may be revised in response to any changes implemented by the State. Alliance will notify all Providers of any changes via the Provider News.*

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

As provider agencies offer a variety of services, requirements may differ due to any applicable licensure requirements, State Service Definitions or Medicaid Clinical Coverage Policies. Therefore, the DHHS Review Tool for Routine Monitoring of Provider Agencies and guidelines allow for these differences. To obtain inter-rater reliability within Alliance and between LME/MCOs, monitoring tools are scored according to guideline requirements

Routine monitoring may be comprised of a routine monitoring tool and a post-payment review or a post-payment review alone. Only the post-payment review tool is completed for Providers of services provided only in licensed facilities which are monitored annually by DHSR. Monitoring claims samples will consist of three (3) months of paid claims data starting 6 months prior to monitoring date and moving forward 90 days. The following is a description of the Provider Monitoring Process as currently conducted by Alliance:

1. Routine monitoring reviews may be conducted on-site or as desk reviews. The selection of Providers for review is at the discretion of Alliance. Providers are notified in writing 21 – 28 calendar days prior to the date of the review, unless Alliance deems that circumstances warrant an unannounced site review. Except when an unannounced site review occurs, Provider agencies are notified of the specific service records needed for the review no less than 5 business days prior to the date of the review. Prior to the review, Providers may request technical assistance regarding review requirements and processes, and may be informed of the time period covered in the claims and other samples. Technical assistance will not include previewing Provider information to determine if it meets compliance criteria.

2. During on-site reviews Alliance staff will provide identification and introduce themselves. Onsite reviews will include an opening conference as well as an exit conference. Any follow up to be completed by the Provider or Alliance will be reviewed during the exit conference. The Provider must present all information by the conclusion of the monitoring event. After the review is concluded any additional information located will not be used to change any established scores or out of compliance findings, but will be considered in implementation of the plan of correction (if assigned).
3. Monitoring tools will be scored in accordance with the guidelines provided with the tools. Providers are notified in writing of the results of the Routine Monitoring within fifteen (15) calendar days of completion of the review. The tools score automatically and note when Providers have not met threshold standards. Providers who score below 85% on a sub-tool or sub-section of the routine tool; or below 100% on the question regarding restrictive interventions; or who demonstrate systemic compliance issues will be issued a statement of deficiencies and will be required to submit a plan of correction. In addition, any claim date of service cited out-of compliance on the post-payment review shall be identified as an overpayment and require a payback to Alliance through the recoupment process
4. If the Provider disagrees with the monitoring action taken, plan of correction or recoupment, they may request reconsideration, as outlined in the results letter. Follow up with Providers who are required to complete a plan of correction will follow the DHHS Policy and Procedure of the Review, Approval and Follow-Up of Plan(s) of Correction (POC), Policy N. ACC002, Revision Date 12/10/2008. Failure to submit an acceptable Plan of Correction or substantially minimize or eliminate deficiencies will be presented to the Alliance Corporate Compliance Committee and may result in sanction up to and including termination from the Network.

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

## P. QUALITY IMPROVEMENT

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

- The establishment of a formal continuous Quality Improvement Committee to evaluate services, plan for improvements, assess progress made towards goals,

and implement quality improvement projects and follow through with recommendations from the projects. This does not apply to LIPs.

- The assessment of need as well as the determination of areas for improvement should be based on accurate, timely, and valid data. The provider's improvement system, as well as systems used to assess services, will be evaluated by Alliance at the provider's qualifying review.
- The submissions of accurate and timely data, as requested, including claims for services delivered, no later than the deadline set by Alliance. Assessment of program fidelity, effectiveness, and efficacy shall be derived from data and any data requested. Providers shall be prepared to submit any and all data, reports, and data analysis upon request.
- Meeting performance standards set by Alliance and by the NC Health and Human Services for behavioral health services.

## Q. DOCUMENTATION AND CONFIDENTIALITY REQUIREMENTS

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

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

i. Informed written Consent for Planned Use of a Restrictive Intervention (as applicable); and
j. Informed written Consent for Participation in Research Projects (as applicable).

2. Evidence of a written summary of client rights given to client/legally responsible person, according to 10A NCAC 27D .0201, and as specified in GS §122C, Article 3.
3. Documentation that client rights were explained to the individual/legally responsible person.
4. NC-TOPPS (as required for IPRS and Medicaid funded MH and SA). Additional information can be found at: www.ncdhhs.gov/mhddsas/providers/NCTOPPS/userlinks.html
5. Person Centered Plan if an enhanced service or as required per the IPRS benefit plan.
6. NC SNAP and/or SIS for consumers with a DD diagnosis.
7. ASAM score for consumers with a SA diagnosis.
8. LOCUS/CALOCUS scores for consumers in MH services.
9. Documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to the DSM-IV (or its successors) and documentation of physical disorders according to the ICD-10, including subsequent amendments and editions.
10. Screening-shall include assessment of presenting problem/needs, whether or not the agency can provide services that can address the individual's needs, and disposition, including recommendations and referrals.
11. Admissions/Clinical Assessment(s) that contain the elements of a Comprehensive Clinical Assessment as described in Chapter 3 of APSM 45-2 for enhanced services and as required by Clinical Coverage Policies.
12. Applicable Service Order: for all services to be provided, signed by the appropriate professional. Note: Each community provider is responsible for obtaining the appropriate diagnoses and a physician's order for billing Medicaid-covered services that it is planning to provide.
13. Service Notes
14. Advance Directives
15. Service Authorizations
16. Discharge Plans/summaries
17. Other elements may be required or clinically relevant depending upon the services received (e.g. Crisis Plans, Medication Administration Record, etc.).
18. Allergies: Any known or suspected allergies or adverse reactions, or the absence of such, must be prominently noted in the record (preferably on the front cover of the record).

NOTE: This is not a complete list of all required record elements. The full list can be accessed at: http://ncdhhs.gov/mhddsas/statspublications/Manuals/rm&dm-manual8-1-14.pdf Chapter 2.

Additional requirements may be listed in each Clinical Coverage Policy related to the service being provided: www.ncdhhs.gov/dma/mp/index.htm Providers are expected to adhere to all, minimum and service specific, requirements.

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

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

**Web Reference:**
ncdhhs.gov/mhddsas/statspublications/Manuals/index.htm
http://archives.ncdcr.gov/Portals/26/PDF/schedules/schedules_revised/Local_Provider.pdf
www2.ncdhhs.gov/control/retention/2015/recordsheet15_rev020515.pdf

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

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

# SECTION IV: CONSUMER RIGHTS AND EMPOWERMENT



## A. CONSUMER RIGHTS

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

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

Consumers of mental health, substance abuse and developmental disability services have the following rights:

- The right to receive information about Alliance, its services, its providers, and member rights and responsibilities presented in a manner that you can understand.
- The right to be treated with respect and recognition of your dignity and your right to privacy.

- The right to participate with providers in making decisions regarding health care.
- The right to a candid discussion with providers on appropriate or medically-necessary treatment options for your conditions, regardless of cost or benefit coverage. (You may need to decide among relevant treatment options, taking into account the risks, benefits and consequences, including your right to refuse treatment and to express your preferences about future treatment decisions regardless of benefit coverage limitation.)
- The right to voice complaints or appeals about the organization or the care it provides.
- The right to participate in the development of a written person-centered treatment plan that builds on individual needs, strengths and preferences. A treatment plan must be implemented within 30 days after services start.
- The right to take part in the development and periodic review of your treatment plan and to consent to treatment goals in it.
- The right to treatment in the most natural, age-appropriate and least-restrictive environment possible.
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- The right to refuse treatment.
- The right to request and receive a copy of your medical record, subject to therapeutic privilege, and to request that the medical record be amended or corrected. If the doctor or therapist determines that this would be detrimental to your physical or mental well-being, you can request that the information be sent to a physician or professional of your choice.
- If you disagree with what is written in your medical records, you have the right to write a statement to be placed in your file. However, the original notes will also stay in the record until the statute of limitations ends according to the MH/DD/SA retention schedule (11 years for adults, 12 years after a minor reaches the age of 18, 15 years for DUI records).
- The right to a second opinion from a qualified health care professional within the network, or Alliance will arrange for the enrollee to obtain one outside of the network at no cost to the enrollee.
- The right to a second opinion.
- The right to ask questions when you do not understand your care or what you are expected to do.
- The right to voice grievances about Alliance or the care you receive from providers in the Alliance Network.
- The right to appeal any Alliance decision to deny, reduce, suspend or terminate a requested service.
- The right to make recommendations about Alliance's member rights and responsibilities policy.

- The right to freedom of speech and freedom of religious expression.
- The right to equal employment and educational opportunities.
- The right to privacy and security of their protected health information. Alliance's Notice of Privacy Practices is attached to this Manual as Appendix E.

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

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

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

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

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

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

**Web Reference:** www.AllianceBHC.org/consumers-families

## B. CONSUMER RESPONSIBILITIES

Consumer Rights information available from Alliance also outlines the corresponding responsibilities of consumers receiving services. Additional responsibilities may be required in 24-hour facilities. The consumer responsibilities are to:

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

## C. CONSENT FOR TREATMENT

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

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

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

## D. RESTRICTIVE INTERVENTIONS

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

## E. ADVANCE INSTRUCTION FOR MENTAL HEALTH TREATMENT

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

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

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

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

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

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

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

**Web Reference:**

NC Division of Medical Assistance on Your Rights
www.ncdhhs.gov/dma/medicaid/rights.htm#advance

North Carolina Advance Health Care Directive Registry
www.secretary.state.nc.us/ahcdr

## F. CONFIDENTIALITY

Alliance privacy practices, and those of our Network Providers, must be based on applicable federal and state confidentiality laws and regulations including but not limited to the Health Information Portability and Accountability Act (HIPAA) and its implementing regulations, 45 CFR Parts 160, 162 & 164, as further expanded by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), which was adopted as part of the American Recovery and Reinvestment Act of 2009, commonly known as "ARRA" (Public Law 111-5) and any subsequent modifications

thereof, the Substance Abuse Confidentiality regulations set forth in 42 CFR Part 2, NCG.S. § 122C-51, et seq., NCG.S. § 108A-80,10A NCAC Subchapter 26B, and DMH/DD/SAS Confidentiality Rules published as APSM 45-1 (effective January 2005). Consumers can request restrictions on use and disclosure of PHI. Consumers have the right to receive a report of disclosures that have been made of PHI.

Each Alliance provider shall ensure that all staff providing services to consumers of Alliance maintains confidentiality of consumers, as well as information related to their treatment. Providers will not discuss, transmit or communicate in any form consumer information of a personal nature, medical or otherwise, except as authorized in writing by the consumer or his legally-responsible person; or as otherwise permitted by applicable federal and state confidentiality laws and regulations.

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

## G. USE OF INFORMATION WITHOUT PRIOR CONSENT

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

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

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

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

## H. CLIENT RIGHTS COMMITTEE

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

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

## I. CONSUMER AND FAMILY ADVISORY COMMITTEE (CFAC)

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

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

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

**Web Reference:** www.AllianceBHC.org/consumers-families/Alliance-cfac

## J. PROHIBITED RESTRICTIONS ON PROVIDERS

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

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

## K. SECOND OPINION

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

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

Medicaid beneficiaries have the right to appeal Alliance decisions to deny, reduce, suspend or terminate a Medicaid service because Medicaid is an entitlement program. Specifically, Medicaid beneficiaries have the right to appeal ~~**or submit a grievance**~~ whenever they do not agree with an "Action" taken by Alliance about a request for services. An *Action* is defined in federal law to include only the following:

- The denial or limited authorization of a requested service (a denial could occur if medical necessity or other criteria are not met to support the request for services), or
- The reduction, suspension or termination of a service before the authorization has expired (services a consumer is currently receiving may be reduced, suspended or terminated based on different factors including not following clinical guidelines or not continuing to meet medical necessity for the frequency, amount, or duration of a service), or
- The denial, in whole or in part, of payment for a service, or
- The failure to provide services in a timely manner, or

- The failure of Alliance to issue decisions or resolve grievances within time frames established in federal law. Grievances are not appealable outside of Alliance.

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

If Alliance makes a decision to deny in whole or in part the request for service authorization, the consumer/guardian will receive a letter by certified mail within fourteen (14) calendar days of the request for service for a routine request or 72 hours for an expedited request (see also Section VI-H) explaining this decision and how to request Reconsideration Review if they disagree. During this time, Alliance will not authorize the requested service in dispute.

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

The consumer/guardian will receive a Notice of Action and appeal form. Providers will receive a copy of the Notice of Action but will not receive the appeal form. Providers should understand Medicaid beneficiary due process/ appeal rights so they can assist consumers with filing an appeal, with the consumer’s written consent. Providers should never pressure or force a consumer to file an appeal against the consumer’s wishes. The first step in appealing Alliance's denial of a request for Medicaid services is to ask for a "Reconsideration Review." The request for a Reconsideration Review must be filed with Alliance within thirty (30) days of the mailing date on the notice of action. A Reconsideration Review means that someone at Alliance who was not involved in the consumer’s case will take a second look at our decision about the consumer’s Medicaid services.

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

Alliance must provide the consumer/guardian the opportunity, before and during the appeals process, to examine the consumer’s case file, including medical records, and any other documents and records considered during the appeals process. Alliance shall also give the consumer/guardian a reasonable opportunity to present evidence and allegations of fact or law, including evidence that was not presented at the time of the original

request. The opportunity by the consumer/guardian to review the case file and submit additional information is explained in the Reconsideration Instructions and Information that are mailed to the consumer/guardian and found on the Alliance website.

The medical policies and criteria for Medicaid services authorized by Alliance can be found at www.ncdhhs.gov/dma/waiver/ in The NC MH/IDD/SAS Health Plan and NC Innovations Waiver. If a person does not have internet access or wishes to receive written copy of these documents, a request may be made by calling (800) 510-9132 to receive a copy by mail.

Alliance has information regarding the appeal process available to consumers. This information can be found on the Alliance website, www.AllianceBHC.org, in brochures distributed in the catchment area or upon request. Providers should be aware that all consumer confidentiality and privacy requirements apply to appeals. Alliance offers training to providers about the consumer appeal process.

**NOTE:** Alliance is prohibited from implementing utilization management (UM) procedures that provide incentives for the individual or entity conducting utilization reviews to deny (reduce, terminate or suspend), limit or discontinue medically necessary services to any enrollee. UM decision-making is based on medical necessity and EPSDT criteria. Alliance does not reward staff for issuing denials of coverage or services. There are no financial incentives for UM decision-makers that would encourage decisions resulting in underutilization.

The laws governing Medicaid enrollee appeals of Medicaid managed care decisions can be found at 42 CFR Part 438 and Chapter 108D of the North Carolina General Statutes.

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

## M. FREQUENTLY ASKED QUESTIONS ABOUT CONSUMER MEDICAID APPEALS

**Q: How much time does a consumer/guardian have to ask for a Reconsideration Review?**
A: The request for a Reconsideration Review must be filed with Alliance within thirty (30) days of the date **o~~f~~n** the notice of action.

**Q: How does a consumer/guardian ask for a Reconsideration Review?**
A: To request a Reconsideration Review, complete the appeal form included with the Notice of Action and fax, email, mail or hand deliver the form to Alliance:

Fax: (919) 651-8682
Email: UMAppeals@AllianceBHC.org
Mail or Hand Delivery: Alliance Behavioral Healthcare, Attention: Appeals Coordinator
4600 Emperor Boulevard Suite 200, Durham, NC 27703

**Q: Can the request be submitted over the phone?**
A: Consumers may call (800) 510-9132 or (919) 651-8547 if they want to make a request by phone, but they will still have to file a signed reconsideration review within thirty (30) days of the date on the notice of action. If a consumer needs assistance with the form, they can contact Alliance at (800) 510-9132 or (919) 651-8547 and someone will help them.

**Q: Can a provider file the appeal?**
A: A provider can help the consumer with completing the form and filing the appeal if the consumer gives them written permission. There is a space on the form for the consumer to identify someone who is going to help them with their appeal.

**Q: What is the timeline for the Reconsideration Review?**
A: The Reconsideration Review must be completed within thirty (30) days after the request is filed. Alliance will schedule a review with a health care professional who has no prior involvement in the case. This person will review the information used in making our decision, in addition to any other information that the consumer/guardian wishes to submit. Additional information must be sent to us within seven (7) days of filing this reconsideration review request form. We will mail a decision within thirty (30) days.

**Q: What if the consumer needs the Reconsideration Review to be processed faster?**
A: A consumer/guardian can ask for an expedited Reconsideration Review if waiting thirty (30) days might seriously jeopardize the consumer's life, health, or functional abilities. A provider can also help with asking for expedited review if they have written permission. If Alliance approves a request for an expedited Reconsideration Review, we will make a decision and provide verbal notification of the determination within 72 hours of the request followed by written notification about the appeal within two (2) calendar days of the verbal notification.

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

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

- The Reconsideration Review request is filed within 10 days of Alliance mailing the Notice of Action.
- The decision involves the termination, suspension, or reduction of currently authorized services.

- The services were ordered by an authorized provider.
- The authorization period for the services has not expired.
- The consumer/guardian requests that services continue.

If all of these conditions are met, the consumer will continue to be authorized for current services unless and until:

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

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

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

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

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

**PLEASE NOTE: Consumers must request a Reconsideration Review and receive a decision before they can request a State Fair Hearing.**

## N. STATE-FUNDED SERVICES APPEAL PROCESS

An appeal of a denial, reduction or termination of State-funded services is handled differently from a Medicaid Reconsideration and State Fair Hearing. State-funded services are not an entitlement and there is no right to appeal to OAH. Alliance is not required to pay for services during the appeal of State-funded services.

The appeal may only be filed by a client or legal representative and must be received in writing within fifteen (15) working days of the date of the notification letter. Alliance will help any consumer who requests assistance in filing the appeal and will acknowledge receipt of the appeal in writing in a letter to the appellant dated the next working day after receipt of the appeal.

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

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

## O. GRIEVANCES

A grievance is a statement of dissatisfaction by an enrollee or consumer of publicly-funded services about any matter other than an appeal of an "action" taken by Alliance. Examples of a grievance may include but are not limited to grievances about quality of care, failure of the provider or Alliance to follow Client Rights Rules; failure of providers to provide services in the consumer's PCP or ISP including emergency services noted in the crisis plan and interpersonal issues such as being treated rudely. Consumers, or a network provider authorized in writing to act on behalf of a consumer, may file a grievance.

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

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

The provider must keep documentation on all grievances received including date received, points of grievances, and resolution information. At its request Alliance has the right to review provider documentation on grievances. Any unresolved complaints or grievances must be referred to Alliance. Alliance contact information ((800) 510-9132) and the toll-free telephone number for Disability Rights of North Carolina ((877) 235-4210) must be published, posted and made available to the consumer and family members.

Any consumer, legally responsible person and/or Provider is encouraged to contact Alliance if they feel that services being provided to a consumer are unsatisfactory or if the consumer's emotional or physical well-being is being endangered by such services. A grievance may be submitted as follows:

a. The individual may call Alliance Access and Information Center at (800) 510-9132.
b. A written statement of the concern may be faxed to (919) 651-8687.
c. A written statement of the concern may be emailed to Complaints@AllianceBHC.org.
d. The complainant may deliver their verbal or written grievance in person at the Alliance Corporate Site, located at 4600 Emperor Blvd, Suite 200 Durham NC, 27703, or any of the Alliance Community Site Locations, which are posted on the Alliance website (www.AllianceBHC.org).

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

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

**For Medicaid Related Grievances**

1. Alliance will seek to resolve grievances expeditiously and provide a written resolution of the grievance by U.S. mail to all affected parties no later than ninety (90) calendar days of the date Alliance received the grievance. Alliance may extend the timeframe by up to fourteen (14) calendar days if (i) the client requests extension or (ii) there is a need for additional information and the delay is in the best interest of the client. Any extension granted shall be communicated to the consumer within one (1) business day either verbally or in writing. Verbal notifications shall be followed up in writing to the consumer.

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

3. If the grievance is filed against a provider:
   a. As part of the conflict resolution process QM staff shall offer the complainant the option of engaging in the provider's internal grievance process or to receive conflict resolution services facilitated by Alliance.

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

4. If information gathered during the informal resolution process is indicative that provider's practice does not meet required standards as defined by statute, rule, clinical coverage policy, contract, etc., and targeted monitoring would provide additional information to determine regulatory compliance then the grievance shall be referred to the Provider Network Evaluation Team for investigation. Referrals to the Evaluation Team should also be made in situations in which there are current concerns requiring on-site monitoring to assess the health and safety of enrollees/consumers.
   a. Referrals to investigations shall be communicated to complainant via U.S. mail.
   b. Within fifteen (15) calendar days of the completion of the investigation Alliance will provide a written resolution of the investigation findings to the complainant and provider via US Mail. The resolution shall include:
      i. Statements of the allegations;
      ii. Steps taken and information reviewed to reach conclusions of each allegation or complaint;
      iii. Conclusions reached regarding each allegation or complaint;
      iv. Citations of statutes and rules pertinent to each allegation or complaint; and
      v. Required action regarding each allegation or complaint.
   c. A complainant or provider who disagrees with the results of the investigation may file an LME/MCO level appeal as set forth below.

**Non-Medicaid Related Grievances**

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

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

3. If the grievance is filed against a provider:
    a. As part of the conflict resolution process QM staff shall offer the complainant the option of engaging in the provider's internal grievance process or to receive conflict resolution services facilitated by Alliance. *Note: consumers are not required to participate in a provider's conflict resolution or grievance process before submitting a grievance to Alliance.*
    b. If the issue is resolved by the provider's grievance resolution process, the provider shall submit the results of the resolution to Alliance's Quality Management Department for entry into Alpha.

4. If information gathered during the informal resolution process is indicative that provider's practice does not meet required standards as defined by statute, rule, clinical coverage policy, contract, etc., and targeted monitoring would provide additional information to determine regulatory compliance then the grievance shall be referred to the Provider Network Evaluation Team for investigation. Referrals to the Evaluation Team should also be made in situations in which there are current concerns requiring on-site monitoring to assess the health and safety of enrollees/consumers.
    a. Upon completion of the complaint investigation Alliance will submit a report of investigation findings to the complainant and provider. The report will be submitted within fifteen (15) calendar days of the completion of the investigation and shall include
        i. Statements of the allegations;
        ii. Steps taken and information reviewed to reach conclusions of each allegation or complaint;
        iii. Conclusions reached regarding each allegation or complaint;
        iv. Citations of statues and rules pertinent to each allegation or complaint; and
        v. Required action regarding each allegation or complaint.
    b. A complainant or provider who disagrees with the results of the investigation may file an LME/MCO level appeal as set forth below.

**LME/MCO Level Appeals**

1. If the complainant is not satisfied with the resolution of their grievance, the complainant, or their provider authorized in writing to act on their behalf, may file an appeal in writing to Alliance's Chief Executive Officer (CEO). The appeal request must be received within twenty-one (21) working days of the date of the resolution letter. Information related to filing an appeal is included in the resolution letter. A consumer, or provider authorized in writing to act on behalf of the consumer receiving a grievance disposition has no right to the administrative appeal procedures described in NC G.S. 108D-6, 108D-7, and 108D-8.

2. The CEO shall:
    a. provide notification of an investigative appeal to the complainant. The appeal is limited to items identified in the original grievance record and the investigation report;

b. convene an appeal review committee (following policy and procedure approved by the client rights committee). The committee's recommendation shall be by majority vote; and
c. issue an independent decision after reviewing the committee's recommendation. The decision shall be dated and mailed to the appellant within twenty (20) working days from receipt of the appeal by either QM staff or the CEO Executive Assistant.

The Alliance grievance policy and actions are closely monitored by the Division of Medical Assistance, the Alliance Quality Management Department, and the Global Quality Management Committee. Alliance maintains an electronic record where all grievances and resolutions are recorded.

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

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

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

## P. COMPLAINTS

Complaints are those concerns identified by Alliance staff, other providers, community partners and other external stakeholders that is not a Grievance as described above. Any stakeholder (internal and external) is encouraged to contact Alliance if they feel that services being provided to a consumer are unsatisfactory, if the consumer's emotional or physical well-being is being endangered by such services, if there are other practice concerns, either clinical or administrative or if the functions of the Local Management Entity/Managed Care Organization (LME/MCO) that are being provided are unsatisfactory. A Complaint may be submitted either through the Alliance Access and Information Center at (800) 510-9132, by written statement of the complaint faxed to (919) 651-8687, by email to Complaints@AllianceBHC.org or verbally in person at the Alliance Corporate Site, located at 4600 Emperor Blvd, Suite 200 Durham NC, 27703, or any of the Alliance Community Offices posted on the Alliance website (www.AllianceBHC.org).

Alliance Quality Management (QM) staff will notify (verbally or in writing) the complainant within five (5) working days of receiving the Complaint. If the complaint requires an immediate response (defined as urgent follow-up with a provider or safety issue) staff receiving the complaint are to handle the information and resolve the immediate need. QM staff will follow-up on the specific complaints of the complainant. Alliance's initial response to a Complaint shall be to attempt to resolve the issue through informal dialogue and to reach agreement between the parties. QM staff will notify the

complainant in writing of the results of the informal process within fifteen (15) working days from receipt of the complaint unless circumstances require additional time. If the complaint is not resolved within 15 working days, then QM staff will notify the complainant of progress on the Complaint resolution. Once a Complaint has been resolved, QM staff shall document the results in Alpha. QM staff shall notify the complainant, in writing, of the resolution within five (5) working days after resolution of the Complaint. If a Complaint cannot be resolved informally, it will be referred to the Provider Network Evaluation Section (Evaluators), Special Investigations Unit (SIU) or Corporate Compliance Committee or designee, depending on the nature of the Complaint.

## Q. CLIENT RIGHTS RESOURCES

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

- Area Program Service Manual (APSM) 95-2, Clients Rights Rules in Community Mental Health, Substance Abuse and Developmental Disabilities.
- APSM 30-1, Rules for Mental Health/Substance Abuse/Developmental Disabilities Facilities and Services.
- ASPM 45-1, Confidentiality Rules.
- APSM 45-2, Records Management and Documentation Manual.
- North Carolina General Statues (NCGS) 122C Article 3; 10A North Carolina Administrative Code (NCAC) 27G.0504, 10A NCAC 27G.0103.
- NCGS 143B-147(a) and NCAC 10A-27I.0600-.0609.

**Web Reference:**
www.ncdhhs.gov/mhddsas/services/advocacyandcustomerservice/clientsrightslawsrules.htm

# SECTION V: BENEFIT PACKAGE



## A. ELIGIBILITY FOR THE MEDICAID WAIVERS

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

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

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

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

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

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

### 1915 (c) NC Innovations HCBS Waiver

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

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

**Web Reference:**
Additional information regarding the NC Innovations HCBS Waiver:
www.ncdhhs.gov/dma/mp/8P.pdf

## B. MEDICAID WAIVER DISENROLLMENT

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

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

Consumers will be automatically removed from enrollment in the NC MH/DD/SAS Health Plan if they are:

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

## C. ELIGIBILITY FOR STATE-FUNDED SERVICES

Consumers who do not have Medicaid may be eligible for State-funded services based on their income and level of need. Income eligibility is based on Federal Poverty Guidelines, the consumer's family income, and the number of dependents. State funding is not an entitlement. Alliance is not required to fund services beyond the available resources.

There are also some services, including most residential services for adults, which are not reimbursed by Medicaid. Therefore, consumers who receive Medicaid may also receive State-funded services, based on their individual needs and availability of funding. Alliance maintains a Registry of Unmet Needs for I/DD consumers to track requests for State funding/non-emergency services that have not been met. A range of crisis services are available to consumers regardless of ability to pay.

Alliance has a limited amount of state funds to pay for treatment services. Therefore service entry requirements and benefit maximums may be different than the Medicaid requirements for the same service. At times, consumers seeking State-funded services may be placed on waiting list when:

- Demand for service exceeds available resources (non-Medicaid funds only), or
- Service capacity is reached as evidenced by no available provider for the State-funded service.

The Alliance Clinical Operations Utilization Management Department works with Providers to move consumers from the waiting list into services when either funding or capacity becomes available using the following guidelines:

- Service need (consumer meets medical necessity for service).
- Risk factors such as health and/or safety issues.
- Risk of hospitalization or a higher level of care if the need is not addressed.
- Whether the resources identified are adequate to meet the consumer's needs.
- If other funding sources are available to meet the consumer's need.
- Length of time the consumer has been waiting.

## D. ELIGIBILITY FOR REIMBURSEMENT BY ALLIANCE

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

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

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

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

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

## E. REGISTRATION/ENROLLMENT OF CONSUMERS

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

### Service Eligibility

Services are divided into multiple service categories:

#### Basic Services

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

#### Enhanced Services

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

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

**Target Populations**

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

**Web Reference:** IPRS link on the NC Division of MH/DD/SAS website
www.ncdhhs.gov/mhddsas/Providers/IPRS/Targetpopulations/index.htm

## F. SERVICE DEFINITIONS AND SERVICE ARRAY

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

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

**Web Reference:** Service Definitions (Medicaid Clinical Coverage Policies) may be found at www.ncdhhs.gov/dma/mp

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

### 1915(c) NC Innovations HCBS Waiver

Services defined in the 1915(c) NC Innovations Home and Community Based Services waiver replace CAP-I/DD services outlined in Clinical Coverage Policy #8M. A consumer must be assigned to NC Innovations in order to receive these services. Please refer to the most current version of the Service Definitions. For services available under the NC Innovations Waiver, further detail can be found on in the NC Innovations website and on the Alliance website:
www.ncdhhs.gov/dma/lme/Final_NC_Innovations_Manual_06252012.pdf
www.ncdhhs.gov/dma/lme/Innovations.html

### (b)(3) Alternative Services

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

The full array of services offered by Alliance is available on the Alliance website at www.AllianceBHC.org/Providers/authorization-information.

## G. HOSPITAL ADMISSIONS

Alliance will provide authorization for all covered services, including inpatient and related inpatient services, according to Medical Necessity requirements. In the event a Provider's contract with Alliance is terminated for any reason, Alliance shall provide authorization for all inpatient hospital services to consumers who are hospitalized on the effective date of termination until such consumer is discharged from the hospital.

## H. MEDICAID TRANSPORTATION SERVICES

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

Each city and/or county has access to Medicaid approved transportation. Transportation is for medical appointments or getting prescriptions at the drug store. Riders have to call two (2) to four (4) days ahead to arrange a ride. There is no fee for consumers who are enrolled in Medicaid. For those who are not enrolled in Medicaid, transportation depends on available space, and there is a fee. County-specific information about Medicaid transportation is available on the Alliance website at www.AllianceBHC.org/consumers-families/medicaid-transportation-information.

# SECTION VI: CLINICAL MANAGEMENT



## A. INTRODUCTION

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

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

The Utilization Management/Care Management Department is responsible for making decisions about initial and ongoing requests for services as well as discharge and retrospective reviews of services. Decisions are based on medical necessity and EPSDT criteria and the frequency, intensity and duration of the service request. Utilization management is the process of evaluating the necessity, appropriateness, and efficiency of behavioral health care services against established guidelines and criteria. Our goal is to ensure that consumers receive the right service, at the right time, at the right level, thus creating the most effective and efficient treatment possible.

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

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

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

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

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

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

Additional Access and Information Center duties include:

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

**Alliance's Responsibility**

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

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

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

## C. ACCESS TO SERVICES

### Access to Routine Services

This process pertains to referrals for Routine Services. The access standard for routine services is to arrange for face-to-face services (assessment and/or treatment) within ten (10) working days (fourteen (14) calendar days) of contacting the Access and Information Center and/or requesting care. The geographic access standard for services is thirty (30) miles or thirty (30) minutes driving time in urban areas, and forty-five (45) miles or forty-five (45) minutes driving time in rural areas.

### Routine Referral Process

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

Access and Information Center staff evaluates the consumer's clinical need as follows:

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

## Urgent Services

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

A consumer's clinical need may be considered urgent if, but not limited to, the following:

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

## Urgent Referral Process

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

## Emergent Services

The Access standard for Emergency Services is for face-to-face emergency care within no more than two (2) hours (or immediately, for life-threatening emergencies) of contacting the Access and Information Line and/or requesting care. The geographic access standard for services is thirty (30) miles or thirty (30) minutes driving time for urban-settings and forty five (45) miles or forty-five (45) minutes driving time in rural areas.

Federal law defines emergency services in the managed care setting as covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition. An emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

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

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

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

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

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

Consumers are informed of the availability and types of emergency services through advertising and development and distribution of brochures on emergency services in the local community. Also, a consumer handbook is accessible on the Alliance website and

available in hard copy by request. This consumer handbook contains information on the ways members can access emergency services. In addition, Access and Information Center staff members inform consumers of the availability and type of the nearest emergency services.

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

APPOINTMENT WAIT TIMES – Providers are required to meet minimum appointment wait times as follows:

- Scheduled appointments – 60 minutes
- Walk-in appointments – 2 hours
- Emergencies – face to face within 2 hours; if life threatening then immediate attention is required.

## D. PROCESS FOR TELEPHONIC ACUTE CARE PRE-AUTHORIZATION

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

The following services do not require prior authorization, but do require notification to Alliance within four (4) hours of a consumer admission:

- Crisis evaluation and observation detoxification services.
- Facility-based crisis services.
- Mobile crisis management services.
- Non-hospital medical detoxification.

### Authorization Requests for Acute Psychiatric Inpatient Services

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

### Discharge

Discharge planning begins at the time of the initial assessment and is an integral part of every consumer’s treatment plan regardless of the level of care being delivered. The discharge planning process includes use of the consumer’s strengths and support

systems, the provision of treatment in the least restrictive environment possible, the planned use of treatment at varying levels of intensity, and the selected use of community services and support when appropriate to assist the consumer with functioning in the community.

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

### Follow-Up After Discharge

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

## E. REGISTRY OF UNMET NEEDS

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

### Process

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

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

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

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

## F. CONSUMER ENROLLMENT

### Registration Process

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

### Process for Providers with an Electronic Link to Alliance

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

### Walk-In Consumers at a Provider Site

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

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

## G. INITIAL ASSESSMENT AND REQUEST FOR AUTHORIZATION

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

### Service Authorization Requests

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

Any Provider can request specific technical assistance on SAR submission by contacting the Alliance Provider Helpdesk and selecting option 3. If experiencing technical difficulties please contact the Alliance Provider Helpdesk at (919) 651-8500.

**Web Reference:** www.AllianceBHC.org/Providers/authorization-information

### EPSDT

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

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

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

## H. INITIAL AUTHORIZATION

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

### Authorization Request Process

Prior-authorization is required for all Alliance covered services, with the following exceptions:

- Initial twenty-four (24) outpatient services per year that are covered under the Medicaid Basic Benefit Package.
- Evaluation and management codes as specified in the Alliance Benefit Plan.
- Some emergency/crisis services for behavioral healthcare as indicated on the Alliance Benefit Plan.
- Codes specifically agreed upon by Alliance and Provider to be listed as “No Authorization Required” under a contract. Reference your contract for applicability.

To remain consistent with Division of Medical Assistance (DMA) guidelines, the Clinical Operations Department is only able to make formal decisions (approval, denial, or extensions when appropriate) when a complete request is received. For an authorization request to be considered “complete” it must contain the following elements:

- Recipient Name.
- Medicaid ID.
- Date of birth.
- Provider contact information and signatures.
- Date of request.
- Service(s) requested.
- Service order.
- Completed check boxes for the following: (Signature Page/Service Order Yes or No Check Boxes related to medical necessity, direct contact with the individual, and review of the individual’s Clinical Assessment).
- Person-Centered Plan (PCP), Individual Service Plan (ISP), or other approved treatment plan.
- Clinical information to support the service(s) requested. This should include information that supports the eligibility for service(s) requested.

- Additional documentation may be required as referenced on the Alliance published Benefit Plan.
- Documents and forms as required by law.

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

If a SAR is received that requires a corresponding PCP, ISP or other approved treatment plan and none is submitted or there is not enough clinical information to support the request, the request will be administratively denied as an incomplete request and the Provider will be notified.

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

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

### Initial Authorization of Enhanced Services

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

## Authorization of Enhanced Services

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

- The clinical home Provider completes the Person-Centered Plan (PCP) with input from consumer, consumer's family, Providers, and other involved professionals or support as indicated.
- The services requested are listed with any limitations noted.
- The Provider for each service is listed on the SAR. Multiple services may be requested on one SAR, however, only one Provider can be listed per SAR.
- The PCP and SAR are submitted to UM for review.
- All UM actions are documented in AlphaMCS and Providers have access to the decisions through the Provider Portal.

Alliance Timeliness Standards

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

| Alliance Timeliness Standard | Turnaround Time |
|---|---|
| Urgent/ Expedited Review | 72 hours |
| Standard Review | 14 calendar days |
| Urgent/Expedited Re-Authorization Review* | 24 hours/72 hours |

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

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

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

Alliance will notify the consumer in writing if there is a decision to extend the review time frame.

## I. CONTINUED AUTHORIZATION OF SERVICES

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

### Continued Authorization of an Enhanced Service

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

## J. DISCHARGE REVIEW

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

### Discharge Review Process

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

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

to develop a plan to provide services to address the consumer's treatment needs within the least restrictive levels of care.

- Whenever a consumer is discharged from detoxification, inpatient psychiatric or partial hospitalization care, the discharge plan should include a follow-up appointment within seven calendar days. Access and Information Center staff works with the discharging facility to ensure that an appointment is made and monitors whether the consumer kept the appointment.
- The UM Care Manager coordinates with the person's clinical home to ensure there are appropriate services in place following discharge from a residential program. If the person does not have a clinical home, and the person meets special needs population criteria, the UM Care Manager refers to Care Coordination for follow-up.

## K. UTILIZATION REVIEW

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

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

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

- High-risk consumers.
- Over-utilization of services.
- Services infrequently utilized.
- High-cost treatment.

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

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

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

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

## L. CARE COORDINATION

Alliance Care Coordinators provide the following supports to consumers with I/DD enrolled in NC Innovations, to consumers with I/DD with recent legal and crisis services involvement, to MH/SA consumers deemed high risk and to those meeting specific special healthcare population criteria:

- Education: about all available MH/IDD/SA services and supports, as well as education about all types of Medicaid and State-funded services and coordination of Medicaid eligibility and benefits.
- Assessment: I/DD Care Coordinators will arrange for needed assessments to identify support needs and to facilitate person-centered planning processes. MH/SA Care Coordinators will arrange for needed clinical assessments for individuals with special health care needs to help identify any ongoing special conditions that require treatment or monitoring.
- Ensure the Development of a Person-Centered Plan: I/DD Care Coordinators will develop the Person-Centered Plan (PCP)/Individual Service Plan (ISP) in collaboration with the consumer, family, and other all service and support Providers. MH/SA Care Coordinators will ensure that a Person-Centered Plan is developed by the Behavioral Health Clinical Home.
- Treatment Planning: Both I/DD and MH/SA Care Coordinators will link consumers to necessary psychological, behavioral, educational, and physical evaluations and

services deemed medically necessary through consultation with the consumer's Provider(s) (including primary medical care) regarding the type, level, duration, and frequency of services outlined in ISPs and PCPs.

- Monitoring: I/DD Care Coordinators will complete on-site visits to evaluate the health and safety of the individual as indicated by the Waiver Amendment, to assess the satisfaction of individuals served, and to monitor implementation of the Individualized Service Plan. MH/SA Care Coordinators will monitor engagement and the effectiveness of services provided to individuals who are receiving MH/SA care coordination. Monitoring may occur telephonically, by participating on treatment teams and onsite visits with service Providers.

**High-Risk/Special Health Care Populations**

Examples of high-risk consumers may include, but are not limited to, consumers who have been hospitalized more than one time in a thirty (30) day period, re-hospitalized within a thirty (30) day period following a hospital discharge, have three (3) hospitalizations or more within a year following a hospital discharge, or have ten (10) or more hospitalizations within a lifetime. Additionally, Medicaid-eligible consumers who meet the following criteria are considered a part of the Special Healthcare Needs Population:

- Adults and Children with Intellectual and/or Developmental Disabilities:
  - Individuals who are functionally eligible for, but not enrolled in, the NC Innovations Waiver, who are not living in an ICF-MR facility (for example individuals on the Registry of Unmet Needs);
  - Individuals with an intellectual or developmental disability diagnosis who are currently, or have been within the past thirty (30) days, in a facility operated by the Department of Correction (DOC) or the Department of Juvenile Justice and Delinquency Prevention (DJJDP) for whom Alliance has received notification of discharge.

- Child Mental Health:
  - Children under 21 years of age who have a current CALOCUS Level of VI AND a diagnosis within the diagnostic ranges listed below:
    - 293-297.99
    - 298.8-298.9
    - 300-300.99
    - 302-302.6
    - 302.8-302.9
    - 307-307.99
    - 308.3
    - 309.81
    - 311-312.99
    - 313.81-313.89
    - 995.5-995.59
    - V61.21

  - Children under 21 years of age with an MH or SA diagnosis who are currently, or have been within the past 30 days, in a facility (including a Youth Development Center and Youth Detention Center) operated by the Department of Public Safety, Division of Juvenile Justice or Department of Corrections for whom Alliance has received notification of discharge.
- Adult Mental Health: Adults who have a current LOCUS Level of VI AND a diagnosis within the diagnostic range listed below:
    - 295-295.99
    - 296-296.99
    - 298.9
    - 309.81
- Substance (non-Opioid) Dependent: Individuals with a substance dependence diagnosis AND Current ASAM PPC Level of III.7 or II.2-D or higher.
- Opioid Dependent: Individuals with an opioid dependence diagnosis AND who have reported to have used drugs by injection within the past thirty days.
- Individuals transitioning from adult care homes and group homes to independent living arrangements.
- Co-occurring Diagnoses:
  - Individuals with both a mental illness diagnosis and a substance abuse diagnosis AND current LOCUS/CALOCUS of V or higher OR current ASAM PPC Level of III.5 or higher.
  - Individuals with both a mental illness diagnosis and an intellectual or developmental disability diagnosis AND current LOCUS/CALOCUS of IV or higher.
  - Individuals with both an intellectual or developmental disability diagnosis and a substance abuse diagnosis AND current ASAM PPC Level of III.3 or higher.

**CM/UM, Care Coordination and Providers for Residential Services**

Alliance UM Care Managers and Care Coordinators consult with Providers and oversee the provision of services for consumers whose MH/IDD/SA disabilities treatment needs highly impact the System of Care and/or who have co-occurring chronic physical illnesses resulting in facility-based services. Not every individual in a residential service will be assigned an Alliance Care Coordinator. When an Alliance Care Coordinator is assigned to an enrollee, the primary purpose of their involvement is to:

- Improve treatment outcomes through consultation and oversight of treatment and crisis management development.
- Ensure appropriate linkage with service and supports.
- Participate with the consumer and Providers in community treatment teams as needed.
- Identify and reduce barriers to care that may prolong residential treatment if not addressed.

# SECTION VII: CLAIMS AND REIMBURSEMENT



## A. INTRODUCTION

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

## B. CONSUMER ENROLLMENT AND ELIGIBILITY PROCESS

### MCS Provider Portal

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

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

Each Provider will be contacted and provided with the user ID and password upon execution of a Network Contract. Providers are required to notify the Alliance Provider Helpdesk when their employees that have access to Alliance AlphaMCS Provider Portal terminate employment so that the logins can be disabled.

### Eligibility Determination

If consumers are enrolled with Medicaid, they are financially eligible for Medicaid reimbursable services from Alliance that are not covered by other insurance or third party payer.

**It is the Provider's responsibility to verify a consumer's eligibility for Medicaid coverage, State funding, and other third party insurance coverage, or if any other payer is involved such as worker's compensation, or other liable parties. Coordination of benefits is required.**

Consumers in certain circumstances may be eligible for State funding of services. The Provider must determine if:

- The consumer does not have Medicaid; or if consumer does have Medicaid but requires contracted services that are not billable to Medicaid.
- The consumer does not have Medicare, other insurance or other third party coverage that will pay for required services.

Consumers who have their services paid in whole or in part by Alliance must be registered by the Provider with Alliance. Consumers with applicable Medicaid coverage through the Alliance area are automatically enrolled with Alliance and do not require enrollment by the Provider. If the consumer is not yet registered or no longer active in the system, the Provider must enroll the consumer or update consumer information through the AlphaMCS Provider Portal. Alliance reviews and must approve all enrollments.

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

## Consumer Confidentiality

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

## Key Data to Capture During Enrollment

All Providers are required to ensure the consumer is an enrolled member and demographic data is up-to-date and accurate in the AlphaMCS consumer profile. If enrollment is not complete prior to service provision, authorizations and claims payment may be affected. This could include denials of authorizations and claims for these services. When furnishing services to consumers without Medicaid, or a consumer who is not enrolled with Alliance, the Provider must complete an electronic enrollment request within fourteen (14) days of the consumer's intake appointment.
To complete registration/enrollment, Providers need to confirm consumer's identity and register them with their legal name, birth date, Social Security number or Medicaid identification number. Additional information may be required including but not limited to:

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

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

### Effective Date of Registration/Enrollment

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

### Member ID

The Alliance Client ID number is assigned by the Alliance Information System once a consumer is enrolled as a member. To obtain this number, the consumer must be confirmed as eligible and registered/enrolled with Alliance. Claims are denied if submitted with an incorrect Alliance Client ID number, or with a valid number that is not registered or active to the Provider on the date of service billed.

The six (6) digit Alliance Client ID number is required to identify a consumer in CCIS and to bill claims through the online DDE system. Claims submitted by HIPAA compliant 837 transaction files may identify recipients of service with their Alliance Client ID number or their active Medicaid ID number.

## C. AUTHORIZATIONS REQUIRED FOR PAYMENT

### System Edits

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

### Authorization Number and Effective Dates

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

### Service Categories or Specific Services

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

### Units of Service

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

### Exceptions to Authorization Rule

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

## D. PAYMENT OF CLAIMS AND CLAIMS INQUIRIES

### ICD-10 Compliance

All HIPAA covered entities shall be compliant with ICD-10 on and after October 1, 2015. ICD-10 compliance means that all Health Insurance Portability and Accountability Act (HIPAA) covered entities are required to use ICD-10 diagnosis and procedure codes including outpatient claims for dates of service on or after October 1, 2015 and inpatient

claims with dates of discharge on and after October 1, 2015. ICD-9 diagnosis and procedure codes can no longer be used for health care services provided on or after this date. Without ICD-10, providers will experience delayed payments or even non-payment and a possible increase in rejected, denied or pended claims. Payments to providers cannot be made without the proper ICD-10 coding. Additional information regarding ICD-10 can be found on line at:

- www.AllianceBHC.org/providers/icd-10/
- www.nctracks.nc.gov/content/public/providers/ICD10.html
- www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/ICD10

**Timeframe for Claim Submission**

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

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

**Submitting Claims Outside of Filing Period**

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

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

The information can be submitted to the Claims Manager via secured email or regular mail. The information will be reviewed within five (5) business days for acceptance or denial of filing outside of the timely filing deadline.

**Process for Submitting Claims to Alliance**

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

## 837 Claim Submissions

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

## Claim Format Requirements

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

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

## Claim Receipt Verification

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

## Submitting Voided Claims and Replacing a Paid Claim

Providers may submit a voided claim for a previously paid claim or replace a paid claim within 180 calendar days post service date. Replacement claims submitted past 180 calendar days are denied for exceeding the timely filing requirements. Voided or Replacement claims may be submitted electronically through the AlphaMCS Provider Portal or via an 837 transaction set. Detailed instructions can be found in the Claims Manual or 837 Companion Guides.

## Paper Claim Submission

Providers are required to submit claims electronically unless an exception has been granted by the Claims Manager or the claim requires attachments that cannot be sent electronically. For a claim to be accepted as valid, the submission must meet the following criteria:

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

### Claim Inquiries

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

- Provider name.
- Recipient's name.
- Recipient's identification number.
- Date of birth of recipient.
- Date of service of recipient.
- Billed services.

### Claim Processing Time

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

### Response to Claims

- Remittance Advice (RA): A Remittance Advice (RA) is available for Providers electronically to download on the AlphaMCS Provider Portal. The RA will include paid, denied, and adjusted claims. Instructions on resolving denied claims can be found in the Alpha Claim Adjudication Codes document located at www.AllianceBHC.org/Providers/finance-and-claims.
- Electronic Remittance Advice (ERA): Providers may also request an 835 electronic transaction in addition to the Explanation of Benefits (EOB). The 835 returns information for paid and denied claims in a standard HIPAA compliant format.

## E. SERVICE CODES AND RATES – CONTRACT PROVISIONS

### Reimbursement Rates

Provider contracts include a listing of eligible services for which the Provider is eligible to be reimbursed. Services are defined by the specific funding source (Grant, Medicaid, State, or Local). All Providers are reimbursed at the Alliance published standard rates for the service rendered unless otherwise stated in their contract.

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

The published rates can be found at www.AllianceBHC.org/Providers/finance-and-claims-forms.

## F. DEFINITION OF CLEAN CLAIM

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

## G. COORDINATION OF BENEFITS

Alliance is the payer of last resort. Providers are required to collect all third party funds prior to submitting claims to Alliance for reimbursement. Third party payers are any other funding sources that are liable to pay for the services provided. This can include worker's compensation, disability insurance, Medicare, or other health insurance coverage.

All claims must identify the amounts collected by third parties, and only request payment for any remaining reimbursable amount. Only the remaining amount of the consumer responsibility under their insurance policy is reimbursable by Alliance when Medicaid is secondary coverage.

### Financial Eligibility Determination Process by Provider

Providers should conduct a comprehensive eligibility determination process whenever a client enters the delivery system. The eligibility determination should include whether a person has private insurance, Healthchoice, is Medicaid or Medicare eligible, or has another payor source. Periodically (no less than quarterly) the Provider should update its eligibility information to determine if there are any changes to first or third party liability for this consumer. It is the Provider's responsibility to monitor this information and to adjust billing accordingly. Changes in income or family size affecting first party liability, changes to third party insurance information should be added to the consumer's record in the system. Determination of financial eligibility by the Provider is not required for Medicaid recipients.

### Obligation to Collect

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

### Reporting of Third Party Payments

Providers are required to record on the claim either the payment or denial information from a third party payer. Copies of the RA or EOB from the insurance company should be retained by the Provider if they submit electronic billing. Claims with third party liability showing a zero paid amount by insurance company must be submitted on a paper claim form. If paper claim forms are submitted to Alliance with third party liability, copies of the insurance company's RA or EOB showing the denial reason codes must be submitted with the claim form.

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

## H. STATE-FUNDED SERVICES ELIGIBILITY

### Eligibility for Benefit Determination

All non-Medicaid consumers must be evaluated at the time of enrollment for their ability to pay. This determination should be updated at least annually to ensure that a family must be at or below 300% of the federal poverty level based on income and household size to be eligible for non-Medicaid funded services.

Any changes in information related to the consumer's family size and income should be updated in the client's profile in AlphaMCS as necessary.

### Process to Establish Eligibility

It is the responsibility of the service Provider to ensure consumer financial eligibility for state and county funded services prior to enrolling consumer with Alliance. The combination of a consumer's adjusted gross monthly income and the number of dependents determines eligibility for services.

Providers should use the Division of MH/DD/SAS published definitions for family size and family income for this determination.

**Web Reference:**
www.ncdhhs.gov/mhddsas/ImplementationUpdates/update077/attachment3-incomeandfamilysize7-10.pdf

If a consumer does not meet eligibility guidelines s/he should pay 100% of the services being provided. In this case, the consumer should not be registered in the AlphaMCS system and claims should not be submitted to Alliance for reimbursement. Cost sharing is not permitted for Medicaid consumers.

## I. RESPONSE TO CLAIMS

### Management of Accounts Receivable – Provider Responsibility

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

# SECTION VIII: PROVIDER COMPLIANCE, SANCTIONS AND ADMINISTRATIVE ACTIONS



## A. INTRODUCTION

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

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

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

## B. CODE OF ETHICS

All contracted Providers will be required to adhere to all relevant codes of ethics associated with individual professional licensure and to abide by a Code of Ethics that will be developed with input from the Provider Advisory Council. Providers should attempt to resolve ethics concerns internally, and should encourage their staff to report unresolved concerns about ethics violations to Alliance.

## C. CORPORATE COMPLIANCE

Alliance Network Providers are required to practice honesty, directness and integrity in dealings with one another, consumers, payors including Alliance, business partners, the public, internal and external stakeholders, “customers”, suppliers, elected officials, and government authorities. Corporate Compliance deals with the prohibition, recognition,

reporting and investigation of suspected fraud, abuse, misappropriation, and other similar irregularities.

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

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

**Reporting to State and Federal Authorities**

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

**Provider Compliance Plan**

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

- Written policies, procedures and standards of conduct that articulate the agency's commitment to comply with all applicable State and Federal standards for the protection against fraud and abuse.
- Designation of a Compliance Officer and Compliance Committee.
- A training program for the Compliance Officer and agency employees.
- Systems for reporting suspected fraud and abuse by employees and consumers and protections for those reporting.

- Provisions for internal monitoring and auditing, including an audit process to verify that services billed were provided by appropriately credentialed staff and was appropriately documented and a process to ensure that staff performing services under the Alliance contract has not been excluded from participation in Federal Health Care Programs under either Section 1128 or 1128A of the Social Security Act. The agency consults with the Health and Human Services Office of the Inspector General's list of Excluded Individuals, the Medicare Exclusion Databases (MED), and the System for Award Management (SAM).
- Procedure for response to detected offenses and for the development of corrective action plans.
- Procedures to promptly report to Alliance, other outside agencies and law enforcement as indicated.

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

## D. COMPLIANCE HOTLINE AND INVESTIGATIONS OF VIOLATIONS

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

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

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

The Compliance Department Special Investigations Unit receives all reports and conducts a pre-investigation for each report. If the pre-investigation indicates a potential compliance violation or suspicious fraudulent activity the Special Investigations Unit will conduct an investigation to evaluate such information, which may include a billing audit. All suspicious fraudulent activity is reported to DMA Program Integrity within 24 hours. Alliance may also disclose the results of investigations to regulatory and/or law enforcement agencies depending on the nature of the allegation.

## E. GUARDING AGAINST FRAUD AND ABUSE

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

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

### Prevention

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

- Employee Education and training regarding the compliance plan, what constitutes fraud and abuse, reporting of suspected fraud and abuse, fraud and abuse in a Managed Care environment, and Alliance Code of Ethics and Conduct is ongoing. Utilization Management (UM) awareness training for UM staff is conducted regularly to prevent, reduce, and detect behaviors associated with inappropriate care or requests for services. Claims awareness training is conducted regularly to Finance staff to prevent, reduce, and detect fraudulent billing practices.
- Provider Education related to compliance, fraud and abuse, and contractual provisions is ongoing through a variety of mechanisms. This Manual includes compliance requirements and information on how to report suspected fraud and abuse. Educational materials include reporting suspected cases through the use of the Fraud and Abuse Line and indicate the responsibility of the Provider to promptly report all cases of suspected fraud and abuse. Periodic articles, updates, and reminders will be produced in the Provider newsletters and presented in All Provider Meetings to further communicate the Compliance Plan.
- Enrollee Outreach and Education through materials to ensure that Enrollees understand the benefits to which they are entitled, the right to select and change a Network Provider, Enrollees' responsibilities and rights including the right to receive a copy of the medical record, and information of how to report fraud and abuse and overpayments.
- Fraud and Abuse Hotline – (855) 727-6721.
- Gatekeeping – the Credentialing and Enrollment process is part of the selection and retention of quality Providers but also serves as a means to control access to the Network by Providers that have been excluded from participation in Federal programs. Upon applying for enrollment with the Alliance Network, applicant's

eligibility and enrollment is determined in part by reviewing the Department of Health and Human Services (DHHS) Office of Inspector General List of Excluded Individuals and Entities (LEIE), and the System for Award Management (SAM) to ensure that Providers who are excluded from participation in Federal programs are not enrolled. Alliance searches the LEIE and the SAM upon enrollment and monthly thereafter. Alliance will also conduct checks with the National Practitioner databank (NPD), the North Carolina Secretary of State registry, and NC DHHS and other LME/MCOs in North Carolina for good standing. Adverse findings from the exclusions checks are immediately reported to the Chief Compliance Officer.

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

**Detection**

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

- Data Analysis – The Special Investigations Unit (SIU) uses data analysis for ongoing and systematic attempts to detect waste, program abuse or fraudulent activities. Suspicious patterns are investigated and if findings indicate fraud they are reported to DMA Program Integrity within 24 hours for determination of Credible Allegation of Fraud.

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

  - Improper coding including up-coding and unbundling or bundling.
  - Double-billing.
  - Failing to reimburse Alliance for funds paid by Alliance and collected from another source.
  - Billing for ineligible consumers, i.e. deceased or missing eligibility span.
  - Services not rendered.
  - Individual enrollee billing for family or group services that should only be billed once.

  - Inappropriate use of services to maximize revenue.
  - Pattern of claims for services that are not medically necessary or, if necessary, not to the extent rendered.
  - Not meeting with patients in a timely manner for first contact.
  - Failure to see individuals with cultural or language barriers.
  - Not rendering court-ordered treatment.
  - Inappropriate refusal to accept a new patient due to prior utilization history or diagnosis.
- A random sample of enrollees are contacted monthly using an Explanation of Benefits survey to verify that services billed by a particular Provider were rendered.
- Alliance employees report any suspected fraud and abuse activities detected during a routine or focused monitoring to the Compliance Department to determine the appropriate course of action.

### Enforcement

Substantiated non-compliance will be reported to the next scheduled Alliance Corporate Compliance Committee (CCC) for determination of sanctions or administrative actions. Substantiated fraud will be reported at the next scheduled Corporate Compliance Committee meeting following notification from DMA, for recommended actions or administrative actions.

### Data and Reporting

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

## F. SANCTIONS AND ADMINISTRATIVE ACTIONS

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

- Targeted post-payment reviews.
- Targeted compliance reviews and investigations.
- Routine monitoring.

- Complaint and grievance investigations.
- Claims audits.

The Compliance Department is responsible for all reviews, audits and investigations of alleged Provider fraud and abuse as well as routine and focused claims audits. Provider Network Evaluations is responsible for all routine monitoring and/or quality of care complaint investigations. Post-payment reviews may be part of any monitoring or investigative activity. When the outcome of any of these reviews, audits or investigations result in findings of noncompliance, a report shall be made to the Corporate Compliance Committee for determination of the appropriate actions, if any. The Provider may also be placed on prepayment review, which is not a sanction but a mechanism by which Alliance does not pay claims until the Provider has submitted written support for each claim and the claims have been approved for payment by Alliance or any prepayment review vendor retained by Alliance. State law does not allow a Provider to appeal a decision to be placed on pre-payment review.

**Sanctions**

Sanctions that may be imposed by the Corporate Compliance Committee include but are not limited to:

- Limiting Referrals.
- Suspension of Referrals.
- Payment Suspension.
- Suspension from Closed Network (including Emergency Suspension to Protect Consumer).
- Site or Service Specific Termination.
- Termination from Closed Network.
- Exclusion from Participation in Closed Network.

**Administrative Actions**

Administrative Actions that may be imposed by the Corporate Compliance Committee include but are not limited to:

- Moratorium on expansion of sites or services.
- Warning/educational letter.
- Plan of Correction.
- Probation (increased monitoring).
- Identification, recovery or recoupment of identified overpayments.

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

## Credentialing Actions

The Alliance Credentialing Committee is tasked with assuring that all Providers, including licensed practitioners, meet standards for initial and continued participation in the Alliance Network. The Credentialing Committee is chaired by Alliance's Medical Director and includes licensed staff members employed by Alliance who represent various licensing boards and at least one or more licensed Provider from within the Alliance Network. The Credentialing Committee reviews licensure, sanctions, criminal background checks, and other relevant documents to determine if the applicant meets Alliance standards.

Conditions that may affect a Provider's credentialing status include but are not limited to:

- Failure to maintain compliance with the credentialing and re-credentialing criteria.
- General area of practice or specialty, in the opinion of the Credentialing Committee, involves experimental or unproved modalities of treatment or therapy not widely accepted in the local medical community.
- Contact with a patient of a sexual or amorous nature, or violation of other clinician/patient boundaries.
- Licensure/Professional Certification sanction, or refusal to comply with sanction or suspension conditions.
- Failure to maintain license.
- Criminal conviction.
- Not maintaining registration with NCTracks as required.

Disciplinary actions that can be taken by Alliance's Credentialing Committee, related to credentialing include but are not limited to:

- Warning/educational letter.
- Suspension pending investigation.
- Revocation of credentialing.
- Referral to Corporate Compliance Committee.

All disciplinary actions based on professional competency or conduct which would adversely affect clinical privileges for a period longer than thirty (30) days or would require voluntary surrender or restriction of clinical privileges, while under, or to avoid, investigation is required to be reported to the appropriate entity (i.e. State Medical Board, National Practitioner Data Bank, Federation of State Medical Boards).
The Alliance Medical Director or designee is responsible for notifying all appropriate entities including State Medical Board, National Practitioner Data Bank, Federation of State Medical Boards, and the appropriate licensing bodies within fifteen (15) business days of any final disciplinary actions described above.

### Network Provider Suspension for Health, Welfare and Safety Issues

Alliance's accrediting body (URAC) has specific requirements for Provider suspension in response to health, welfare and safety issues. If the Alliance Medical Director or Chief of Clinical Operations learns that a Network Provider is engaged in behavior or practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of any consumer, Alliance may immediately suspend, pending investigation, a Network Provider's participation in the Network. A suspended Network Provider will not receive claims reimbursement, authorization or funding to continue service or receive new referrals from Alliance.

Written notification of the intent to suspend the Network Provider pending investigation, including the effective date of suspension, will be sent within one (1) business day of discovery of the alleged issue. The Network Provider will be notified of the basis of the determination and effective date of suspension in writing.

Following issuance of the emergency suspension notice, Alliance will complete a full investigation into the allegations and issue a final decision that will include an explanation of the reconsideration process. Alliance makes every effort to expedite these investigations to validate or refute the allegations, given that the Network Provider has been suspended. However, Alliance will not compromise the outcome to complete the case quickly.

As outlined in this Manual, a dispute resolution process is available to Providers.

## G. IDENTIFICATION AND RECOVERY OF OVERPAYMENTS AND UNDERPAYMENTS

Alliance has the responsibility to ensure that public funds are being used for the appropriate level and intensity of services/supports, as well as in compliance with applicable federal and state laws, rules, regulations, the NC State Plan for Medical Assistance, the 1915 (b)/(c) Medicaid Waivers, Clinical Coverage Policies, State Service Definitions, Department or Alliance requirements (including but not limited to the DMH/DD/SAS Records Management and Documentation Manual - APSM 45-2, Eff. April 1, 2009, the Alliance Claims Manual, and the Alliance Provider Operations Manual) or any other Alliance revenue source requirements and Generally Accepted Accounting Practices. The Compliance Department, Claims Department and Provider Network Evaluation Unit perform a variety of audits and review to identify overpayments and underpayments. The Alliance Finance Department conducts reviews of financial reports, financial statements, and accounting procedures. A non-exhaustive list of the types of audits and reviews are listed below:

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

as part of fraud and abuse investigations. The Finance Department will assist with the review of financial reports, financial statements, and accounting procedures.

- Claims audit may include a review of the Provider's evaluation of consumer's income, consumer's determined ability to pay, third party insurance verification, first and third party billing, receipts and denials. A review of Coordination of Benefits information may also be conducted to verify support of claimed amounts billed to Alliance.
- Post-payment reviews are conducted at a minimum of every two (2) years. The Provider Network Evaluators are responsible for conducting these audits. The Billing Audit Sample will consist of three (3) months of paid claims data from the current or previous fiscal year. Results that indicate waste, abuse or fraud will be reported to the Compliance Department upon completion of the audit.
- Justified Cause Billing Audits can be recommended by CCC or CQIT as a result of previous issues cited or observations noted during a routine billing audit including but not limited to the following:
    - Unavailability of medical records documentation for billing (service notes).
    - Inconsistent documentation to support billing.
    - Concerns regarding potential fraud or abuse, and/or
    - Concerns regarding falsification of a Provider's credentials.
    - Concerns regarding lack of required supervision documentation.
    - Concerns regarding possible double billing.
    - Concerns regarding staffing ratios for service provision.
- Focused post-payment reviews will be conducted as part of Alliance monitoring responsibilities. Focused post-payment reviews may be conducted on-site at the Provider agency or as a desk audit and may include but not be limited to the following:
    - High-Cost/High-Volume/High-Risk audits will be conducted in conjunction with scheduled post-payment reviews where applicable.
    - A Service Specific Audit can be conducted when a new contracted Provider enters the Alliance Network, a contracted Provider has been approved to provide an additional service, new or revised service definitions/rule changes occur, or when concerns arise regarding service delivery with a specific service.
    - Block Grant Audits will be conducted in conjunction with scheduled post-payment reviews where applicable.
    - Alliance will conduct annual monitoring reviews of the following service provision: Self-Directed Services, Financial Management and Support Brokerage Service Provider(s).
    - Contract Termination Audits may be conducted upon notice of termination, and prior to final payment as appropriate and necessary. Alliance will perform a Contract Termination Audit on unpaid claims to ensure that all Contractual and other fiscal requirements have been fulfilled.

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

## Voluntary Repayment of Claims

Providers must conduct self-audits to identify overpayments and ensure all claims submitted for reimbursement are supported by documentation that meets all requirements for billing a service and that billing was not submitted in error.

**Under federal law, Providers are required to report and return self-identified overpayments within sixty (60) days of identification. Failure to do so may be a violation of the False Claims Act or result in the imposition of sanctions, up to and including termination, by Alliance.**

Claims which require repayment can be voided electronically within 180 days from the date of service either through the AlphaMCS Provider Portal, or an 837 file submission.

Refund checks may be submitted along with a completed Provider Refund form and sent by mail to the Finance Department for processing. Any Provider Refund forms not submitted with payment will be referred to the Claims Department for processing. The Claims Department will deduct voids or refund requests from future claim payments. All voided claim recoupment and approved adjustments will be processed and reported on the Alliance Remittance Advice after the request has been thoroughly reviewed by Alliance Claims Department.

- For Medicaid: if Provider chooses the option of having the overpayment recouped, a revert will be entered into the system which will recoup the overpayment from future check writes, until the overpayment is satisfied.
- For State-funded: overpayments will be recouped immediately upon identification and will appear on the Provider's next remittance advice (RA).

If Alliance or a Provider determines that the Provider has received revenues as a result of an error or omission, Alliance will consult with the Provider on the method of repayment. If the Provider fails to repay Alliance within the specified period, Alliance will recoup the amount owed from current and/or future claims according to the procedure described directly above.

## Notices of Overpayment and Recoupments

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

If Alliance identifies an overpayment based on a determination that the Provider has failed to comply with applicable federal and state laws, rules, regulations, the NC State Plan for Medical Assistance, the 1915 (b)/(c) Medicaid Waivers, Clinical Coverage Policies, State Service Definitions, Department or Alliance requirements (including but not limited to the DMH/DD/SAS Records Management and Documentation Manual - APSM 45-2, Eff. April 1, 2009, the Alliance Claims Manual, and the Alliance Provider Operations Manual) or any other Alliance revenue source requirements, the Alliance Claims Department will notify the Provider of the identified overpayment and process for requesting reconsideration in accordance with the Alliance *Provider Dispute Resolution* Procedure and will recoup the amount owed from current and/or future claims.

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

Alliance may establish a payment plan for the amount owed including interest and any penalty upon the approval of the Chief Financial Officer and may not exceed a term of 6 months. A request for a payment plan must be submitted on agency letterhead and signed by an authorized person. A payment plan will not be approved if the amount owed is less than 30% of their average weekly claims payment.

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

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

**Identification and Reimbursement of Underpayments**

If an audit or post payment review reveals that a Provider has been underpaid or Alliance otherwise identifies an overpayment, the Alliance Business Operations

Department is responsible for calculating the amount of the underpayment, notifying the Provider and remitting the underpayment electronically within thirty (30) days of identification. Alliance is required to pay interest in the amount of eight percent of the claim amount beginning on the date following the day on which the payment should have been made.

## H. INCIDENT REVIEW

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

### Monitoring of Incidents

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

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

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

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

## Alliance Incident Review Process

Alliance is required to monitor certain types of incidents that occur with Network Providers, as well as Providers who are not in the Network but operate services in the Alliance catchment area. Alliance is also required to monitor the State IRIS system.

**Web Reference:** iris.dhhs.state.nc.us/

Upon receipt, the Alliance Quality Management Department reviews all incidents for completeness, appropriateness of interventions and achievement of short and long term follow up both for the individual consumer, as well as the Provider's service system. If questions/concerns are noted when reviewing the incident report the Quality Management staff will work with the Provider to resolve these.

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

## Monitoring to Ensure Quality of Care

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

Alliance will review the incidents reported and determine whether any follow up is needed and may conduct investigations of incidents reported directly by Providers on Incident Reports, as well as reports provided by consumers, families and the community.

# SECTION IX: DISPUTE RESOLUTION PROCESS FOR PROVIDERS

Alliance follows a fair, consistent, respectful, timely and impartial dispute resolution process for Network Providers to appeal contract disputes, administrative actions or sanctions. Provider dispute mechanisms only apply to Alliance Network Providers. Alliance does not offer the opportunity to appeal to Applicants who are denied participation in the Closed Network. Not all Network Provider disputes are subject to the dispute process. Network Providers may not appeal a decision by Alliance not to renew or extend a Network Contract beyond its original term, and may not appeal contract termination or suspension based on the following: notification to Alliance of exclusion from participation in federally-funded health care programs by the U.S. HHS Office of Inspector General, Immediate Jeopardy finding issued by the Centers for Medicare and Medicaid Services, action taken by the NC Department of Health and Human Services or any of its Divisions, loss of required facility or professional licensure, accreditation or certification, Provider is excluded from participation in any other North Carolina State health care program, such as Health Choice or another LME-MCO, or Federal, State or local funds allocated to Alliance are revoked or terminated in a manner beyond the control of Alliance for any part of the Contract period.

There are two tracks for Provider dispute resolution. One track is for disputes involving professional competence/conduct or **Sanctions** that impact the Network Provider's status in the Closed Network. The other track is for **Administrative Actions** that do not involve professional competence/conduct or impact the Network Provider's status in the Closed Network.

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

### Requesting Reconsideration

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

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

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

Alliance Behavioral Healthcare
ATTN: COMPLIANCE – PROVIDER RECONSIDERATIONS
4600 Emperor Boulevard, Suite 200
Durham, NC 27703

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

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

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

### Corporate Compliance Committee Process

The Alliance Corporate Compliance Committee is responsible for making decisions about Administrative Actions and Sanctions against Network Providers. Actions and Sanctions are considered final upon issuance by the Compliance Department, and the Network Provider may initiate the dispute resolution process upon receipt of a Notice of Action or Sanction. The Notice will include instructions for how to initiate the dispute resolution process.

### Reconsideration Process for Sanctions or Other Actions Related to the Network Provider's Professional Competence or Conduct

1. Upon receipt of a timely request for reconsideration of a sanction or action related to the Network Provider's Professional Competence or Conduct, Alliance will convene a first level panel. If the Network Provider does not request a reconsideration review within twenty-one (21) days from receipt of the final notification of Administrative Action or Sanction, the decision shall become final.
2. A first level panel meeting will be scheduled at the Alliance Headquarters no later than fourteen (14) days from the receipt of the request for reconsideration. The Corporate Compliance Committee designee will provide each panel member with a summary of the dispute/problem; identification of panel members, including indication of which member of the panel is the clinical peer of the Network Provider

who is the subject of the dispute; and the supporting documentation submitted by the Network Provider.

3. The Network Provider is informed of the date, time and place of the meeting at least three (3) days in advance and invited to appear in person or by telephone and to present arguments and documentation to the first level panel. The Network Provider must notify Alliance in advance if they intend to bring legal counsel to the panel meeting. The Network Provider must provide any additional written documentation to be considered during the Reconsideration Process at the time the Request for Reconsideration is filed.
4. The first level panel will notify the Compliance Department of their decision no later than seven (7) days following the panel meeting. The Compliance Department will issue a written decision to the Network Provider no later than seven (7) days following the panel decision.
5. If not satisfied with the first level panel decision, the Network Provider may request reconsideration by a second level panel within seven (7) days from receipt or attempted first delivery of the first level panel decision as set forth in 2. above. If the Network Provider does not request a second level panel review within seven (7) days from receipt of the first level panel decision, the decision shall become final.
6. The second level panel will conduct a Desk Review of the first level panel decision within fourteen (14) days of receipt of the request for a second level review, and may consider any additional documentation submitted by the Network Provider along with the second request for reconsideration.
7. The second level panel will notify the Compliance Department of their decision no later than seven (7) days from completion of the Desk Review. The Compliance Department will issue a final written decision to the Network Provider no later than seven (7) days following the panel decision. The second level panel decision is final and there is no right to appeal beyond the second level panel.

**Reconsideration Process for Administrative Actions**

1. Upon receipt of a request for timely reconsideration of an Administrative Action, Alliance will convene a reconsideration panel consisting of three Alliance employees who were not involved in the original decision. If the Network Provider does not request a reconsideration review within twenty-one (21) days from receipt or attempted delivery of the Alliance final notification of Administrative Action or Sanction, the decision shall become final.
2. The reconsideration panel meeting will be scheduled at the Alliance Headquarters no later than fourteen (14) days from the receipt of the request for reconsideration. The Network Provider will be invited to appear in person or by telephone and to present arguments and documentation to the reconsideration panel. The Network Provider must provide any additional written documentation to be considered during the Reconsideration Process at the time the Request for Reconsideration is filed.

3. The reconsideration panel will notify the Compliance Department of their decision no later than seven (7) days following the panel meeting. The Compliance Department will issue a final written decision to the Network Provider no later than seven (7) days following the panel decision. This decision is final and there is no right to appeal beyond the reconsideration panel.

**Reconsideration Process for Claims Denials or Other Provider Disputes**

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

# SECTION X: RESOURCES FOR PROVIDERS

A. Training and Technical Assistance
B. Web-Based Provider Resources

## A. TRAINING AND TECHNICAL ASSISTANCE

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

### Training Calendar

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

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

**Web Reference:** www.AllianceBHC.org/Providers/training

## B. WEB-BASED PROVIDER RESOURCES

A wide variety of links to web-based resources of potential interest to the Provider Network can be found on the Alliance website at www.AllianceBHC.org/Providers/Provider-resources.

The list is not represented as being comprehensive and Alliance does not necessarily endorse any of the programs or information contained in the websites accessed through the provided links.

# APPENDIX A: GLOSSARY OF TERMS

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

**Web Reference:** www.cms.hhs.gov/medicaid/eligibiity/default.asp.

**Abuse and Waste:** Incidents or practices that are inconsistent with sound fiscal, business, or medical practices that could result in an unnecessary cost to Alliance, the State or Federal government, or another organization. It could also result in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (42 CFR 455.2)

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

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

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

**ANSI:** American National Standards Institute

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

**Appeal:** A request for review of an action, as "action" is defined in section IV-L.

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

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

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

**Basic Augmented Services:** The Basic Augmented Benefit package includes those services that will be made available to Medicaid-entitled individuals and, to the extent

the resources are available, to non-Medicaid individuals meeting Priority population criteria. A consumer requiring this level of benefit is in need of more than the automatically authorized eight (8) or twelve (12) visits in order to maintain or improve his/her level of functioning. An authorization for the services available in this level will need to be requested through the LME/MCO's Utilization Management Unit. Authorization is based on the consumer's need and medical necessity criteria for the services requested.

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

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

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

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

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

**Care Coordination Department (CCD):** A division of Alliance that provides outreach 1and Treatment Planning Case Management functions for special, high-impact population of consumers.

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

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

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

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

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

**CMS:** Centers for Medicare and Medicaid Services

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

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

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

**Consumer:** A person that needs services for treatment of a mental health, intellectual and/or developmental disability, or substance use/addiction condition.

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

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

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

**Crisis Plan:** An individualized, written plan developed in conjunction with the consumer and treatment team. The Plan contains clear directives information to assist in

de-escalating a crisis, for consumer supports, as well as crisis response clinicians or others involved. Crisis plans are developed for consumers at-risk for inpatient treatment, incarceration, or out-of-home placement.

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

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

**Description of Consumer Clinical Issues (DCCE):** A statement of need for services.

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

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

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

**DMA:** The State of North Carolina, Division of Medical Assistance

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

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

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

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

**Emergency Services:** Covered inpatient and outpatient emergency services are:

- Furnished by a Provider that is qualified to furnish such services, and
- Needed to evaluate or stabilize an emergency medical condition as defined above.

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

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

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

**Enrollment:** Action taken by the Division of Medical Assistance (DMA) to add a Medicaid recipient's name to the monthly enrollment report.

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

**EPSDT:** Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is the Federal Medicaid benefit that says Medicaid must provide all necessary health care services to Medicaid eligible children under twenty-one (21) years of age. Even if the

service is not covered under the NC Medicaid State Plan, it can be covered for recipients under 21 years of age if the service is listed at 1905 (a) of the Social Security Act and if all EPSDT criteria are met.

**Facility:** Any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers, and includes:

- Licensed facilities are any 24-hour residential facilities required to be licensed

under Chapter 122C of the North Carolina General Statutes, such as Psychiatric Residential Treatment Facilities (PRTFs), Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), Supervised Living Facilities, Residential Treatment/Rehabilitation Facilities for Individuals with Substance Abuse Disorders, Outpatient Opioid Treatment Facilities, .5600 group homes or other licensed MH/IDD/SA facilities. These facilities may require a Certificate of Need or Letter of Support and must meet all applicable state licensure laws and rules, including but not limited to NCG.S. §122C-3 and Title 10A, Subchapter 27C, 27D, 27E, 27F,27G, 26B and 26C.

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

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

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

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

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

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

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

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

**GAF:** Global Assessment of Functioning.

**Grievance:** An expression of dissatisfaction about any matter other than an action, as *action* is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the LME/MCO level and access to the State fair hearing process. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee, and failure to respect the consumer's rights.

**Grievance Procedure:** The written procedure pursuant to which consumers may express dissatisfaction with the provision of services by the LME/MCO and the methods for resolution of consumer's grievance by the LME/MCO.

**HIPAA:** Health Insurance Portability and Accountability Act of 1996.

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

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

**Intellectual/Developmental Disabilities (IDD):** Characterized by the following: Impairment of general intellectual functioning and adaptive behavior that occurs before age twenty-two (22) which:

- Limits one (1) or more major life functions.
- IQ of sixty-nine (69) or below.
- Impairment has continued since its origination or can be expected to continue indefinitely.

**Least Restrictive Environment:** The least intensive/restrictive setting of care sufficient to effectively treat a consumer.

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

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

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

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

**Managed Benefit:** Services that require authorization from Utilization Management.

**MCO:** Managed Care Organization

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

**Medicaid Consumer Registration (MERF):** Form used to register Medicaid consumers with Alliance while in unmanaged basic benefit services, or while accessing hospital beds, and for the release of information regarding eligibility for services.

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

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

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

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

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

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

- Provided for the diagnosis, secondary or tertiary prevention, amelioration, intervention, rehabilitation, or care and treatment of a mental health, developmental disability or substance abuse condition, and
- Necessary for and appropriate to the conditions, symptoms, intervention, diagnosis, or treatment of a mental health, developmental disability or substance abuse condition, and

- Within generally accepted standards of medical practice, and
- Not primarily for the convenience of an Consumer, and
- Performed in the least costly setting and manner appropriate to treat the Consumer's mental health, developmental disability or substance abuse condition.

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

**MMIS:** Medicaid Management Information System

**Natural Resource Linking:** Processes that maximize the use of family and community support systems to optimize functioning.

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

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

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

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

**NCTracks:** The new multi-payer Medicaid Management Information System for the NC Department of Health and Human Services**.**

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

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

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

**PIHP:** Prepaid Inpatient Health Plan.

**Primary Diagnosis:** The most important or significant condition of an individual at any time during the course of treatment in terms of its implications for the individual's health, medical care and need for services.

**Priority Populations:** People with the most severe type of mental illness, severe emotional disturbances, as well as, substance abuse disorders with complicating life circumstances conditions, and/or situations which impact the person's capacity to function, often resulting in high-risk behaviors.

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

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

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

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

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

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

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

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

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

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

**Recipient:** A person who is receiving services.

**Reconsideration Review:** A review of a previous finding or decision by Alliance based on the Provider's Reconsideration Request and any additional materials presented by the Provider.

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

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

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

**SED (Children with Severe Emotional Disturbances)**: Describes consumers who:

- Are age seventeen (17) or under
- Have mental, behavioral, or emotional disturbance severe enough to substantially interfere with or limit the minor's role or function in family, school, or community activities
- Score less than sixty (60) on the Global Assessment Scale (GAF).

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

**SMI** (Persons with Severe Mental Illness): Describes consumers who:

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

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

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

**Spend Down:** Medicaid term used to indicate the dollar amount of charges a Medicaid consumer must incur before Medicaid coverage begins during a specified period of time.

**SPMI** (Persons with Severe and Persistent Mental Illness): Describes consumers who:

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

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

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

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

**Treatment Planning Case Management:** A managed care function that ensures that consumers meeting Special Needs Population criteria receive needed assessments and assistance in accessing services. Alliance Care Coordinators carry out this function working with Providers if the consumer is already engaged with Providers, or assists in connecting and engaging the consumer with Providers that will provide the necessary services to meet his/her needs. Activities may include:

- Referral for assessment of the eligible individual to determine service needs.
- Development of a specific care plan.

- Referral and related activities to help the individual obtain needed services.
- Monitoring and follow-up.

**Unmanaged Benefit:** Services that do not require authorization from Utilization Management (UM).

**URAC:** The national accrediting body under which Alliance Behavioral Healthcare is accredited.

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

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

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

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

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

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

# APPENDIX B: COMMONLY USED ACRONYMS

## A

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

## B

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

## C

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|---|---|
| CABHA | Critical Access Behavioral Health Agency |
| CALOCUS | (C & A LOCUS) Child and Adolescent Level of Care Utilization System |
| CAP | Community Alternative Program |
| CAP-DA | Community Alternative Program for Disabled Adults |
| CAP-C | Community Alternative Program for Children |
| CAP-I/DD MR/DD | Community Alternative Program for Persons with Intellectual/ Developmental Disabilities |
| CARF | Commission on Accreditation of Rehabilitation Facilities |
| CASP | Cross Area Service Program |
| CBT | Cognitive-Behavioral Therapy |
| CC | Care Coordination |

| | |
|---|---|
| CCA | Comprehensive Clinical Assessment |
| CCS | Certified Clinical Supervisor (NCSAPPB) |
| CCIS | Care Coordination Information System |
| CCNC | Community Care of North Carolina |
| CDSA | Child Developmental Service Agency |
| CDW | Client Data Warehouse |
| CFAC | Consumer and Family Advisory Committee |
| CFS | Child and Family Services |
| CFT | Child and Family Team |
| CG | Community Guide |
| CHAMPUS | Civilian Health and Medical Program of the Uniformed Services |
| CHIP | Children's Health Insurance Program |
| CIT | Crisis Intervention Team (Law Enforcement & Fire/Police) |
| CM | Care Management |
| CMH | Child Mental Health |
| CMHREF | Child MH/SA Referral Number (Medicaid clients only) |
| CMS | Centers for Medicare and Medicaid (formerly HCFA) |
| CMSED | Child Mental Health Severely Emotionally Disturbed |
| COA | Council on Accreditation |
| COB | Coordination of Benefits |
| COBRA | Consolidated Omnibus Budget and Reconciliation Act |
| CPS | Child Protective Services |
| CPT | Current Procedural Terminology (Reimbursement Codes) |
| CQI | Continuous Quality Improvement |
| CQL | Council on Quality and Leadership |
| CRA | Community Reinforcement Approach |
| CRE | Case Responsible Entity |
| CRH | Central Regional Hospital |
| CRIPA | Civil Rights of Institutionalized Persons Act |
| CSA | Child Substance Abuse |
| CSAP | Center for Substance Abuse Prevention (federal) |
| CST | Community Support Team |
| CSU | Crisis Stabilization Unit |
| CT | Cognitive Therapy |

## D

| | |
|---|---|
| D.A. | Diagnostic Assessment |
| DBA | Doing Business As |
| DBT | Dialectical Behavioral Therapy |
| DCI | Description of Clinical Issues (form) |
| DD | Developmental Disability/Developmentally Delayed |
| DDE | Direct Data Entry (for claims) |
| DDS | Disability Determination Services |
| DEC | Developmental Evaluation Center |
| DENR | Department of Environment and Natural Resources |
| DHHS | Department of Health and Human Services |

| | |
|---|---|
| DHSR | Division of Health Services Regulation |
| DJJ | Division of Juvenile Justice |
| DMA | Division of Medical Assistance |
| DME | Durable Medical Equipment |
| DMH/DD/SAS | Division of Mental Health/Developmental Disabilities/Substance Abuse Services |
| DOB | Date of Birth |
| DOC | Department of Corrections |
| DOE | Department of Education |
| DOJ | Department of Justice |
| DOS | Date of Service |
| DPI | Department of Public Instruction |
| DPS | Department of Public Safety |
| DSB | Division of Services for the Blind |
| DSDHH | Division of Services for the Deaf and Hard of Hearing |
| DSM-V | Diagnostic and Statistical Manual of Mental Disorders |
| DSS | (County) Department of Social Services |
| DWI | Driving While Impaired |
| Dx | Diagnosis |

## E

| | |
|---|---|
| EBD | Emotionally/Behaviorally Disturbed |
| EBP | Evidence-Based Practice |
| ECAC | Exceptional Children's Assistance Center |
| ECI | Early Childhood Intervention |
| ECS | Electronic Claims Submission |
| ED | Emergency Department |
| EDI | Electronic Data Interchange |
| EHA | Education for All Handicapped Children Act |
| ELP | Essential Lifestyle Plan |
| ELT | Executive Leadership Team |
| EMR | Electronic Medical Record |
| EMTALA | Emergency Medical Treatment Active Labor Act |
| EOB | Explanation of Benefits |
| EPSDT | Early and Periodic Screening, Diagnosis and Treatment |
| ES | Emergency Services |

## F

| | |
|---|---|
| FASD | Fetal Alcohol Spectrum Disorder |
| F&CS | Family and Children's Services |
| FC | Foster Care |
| FCH | Foster Care Home |
| FDA | Food and Drug Administration |
| FEM | Frequency and Extent of Monitoring |
| FNS | Food and Nutrition Services |
| FPL | Federal Poverty Level |

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|---|---|
| FSN | Family Support Network |
| FSQ | Family Satisfaction Questionnaire |
| FY | Fiscal Year |

## G

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|---|---|
| GAAP | Generally Accepted Accounting Principles |
| GAIN | Global Appraisal of Individual Needs |
| GAST | Geriatric/Adult Mental Health Specialty Team |
| GCC | Governor's Crime Commission |
| GS | General Statutes |

## H

| | |
|---|---|
| HCBS | Home and Community Based Services |
| HCPCS | Healthcare Common Procedure Coding |
| HHS | United States Department of Health and Human Services |
| HIPAA | Health Insurance Portability & Accountability Act of 1996 |
| HIPP | Health Insurance Premium Payment |
| HMO | Health Maintenance Organization |
| HR | Human Resources |
| HUD | U.S. Department of Housing and Urban Development |

## I

| | |
|---|---|
| I&R | Information and Referral |
| IAC | Interagency Council |
| ICC | Interagency Coordinating Council |
| ICD-9 | International Statistical Classifications of Diseases (diagnostic codes) |
| ICD-10 | International Statistical Classifications of Diseases (diagnostic codes) |
| ICF | Intermediate Care Facility |
| ICF-I//DD | Intermediate Care Facility for Persons with Intellectual/ Developmental Disabilities |
| I/DD | Intellectual/Developmental Disability |
| IDEA | Individuals with Disabilities Act |
| IEP | Individualized Education Program |
| IFSP | Individual Family Services Plan |
| IIH | Intensive In-Home Services |
| ILC | Independent Living Center |
| IOP | Intensive Outpatient Program (Substance Abuse) |
| IRIS | Incident Response Improvement System |
| IRWG | Incident Reporting Work Group |
| IS | Information Systems ISP Individual Service Plan |
| IVC | Involuntary Commitment |

## J/K

| | |
|---|---|
| JCAHO | The Joint Commission, formerly known as Joint Commission on Accreditation of Health Care Organizations |
| JCC | Juvenile Court Counselor |
| JCPC | Juvenile Crime Prevention Council |
| JDC | Juvenile Detention Center |
| JJSAMHP | Juvenile Justice Substance Abuse/Mental Health Partnership |
| JOBS | Job Opportunities and Basic Skills Program |
| JTPA | Job Training Partnership Act |

## L

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|---|---|
| LCAD | LME Consumer Admission and Discharge (form) |
| LCAS | Licensed Clinical Addictions Specialist |
| LCSW | Licensed Clinical Social Worker |
| LEA | Local Education Agency |
| LIP | Licensed Independent Practitioner |
| LME | Local Management Entity |
| LME/MCO | Local Management Entity/Managed Care Organization |
| LMFT | Licensed Marriage and Family Therapist |
| LOC | Level of Care |
| LOCUS | Level of Care Utilization System for Psychiatric Services |
| LON | Letter of Notification |
| LP | Licensed Professional |
| LPA | Licensed Professional Associate |
| LPC | Licensed Professional Counselor |

## M

| | |
|---|---|
| MCH | Maternal and Child Health |
| MCM | Mobile Crisis Management |
| MERF | Medicaid Consumer Registration Form |
| MFP | Money Follows the Person |
| MHBG | Mental Health Block Grant |
| MI | Motivational Interviewing |
| MOE | Maintenance of Effort |
| MST | Multi-systemic Therapy |
| MCO | Managed Care Organization |
| MH | Mental Health |
| MID | Medicaid Identification Number |
| MOU | Memorandum of Understanding |
| MRA | Maximum Reimbursable Amount |
| MRR | Medicaid Reimbursement Rate |
| MSW | Master of Social Work |

## N

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|---|---|
| NA | Narcotics Anonymous |
| NAMI | National Alliance on Mental Illness |

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|---|---|
| NCAC | North Carolina Administrative Code |
| NCBLPC | North Carolina Board of Licensed Professional Counselors |
| NCGS | North Carolina General Statute |
| NCHFA | North Carolina Housing Finance Agency |
| NCSAPPB | North Carolina Substance Abuse Professional Practice Board |
| NC SNAP | North Carolina Support Needs Assistance Profile |
| NC-TOPPS | North Carolina Treatment Outcome Program Performance System |
| NEA | Notification of Endorsement Action |
| NIDA | National Institute on Drug Abuse |
| NIMH | National Institute of Mental Health |
| NMHA | National Mental Health Association |
| Non-UCR | Non Unit Cost Reimbursement |
| NPI | National Provider Identification |
| NPPES | National Plan and Provider Enumeration System |
| NREPP | National Registry of Evidence-based Programs and Practices (SAMHSA) |

## O

| | |
|---|---|
| OAH | Office of Administrative Hearings |
| ODD | Oppositional Defiant Disorder |
| OJJDP | Office of Juvenile Justice and Delinquency Prevention (national) |
| OMB | Office of Management and Budget |
| OPC | Outpatient Commitment |
| OTC | Over-the-Counter Medication |

## P

| | |
|---|---|
| PACT | Parents and Children Together (or Parent and Children Training) |
| PAC | Provider Advisory Council |
| PATH | Projects for Assistance in Transition from Homelessness |
| PCS | Personal Care Services |
| PCP | Person-Centered Plan |
| PCP | Primary Care Physician |
| PDD | Pervasive Developmental Disorder |
| PL | Public Law |
| PMPM | Per Member Per Month |
| PMT | Provider Monitoring Tool |
| PNO | Provider Network Operations Department (Alliance) |
| POC | Plan of Correction |
| POS | Place of Service |
| PSA | Public Service Announcement |
| PRTF | Psychiatric Residential Treatment Facility |
| PSR | Psychosocial Rehabilitation |
| PSS | Peer Support Services |
| PTSD | Post-Traumatic Stress Disorder |

## Q

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|---|---|
| QA | Quality Assurance |
| QDDP | Qualified Developmental Disability Professional |
| QI | Quality Improvement |
| QM | Quality Management |
| QMHP | Qualified Mental Health Professional |
| QP | Qualified Professional |
| QSAP | Qualified Substance Abuse Professional |

## R

| | |
|---|---|
| RA | Remittance Advice |
| RAD | Reactive Attachment Disorder |
| RARF | Regional Assessment and Referral Form |
| RFA | Request for Application |
| RFP | Request for Proposal |
| RMDM | Records Management and Documents Manual |

## S

| | |
|---|---|
| SA | Substance Abuse OR Special Assistance |
| SACOT | Substance Abuse Comprehensive Outpatient Treatment |
| SAIOP | Substance Abuse Intensive Outpatient Program |
| SAMHSA | Substance Abuse Mental Health Services Administration (Federal) |
| SAPTBG | Substance Abuse Prevention and Treatment Block Grant |
| SAR | Service Authorization Request |
| SAS | Substance Abuse Services |
| SED | Seriously Emotionally Disturbed |
| SCFAC | State Consumer and Family Advisory Committee |
| SFY | State Fiscal Year |
| SIPS | State Information Processing System |
| SIS | Supports Intensity Scale |
| SMI | Serious Mental Illness |
| SPMI | Severe and Persistent Mental Illness |
| SOC | System of Care |
| SSA | Social Security Administration |
| SSDI | Social Security Disability Insurance |
| SSI | Supplemental Security Income |
| SSN | Social Security Number |
| STR | Screening, Triage, Referral (form) |
| SW | Social Worker |

## T

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|---|---|
| TA | Technical Assistance |
| TASC | Treatment Accountability for Safer Communities |
| TBI | Traumatic Brain Injury |
| T/C | Telephone Call |

| | |
|---|---|
| TEACCH | Treatment and Education of Autistic Children and Other Communication Handicaps |
| TFC | Therapeutic Foster Care |
| TJC | The Joint Commission, formerly known as Joint Commission on Accreditation of Health Care Organizations |
| TP | Target Population (Target Pop) |
| TPA | Trading Partner Agreement |
| TPL | Third Party Liability |
| TTY | Teletext Device Typewriter |
| Tx | Treatment |

## U

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|---|---|
| UCR | Unit Cost Reimbursement |
| UM | Utilization Management |
| UR | Utilization Review |

## V

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|---|---|
| VA | Veterans Administration/Veterans Affairs |
| VR | Vocational Rehabilitation |

## W

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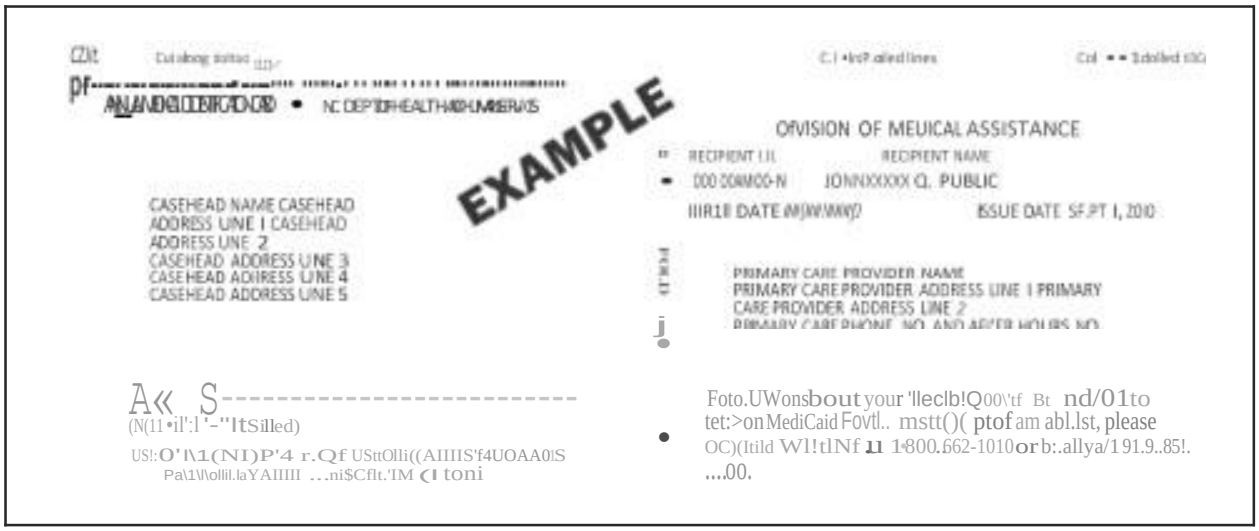
|---|---|
| WF | Work First |
| WFFA | Work First Family Assistance (Nationally known as TANF) |
| WIC | Special Supplemental Food Program for **W**omen, **I**nfants and **C**hildren |

# APPENDIX C: EXAMPLE OF MEDICAID CARD



# APPENDIX D: NOTICY OF PRIVACY PRACTICES

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

Effective Date of This Notice: September 23, 2013

Alliance Behavioral Healthcare ("Alliance") is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this Notice or if you want more information about the privacy practices at Alliance Behavioral Healthcare, please contact the Privacy Officer at (800) 510-9132 or at 4600 Emperor Boulevard Durham, NC 27703.

## Understanding Your Medical Record/Health Information

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

## Our Responsibilities

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

## How Alliance Behavioral Healthcare May Use or Disclose Your Health Information

The following categories describe ways that Alliance may use or disclose your health information. Any use or disclosure of your health information will be limited to the minimum information necessary to carry out the purpose of the use or disclosure. For each category of uses and disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

**Note that we can only use or disclose alcohol and drug abuse records with your consent or as specifically permitted under federal law. These exceptions are listed on the next page.**

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

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

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

**Required by Law –** Alliance may use and disclose your health information as required by law. Some examples where we are required by law to share limited information include but are not limited to: PHI related to your care/treatment with your next of kin, family member, or another person that is involved in your care; with organizations such as the Red Cross during an emergency; to report certain type of wounds or other physical injuries; and to the extent necessary to fulfill responsibilities when a consumer is examined or committed for inpatient treatment.

**Public Health –** Your health information may be reported to a public health authority or other appropriate government authority authorized by law to collect or receive information for purposes related to: preventing or controlling disease, injury or disability; reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

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

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

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

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

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

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

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

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

**Applicability of More Stringent State Laws –** Some of the uses and disclosures described in this notice may be limited in certain cases by applicable State laws or rules that are more stringent than Federal laws or regulations, including disclosures related to mental health and substance abuse, intellectual/developmental disabilities, alcohol and other drug abuse (AODA), and HIV testing.

### Use and Disclosure of Health Information without your Authorization

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

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

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

### When Alliance Behavioral Healthcare May Not Use or Disclose Your Protected Health Information

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

- Your authorization is necessary for most uses and disclosures of psychotherapy notes.
- Your authorization is necessary for any disclosures of health information in which the health plan receives compensation.

- Your authorization is necessary for most uses and disclosures of alcohol and drug abuse records (exceptions are listed above).

**Statement of Your Health Information Rights**

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

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

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

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

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

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

**Right to a Copy –** You have a right to receive an electronic copy of this Notice at any time. To obtain a paper copy of this Notice, send your written request to the Privacy Officer at 4600 Emperor Blvd., Durham, NC 27703. You may also print a copy of this Notice at www.AllianceBHC.org/consumers-families/consumer-rights/notice-of-privacy- practices.

**Right to be Notified of a Breach –** You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact the Privacy Officer at 4600 Emperor Blvd Durham, NC 27703 or by calling (800) 510-9132.

### Changes to this Notice and Distribution

Alliance Behavioral Healthcare reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that it maintains. As your health plan, we will provide a copy of our notice upon your enrollment in the plan and will remind you at least every three years where to find our notice and how to obtain a copy of the notice if you would like to receive one. If we have more than one Notice of Privacy Practices, we will provide you with the Notice that pertains to you. The notice is provided and pertains to the named Medicaid beneficiary or other individual enrolled in the plan.

As a health plan that maintains a website describing our customer service and benefits, we also post to our website the most recent Notice of Privacy Practices which will describe how your health information may be used and disclosed as well as the rights you have to your health information. If our Notice has a material change, we will post information regarding this change to the website for you to review. In addition, following the date of the material change, we will include a description of the change that occurred and information on how to obtain a copy of the revised Notice in any annual mailing required by 42 CFR Part 438.

### Complaints

Complaints about this Notice of Privacy practices or about how we handle your health information should be directed to the Privacy Officer at 4600 Emperor Blvd Durham, NC 27703 or by calling (800) 510-9132. Alliance Behavioral Healthcare will not retaliate against you in any way for filing a complaint. All complaints to Alliance Behavioral Healthcare must be submitted in writing. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services at www.hhs.gov/ocr/privacy/hipaa/complaints/ or call (800) 368-1019.