POLICY AND PROCEDURE

POLICY NAME: Utilization Management Program Description	**POLICY ID:** WNC.UM.01
BUSINESS UNIT: WellCare of North Carolina	**FUNCTIONAL AREA:** Utilization Management
EFFECTIVE DATE: 07/01/2021	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE: 06/19/2023	
REGULATOR MOST RECENT APPROVAL DATE(S): 10/10/2023	

POLICY STATEMENT:
The Utilization Management (UM) process influences the continuum of care by evaluating the necessity and efficiency of health care through systematic monitoring of medical necessity and quality, maximizing the cost-effectiveness of the care and service provided to members. This consists of the evaluation of medical necessity and the efficient use of medical and behavioral health services, procedures, facilities, specialty care, inpatient, outpatient, home care, skilled nursing services, ancillary services, and pharmaceutical services. UM has established policies that include the delivery of medical care, behavioral health care, and pharmaceutical management, including services and physicians' impact on the provision of health care.

PURPOSE:
The purpose aims to describe the Utilization Management Program.

SCOPE:
This policy applies to all directors, officers, and employees of WellCare of North Carolina (WNC) (collectively, the "Health Plan").

DEFINITIONS:

Adverse Benefit Determination: An adverse benefit determination include:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner, as defined by the State.
- The failure of the Health Plan to act within State specific contractual timeframes from the date the Health Plan receives a grievance, or from the date the Health Plan receives an appeal.
- For a resident of a rural area with only one (1) managed care entity, the denial of an enrollee's request to exercise the right to obtain services outside the network.
- The denial of an enrollee's request to dispute a financial liability including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Department: The NC Department of Health and Human Services Division of Health Benefits that oversees the NC Medicate program.

Utilization Management (also referred to as "UM"): The ongoing process of assessing, planning, organizing, directing, coordinating, monitoring, and evaluating the utilization of healthcare services. The program description applies to the Health Plan offered by WellCare of North Carolina.

POLICY:
The purpose of the UM Program Description (UMPD) is to outline the principles of UM as they are applied on all levels of care and to maintain a comprehensive, coordinated process that promotes and monitors the effective utilization of health care resources within the Health Plan's delivery system. The UM Program defines and describes a multidisciplinary, comprehensive approach and process to manage resource allocation. The UM process influences the continuum of care by evaluating the necessity and efficiency of health care through systematic monitoring of medical condition and quality and maximizes the cost-effectiveness of the care and service provided to members.

The Health Plan's UM program focuses on medical, behavioral health, and pharmacy services based on nationally recognized, evidence-based clinical practice guidelines and decision support methodologies to support UM and prior authorization for services not defined in mandated clinical coverage policies.

The Health Plan documents the UM program, including referral and prior authorization processes, in this policy and submits it to the NC Department of Health and Human Services (The Department) upon request for review. The UM Program Policy is revised based on changes requested by the Department and submitted to the Department in writing any changes to the UM Program Policy at least sixty (60) calendar days before such modifications go into effect.

The Health Plan posts the UM Program Policy on its publicly available website for providers and members or in other forms as requested by the provider or member at no cost. The Health Plan includes an apparent reference to the web address of the UM Program Policy in both its Provider and Member Handbooks. The Health Plan conducts training and education with providers and prescribers on changes to the UM program before the effective date of the change as part of the Provider Training Plan as described in Section V.D.3. Provider Relations and Engagement.

The Health Plan makes the Chief Medical Officer (CMO) or designee available to discuss and report on the Utilization Management Program, as requested by the Department.

WellCare of North Carolina Medicaid
Utilization Management
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GOALS

The Health Plan UM Program goal is to outline the principles of utilization management as they are applied on all levels of care, maintain a comprehensive, coordinated process, and advocate for the appropriate utilization of resources for medical and behavioral health care services. In addition, the Program strives to provide culturally sensitive delivery of services and access to the most appropriate and cost-efficient medical and behavioral healthcare services to achieve the best outcomes while delivering quality healthcare at the most appropriate setting and time for the members.

The UM Program aims to optimize members' health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing cost trends. The UM Program aims to provide services that are covered benefits, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting, and meet professionally recognized standards of care.

CONFIDENTIALITY

Confidential information is any data that can directly or indirectly identify a member or physician. The Health Plan adheres to the following:

- Staff and consultants are required to sign a confidentiality statement.
- All members of the UM Committee are required to sign a confidentiality waiver.
- All employees and practitioners are permitted to access and disclose confidential information only as necessary to fulfill assigned duties and responsibilities.
- Medical information sent by mail or fax to the recipient's attention is marked "personal and confidential."
- All medical information is secured in a locked location, with access limited to essential personnel only.
- Medical information stored in the software system is protected under multiple levels of security by system configuration, which includes user access passwords.
- Confidential information is destroyed by a method that induces destruction when no longer needed.
- The Health Plan abides by all federal and state laws governing the issue of confidentiality.

AUTHORITY

The Health Plan Board of Directors (BOD) has ultimate authority and accountability for overseeing the quality of care and services provided to members. The BOD oversees the development, implementation, and evaluation of the Quality Improvement Program, which includes the UM Program. The UM Program is reviewed and approved by the Health Plan's BOD annually. The Health Plan BOD delegates the daily oversight and operating authority of UM activities to the Utilization Management Advisory Committee (UMAC). The UMAC also has leadership and operating control over the utilization management activities, including the review and appropriate approval of medical necessity criteria and protocols and utilization management policies and procedures. The UMAC is responsible for reviewing all utilization management issues and related information. The UMAC reports to Quality Improvement Committee (QIC), which, in turn, reports to the BOD.

The CMO is responsible for and supports The Health Plan's UM Program. The Health Plan CMO, Vice President of PHCO (VPPHCO), and/or any designee as assigned by the Health Plan President and CEO are the senior executives responsible for implementing the UM program, including cost containment, medical quality improvement, medical review activities on utilization review, quality improvement, complex, and controversial or experimental services. In addition to the CMO, the Health Plan may have one or more Medical Directors. A pharmacist oversees the implementation, monitoring, and directing of pharmacy services. A behavioral health practitioner is involved in implementing, monitoring, and directing behavioral health aspects of the UM Program.

The CMO's responsibilities include, but are not limited to, coordination and oversight of the following activities:

- Development/revision of UM policies and procedures as necessary to meet state and federal statutes and regulations and accrediting body requirements.
- Monitor compliance of the UM Program.
- Provide clinical support to the UM staff in the performance of their UM responsibilities.
- Assure medical necessity criteria used in the UM process are appropriate and reviewed by physicians and other practitioners according to policy.
- Assure the medical necessity criteria are applied in a consistent manner.
- Assure review of cases that do not meet medical necessity criteria are conducted by physicians or other healthcare professional as appropriate, in a manner that meets all pertinent statutes, regulations and Plan policy, and takes into consideration the individual needs of the involved members and assessment of the local delivery system.
- Review, approve, and sign (if required) denial letters for cases that do not meet medical necessity criteria after appropriate review has occurred.

- Assure the medical necessity appeal process is carried out in a manner that meets all applicable contractual requirements, as well as all federal and state statutes and regulations, is consistent with all applicable accreditation standards, and is done in a consistent and efficient manner.
- Provide a point of contact for practitioners calling with questions about the UM process.
- Communicate/consult with practitioners in the field as necessary to discuss UM issues.
- Coordinate and oversee the delegation of UM activity as appropriate and monitor each delegated arrangement assuring all applicable contractual requirements and accreditation standards are met.
- Assure there is appropriate integration of physical, behavioral, and social health services for all Plan members.
- Participate in and provide oversight to the UMAC and all other physician committees or subcommittees.
- Recommend and help monitor corrective action as appropriate for practitioners with identified deficiencies related to UM.
- Serve as a liaison between UM and other Plan departments.
- Educate practitioners regarding UM issues, activities, reports, requirements, etc.
- Report UM activities to the QIC as needed.

UTILIZATION MANAGEMENT ADVISORY COMMITTEE (UMAC)

Oversight and operating authority of UM activities are delegated to the UMAC, which reports to the Health Plan's QIC and BOD. The UMAC is responsible for the review and appropriate approval of medical necessity criteria and protocols and UM policies and procedures. The UMAC coordinates the annual review and revision of the UM Program Description, Work Plan, and the Annual UM Program Evaluation. These documents are presented to the UMAC for approval. The UMAC monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate under or over-utilization, which may impact healthcare services, coordination of care, and appropriate use of services and resources, as well as member and practitioner satisfaction with the UM process. Analysis of the above tracking and monitoring processes, as well as status of corrective action Plans, as applicable, are reported to the UMAC.

In addition to the above, the UMAC also provides ongoing evaluation of the appropriateness and effectiveness of practitioner quality incentive payments and assists in modifying and designing an appropriate quality incentive program.

UMAC MEMBERS

The UMAC Chairperson is the CMO or their designee. The committee includes cross-functional representatives from the Health Plan's clinical and quality departments and representatives from various business areas across the organization. In addition, external practitioners representing a range of specialties across the service area participate as voting members of the committee. They are called upon for their input based on their expertise and knowledge of current clinical practices. The UMAC actively involves participating network practitioners in utilization review activities as available and to the extent that there is no conflict of interest. The UM Program Description and policies define when such a conflict may exist and describe the remedy when conflicts occur. Participation in the Health Plan's UMAC is one of the primary ways network practitioners participate in Plan utilization review activities.

Chairpersons of all UMAC sub-committees and others may participate as needed. Sub-committee participants do not have voting rights. Only the physician members of the UMAC have voting rights, and a quorum shall be defined as at least three (3) voting members. In the event of a tie vote, the Chairperson shall serve as a tiebreaker.

MEETING FREQUENCY AND DOCUMENTATION OF PROCEEDINGS

The UMAC meets at least four times a year, every quarter, with the authority to convene additional meetings as circumstances require. Committee members and participants may attend meetings virtually and telephonically. Minutes are maintained for each session and housed on the Quality Department's SharePoint.

UM QUALIFICATIONS, TRAINING, AND RESPONSIBILITIES

The Health Plan supports continuing education and training for UM staff to maintain and increase skills and competency in performing UM functions. The Health Plan recruits highly qualified healthcare professionals with experience and expertise in UM or applicable, related experience. Qualification and educational requirements are delineated in each position's position description. Each new UM staff member is provided a minimum of two weeks of intensive hands-on orientation and training with a staff preceptor.

The Health Plan provides formal training, including seminars and workshops, to all UM staff on an annual basis to cover topics that include, but are not limited to, diagnosis and CPT coding, UM criteria application, and UM updates. The Health Plan monitors the appropriate application of UM criteria/guidelines, processing authorizations, concurrent review, and discharge planning documentation on an ongoing basis. If a UM staff member falls below the established performance

standards, the Health Plan provides coaching, additional tools, and training to support staff in reaching desired performance expectations.

- Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or members is prohibited. UM employee compensation includes hourly and salaried positions. All PHCO staff are required to sign an affirmative statement regarding compensation annually. The Health Plan and its delegated Utilization Review agents do not permit or provide compensation or anything of value to its employees, agents, or contractors based on the following:
    - The percentage of the amount by which a claim is reduced for payment
    - The number of claims or the cost of services for which the person has denied authorization or payment
    - Decisions that result in under-utilization; or
    - Any other method that encourages the rendering of an adverse determination.

- The Health Plan determines appropriate staffing based on membership, state contract, and federal requirements, which may include, but is not limited to, the following:

Chief Medical Officer/Medical Director
As previously stated, the CMO oversees every aspect of the UM Program. The CMO/Medical Director is a physician currently licensed to practice medicine. Based on the needs of the Health Plan, a Medical Director may also be involved in the medical review. The CMO and Medical Director are hereafter collectively referred to as 'Medical Director'. The Medical Director must supervise all medical necessity decisions and conduct Level II medical necessity reviews. Persons authorized to make a clinical denial based on medical necessity include licensed MDs, DOs, DDSs, and licensed pharmacists.

Behavioral Health Medical Director
A behavioral health MD is involved in implementing, monitoring, and directing the behavioral health care aspects of the Health Plan's UM program. A behavioral health MD may participate in UM rounds to assist in identifying behavioral health care needs and integrating behavioral and physical care. Behavioral health MDs may also participate on various Plan committees. The behavioral health practitioner may be a clinical director, a Plan network practitioner, or a behavioral health delegate. A physician, appropriate behavioral health practitioner (i.e., doctoral-level clinical Psychiatrist or certified addiction medicine specialist), or pharmacist, as appropriate, must be consulted on any behavioral health care denial of care based on medical necessity.

Pharmacist/Pharmacy Director
The Health Plan Pharmacist (PRPh) is a licensed pharmacist. The PRPh monitors and analyzes pharmacy utilization and reports findings at least quarterly to the Health Plan UMAC.

Board-Certified Clinical Consultants
In some cases, for specific appeal reviews, the clinical judgment needed for a UM decision is specialized. In these instances, the Medical Director may consult a board-certified physician from the appropriate specialty for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside the Health Plan may be contacted when necessary to avoid a conflict of interest. The Health Plan defines conflict of interest to include situations in which the practitioner who would generally advise on a UM decision made the original request for authorization or determination or is affiliated with the same practice group as the practitioner who made the initial request or determination.

Service Consultants
UM staff must call upon service experts outside the Health Plan to assist in making authorization determinations for specialty services in certain cases. In these instances, a licensed/certified service consultant specializing in the area of service in question is contacted. Specialty service consultants may include but are not limited to Occupational Therapists, Physical Therapists, Speech Therapists, Physician Assistants, Certified Nurse Practitioners, etc.

Vice President of Population Health (VPPH)
The VPPH oversees the day-to-day operational activities of the Health Plan's UM Program. The VPPH is appropriately licensed personnel or, as dictated by state requirements, with experience in UM activities. The VPPH reports to the Health Plan President and Chief Executive Officer (CEO). The VPPH, in collaboration with the Chief Medical Officer, assists with developing the UM strategic vision in alignment with the corporate and Plan objectives, policies, and procedures.

Utilization Management Director / Manager
The UM Director/Manager is appropriately licensed personnel or as dictated by state requirements. The UM Director/Manager directs and coordinates the department's activities, including supervising the prior authorization and

concurrent review nurses. The UM Director/Manager reports to the VPPH. The UM Director/Manager works with the VPPH and Care Management Director/Manager to execute the strategic vision in conjunction with corporate and Plan objectives, attendant policies and procedures, and state contractual and federally mandated responsibilities.

Care Management Director / Manager
The Care Management Director / Manager of Care Management (CM) is appropriately licensed personnel or as dictated by state requirements. The CM Director/Manager directs and coordinates the department's activities, including supervision of the Care Managers, Program Specialists, and Program Coordinators. The CM Director/Manager reports to VPPH. The CM Director / Manager works with the VPPH and the UM Director/Manager to execute the strategic vision in conjunction with corporate Plan objectives, attendant policies and procedures, and state contractual responsibilities.

Prior Authorization Nurse / Concurrent Review Nurse
Prior Auth and Concurrent Review, Nurses are nurses with clinical and preferred UM experience. There are different levels of nurses within the organization, which may be referenced as Prior Auth Nurse I or II or Concurrent Review Nurse I or II. Nurse(s) who coordinate discharge planning and apply approved UM medical necessity criteria for concurrent review and requests for discharge services report to and are supervised by the Director/Manager of UM. Concurrent Review nurses are responsible for the daily oversight and evaluation of members admitted to hospitals, psychiatric facilities, psychiatric residential treatment facilities, rehabilitation centers, and nursing facilities.

Prior Authorization and Concurrent Review nurses are prohibited from making adverse medical necessity determinations at any level. When a request for authorization of services does not meet the recognized UM criteria, the case is referred to the Medical Director for a Level II medical necessity review and determination.

Program / Care Coordinators
Program / Care Coordinators are trained non-clinical staff with significant experience in healthcare, such as lab technicians or medical office assistants. They work under the direction of the Care Manager and refer all clinical decisions to the Care Manager. This staff assists the care manager with administrative duties such as follow-up calls, data collection for screening assessments, obtaining test results, coordinating home health services, and obtaining transportation. They may attend marketing and outreach meetings and coordinate services with community-based organizations.

Referral Specialists
Referral Specialists are individuals with significant administrative experience in the health care setting. Experience with ICD-10, CPT, and HCPCS coding is preferred. Referral Specialists collect demographic data necessary for preauthorization. Referral Specialists report to and are supervised by the UM Director/Manager or qualified designee. Referral Specialists cannot make clinical determinations, referring all clinical decisions to a Care Manager.

Attestation to Confirm Compliance
The Health Plan shall submit a signed attestation to the Department to confirm compliance with the UM and clinical coverage requirements in the Contract, in a format and frequency specified by the Department. The attestation is submitted annually, or as otherwise directed by the Department. The Department will conduct ad hoc reviews of the Health Plan's adherence to the attestation of compliance with UM and clinical coverage requirements on an ongoing basis. The Health Plan shall provide an analysis of their compliance with the attestation upon request as follows:

- Within thirty (30) Business days for routine requests.
- Within seven (7) Business days for expedited requests.

INTEGRATION WITH OTHER PROGRAMS
The Utilization Management (UM), Pharmacy, Quality Improvement (QI), and Fraud and Abuse Programs are closely linked in function and process.

The UM process utilizes quality indicators as a part of the review process and provides the results to the Health Plan's QI department. As staff performs utilization management functions, quality indicators prescribed by the Health Plan as part of member safety are identified. The required information is documented on the appropriate form and forwarded to the QI department for review and resolution. As a result, the utilization of services is interrelated with the quality and outcome of the services.

Any quality-of-care concerns gathered through interaction between the UM staff and the practitioner or facility staff are directed to the Quality Team for review. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of non-covered benefits, or adverse events. The data is forwarded to the QI Department in the format prescribed by Plan for review, investigation, and resolution as needed. If the concern is quality-of-care, the QI staff conducts the analysis and sends the outcome to the CMO or designated medical director.

Results of quality-of-care concern reviews are shared with the practitioner or facility and are tracked and trended as appropriate for future follow-up.UM policies and processes are integral in preventing, detecting, and responding to fraud and abuse among practitioners and members. The PHCO department works closely with the Compliance Officer and the Special Investigations Unit (SIU) to resolve any potential issues that may be identified.

In addition, the Health Plan coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Services provided by local public health departments
- Area Agencies on Aging (AAA)
- Community Agencies for Senior Living
- Community-based services for behavioral health

UTILIZATION MANAGEMENT PROCESS

The Utilization Management (UM) Department also handles medical and behavioral health reviews. Medical nurse reviewers review medical health service authorizations, and behavioral health (MH/SUD) authorization requests are assigned to Behavioral Utilization Care Managers. Mixed authorization requests containing medical and behavioral health services are transferred separately to the appropriate UM reviewer.

The clinical decision process begins when the Health Plan receives a request for authorization of service. Request types may include approval of specialty services, outpatient services, ancillary services, scheduled inpatient services, and obstetrical deliveries. The utilization management process encompasses the following program components: 24-hr nurse triage, second opinions, prior authorization, concurrent review, ambulatory review, retrospective review, discharge planning, referrals (including complex DCP for members with chronic disease or co-morbid complex medical and/or psychosocial needs, ongoing education, or continued support) and care coordination. The process is complete when the requesting practitioner and member are notified of the determination.

Utilization denials (adverse determinations) are based on a lack of medical necessity or covered benefits. The Health Plan does not reward practitioners, providers, or associates who perform utilization reviews, including those of the delegated entities, for denials. Individuals are not compensated or otherwise given incentives to encourage denials.

The Health Plan does not require providers to perform any treatment or procedure contrary to the provider's conscience, religious beliefs, or ethical principles.. If a provider declines to perform a service because of ethical reasons, the Member should be referred to another provider licensed, certified, or accredited to provide care for the individual service or be assigned to another PCP licensed, certified, or accredited to provide care appropriate to the Member's medical condition. The Health Plan does not prohibit or restrict a provider from advising a member about their health status, medical care, or treatment, regardless of whether benefits for such care Covered Services are if the provider is acting within the lawful scope of practice. Furthermore, if the Health Plan elects not to provide, reimburse for, or provide coverage of counseling or referral services because of an objection on moral or religious grounds, it will furnish information about the services it does not cover. If WellCare does not, because of moral or religious objections, cover the services the member seeks, the Member may initiate a request for disenrollment at any time.

CLINICAL INFORMATION

Clinical information received, and rationale for the medical necessity determination and/or leveling of care is documented and maintained in the clinical authorization system. The information required is manageable for the member, the practitioner/staff, and the health care facility staff. Only the minimally necessary information is obtained for health care services that require prior authorization.

The UM Department maintains a process for gathering pertinent clinical information and applying criteria/guidelines during the utilization review decision-making process based on individual needs, age, co-morbidities, complications, the progress of treatment, psychosocial situation, home environment, when applicable, and assessment of the local delivery system. Each medical decision must be case specific regardless of available practice guidelines. Authorization is provided when the requested service is medically necessary, delivered at the appropriate level of care, and provided most efficiently and cost-effectively without compromising the quality of care.

SUBMISSION OF CLINICAL INFORMATION

UM requests and supporting clinical information for review may be submitted to the PHCO department by phone, facsimile, or web portal (as available) from the servicing/managing practitioner or facility. Although a health care practitioner may designate one or more individuals as the contact for the PHCO staff, in no event does this preclude PHCO staff from contacting a health care practitioner or others in their employment when there is unreasonable delay or when the designated individual is unable to provide the necessary information or data requested.

COVERED BENEFITS
Appropriate professionals make medical necessity determinations. They include decisions about covered medical benefits defined by the Health Plan, including inpatient and outpatient services, as listed in the summary of benefits and services that could be considered covered or non-covered, depending on the circumstances.

Covered Benefits may include any or all of the following with associated coverage limitations:

- Ambulatory surgical services
- Durable medical equipment
- Emergency transportation services
- Home health services
- Inpatient hospital services
- Laboratory and radiological services
- Long-term acute care (LTAC)
- Rehab facility services
- Behavioral health services
- Skilled Nursing facility services
- Occupational therapy services
- Orthotic and prosthetic services
- Outpatient hospital services
- Pharmacy, including Part B drugs and services
- Physical therapy services
- Physician/Nurse practitioner services
- Speech therapy services
- Specific transplants and associated services

CLINICAL CRITERIA
Utilization Management aims to help guide best-practice medicine most efficiently and economically while addressing member-specific needs. To that end, the clinical decision criteria utilized align the interests of the Health Plan, the practitioner, and the member. The UM criteria are nationally recognized, evidence-based standards of care and include input from recognized medical experts. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. Utilization review criteria are utilized as an objective screening guide and are not intended to be a substitute for physician judgment. Utilization review decisions are made following currently accepted medical or healthcare practices while considering the individual member's needs and complications at the time of the request and the local delivery system available for care. The Medical Director reviews all potential medical necessity denials for medical appropriateness. The Medical Director is the only one with authority to implement an adverse determination that results in a reduction, suspension, denial, or termination of services.

InterQual is used as an initial review tool for services not otherwise defined in clinical coverage policies and provides a straightforward, consistent, evidence-based platform for care decisions that promote the appropriate use of services, enhance quality, and improve health outcomes the Health Plan uses InterQual as needed to determine medical necessity and appropriateness of physical health care. InterQual is developed by generalist and specialist physicians representing a national panel from academic and community-based practice, both within and outside the managed care industry. All services that do not meet InterQual or other policy criteria upon initial nurse review are subject to medical director review. Medical directors apply their clinical judgement to cases including the individual member's needs and complications at the time of the request and the local delivery system available for care.

American Society for Addictions Medicine (ASAM) evidence-based care guidance and behavioral health guidelines developed by organizations such as the American Psychiatric Association are used to make UM decisions regarding behavioral health treatment. UM decisions for behavioral health services are driven by licensed behavioral health professionals. Medical necessity denials of behavioral health services are made by a licensed psychiatrist, except for psychological or neuropsychological requests received from a psychologist, which a currently licensed Psychologist may review. In addition, members with significant behavioral health needs are assigned to care managers with behavioral health qualifications.

CLINICAL INFORMATION
Clinical information received, and rationale for the medical necessity determination and/or leveling of care is documented and maintained in the clinical authorization system. The information needed is manageable for the member, the practitioner/staff, and the health care facility staff. Only the minimally necessary information is obtained for health care services that require prior authorization.

The UM Department maintains a process for gathering pertinent clinical information and applying criteria/guidelines during the utilization review decision-making process based on individual needs, age, co-morbidities, complications, the progress of treatment, psychosocial situation, home environment, when applicable, and assessment of the local delivery system. Each medical decision must be case specific regardless of available practice guidelines. Authorization is provided when the requested service is medically necessary, delivered at the appropriate level of care, and provided most efficiently and cost-effectively without compromising the quality of care.

MEDICAL NECESSITY REVIEW

Covered services are those medically necessary health care services provided to members as outlined in the Health Plan's contract with the State and/or CMS, or member's evidence of coverage. The Health Plan provides medically necessary services that address the:

- Prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability.
- Ability for a member to achieve age-appropriate growth and development.
- Ability for a member to attain, maintain, or regain functional capacity.
- Opportunity for a member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

Pursuant to the Department, all medical services performed must be medically necessary and may not be experimental in nature. Medical necessity shall be determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

The appropriate use of criteria is incorporated in all phases of the utilization decision-making process by licensed staff. The application of clinical guidelines, individual clinical information, and local geographical practice patterns is considered during the utilization decision process. The Medical Director(s) seek clarification from the ordering or attending physician when indicated to ensure the appropriate utilization decisions are made. Panels of board-certified specialists are available to assist Medical Directors in the decision process. The UM Department will provide copies of UM policies, criteria, or guidelines used in the authorization processes to physicians and/or members upon request.

Two levels of UM medical necessity review are available for all authorization requests:

- Level I *review* is conducted on covered medical benefits by a care manager or prior authorization nurse (PA Nurse) who has been appropriately trained in the principles, procedures, and standards of utilization and medical necessity review. A Level I review is conducted i while considering the individual member's needs and complications at the time of the request and the local delivery system available for care. At no time does a Level I review result in a reduction, denial, or termination of service. A Medical Director or qualified designee can only make adverse determinations during a Level II review.
- Level II *review* is conducted on a case-by-case basis by an appropriately licensed practitioner or other health care professional as appropriate. Automatic referral for Level II review includes requests for services or procedures that do not have existing medical necessity criteria or are potentially experimental or considered new technology. A Level II review is also indicated when the request does not meet the existing medical necessity criteria. All Level II reviews are conducted with consideration given to continuity of care, individual member needs at the time of the request, medical necessity, clinical coverage policies, and the local delivery system available for care. A board-certified consultant may be used in making a medical necessity determination.

PRIOR AUTHORIZATION / ORGANIZATION DETERMINATIONS

Prior authorization requires that the provider or practitioner make a formal organization determination request to the Health Plan before the service is rendered. Members may submit a request for an organization determination. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the proposed health services, including the setting where the proposed care takes place.

Prior Authorization is required for only those procedures/services for which the quality of care or financial impact can be favorably influenced by medical necessity or appropriateness reviews, such as non-emergent inpatient admissions, all out-of-network benefits, and certain outpatient services, ancillary services, and specialty injectables as described on the Prior Authorization List. Prior Authorization is not required for emergency or urgent care services and out-of-area renal dialysis.

The Health Plan's PHCO department reviews the Prior Authorization List at least annually, in conjunction with the Health Plan VPPH and Plan CMO, to determine if any services should be added or removed from the list. Such decisions are based on Plan program requirements or to meet CMS or state statutory or regulatory requirements. The Practitioner/Member Services and Network Management Departments are consulted on proposed revisions to the prior authorization list. Practitioners are appropriately notified when such modifications occur.

CONCURRENT REVIEW PROCESS

The concurrent review process assesses the clinical status of the member, verifies the need and level of continued hospitalization or ongoing ambulatory care, facilitates the implementation of the practitioner's plan of care, promotes timely care, determines the appropriateness of treatment rendered, and monitors the quality of care to verify professional standards of care are met. Information assessed during the review includes:

- Clinical information to support the appropriateness and level of service proposed,
- Whether the diagnosis is the same or changed,
- Assessment of the clinical status of the member to determine special requirements to facilitate a safe discharge to another level of care,
- Additional days/service/procedures proposed, and
- Reasons for extension of the treatment or service.

Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. Concurrent review can occur on-site or telephonic. The frequency of reviews is based on the severity/ complexity of the member's condition and/or necessary treatment and discharge planning activity and are not routinely conducted daily. If, at any time, services cease to meet inpatient or ambulatory criteria, discharge criteria are met and/or alternative care options exist, the care manager contacts the facility and obtains additional information to justify the continuation of services. When medical necessity for the case cannot be determined, the case is referred to the Medical Director or appropriate behavioral health professional for review. The need for care management or discharge planning services is assessed during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost-effective alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issues, the concern is referred to the Health Plan's QI Department for investigation and resolution. The Health Plan makes a determination for urgent concurrent, expedited continued stay and/or post-stabilization review in compliance Coverage and authorization of services.

DISCHARGE HEALTH PLANNING

Discharge planning is a method of coordinating care, controlling costs, and arranging appropriate services upon hospital discharge. For members who have not fully recovered or do not require the highly specialized and intensive services of acute hospital care, the concurrent review nurses assist members in receiving the most timely, appropriate, safe, and cost-effective discharge with additional healthcare services such as home health care or proper placement in an extended care facility.

Discharge planning should occur early in a member's hospital stay. The care manager reviews the post-hospital needs of the member with the member, the member's family, and the PCP. The care manager works with the UM/UR staff of the hospital, PCP, and managing physician to arrange for services needed before the member is discharged from the hospital, as required. Community-based agencies are included in the discharge planning as appropriate.

COORDINATION OF SERVICES

Coordination of services and benefits is a critical function of Care Management both during inpatient acute episodes of care and for complex or unique needs cases. Coordination of care encompasses the synchronization of medical, social, and financial services and may include management across payer sources. The care manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the Health Plan or the member has met the benefit limitation.

Other attempts to promote continuity and care coordination include member notifications to those affected by a PCP or practice group termination from the Health Plan. The Health Plan assists the member in choosing a new PCP and transferring the medical records to the new PCP. If the provider is not termed due to a quality issue, the Health Plan may also authorize continued treatment with the provider under certain situations. The Health Plan also coordinates continuity of care when a new member comes onto the Health Plan, or a member terminates from the Health Plan.

EXTENDED SPECIALIST SERVICES

Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, the policies include guidance on how members with life-threatening conditions or diseases requiring specialized medical care over a prolonged period can request and obtain access to specialty care centers.

REFERRALS
Primary Care Providers (PCP) are required to direct the member's care. As noted on the Prior Authorization List, they must obtain prior approval for referral to certain specialty physicians and all non-emergent, out-of-network practitioners (for HMO plans). A referral is considered a request to the Health Plan for approval of services as listed on the prior authorization list.

SECOND OPINIONS
A second opinion may be requested when there is a question concerning diagnosis or options for surgery or other treatment of a health condition or when requested by any member of the member's health care team, including the member, family, and/or guardian, may ask for a second opinion. Authorization for a second opinion is granted to an out-of-network practitioner if no in-network practitioner is available. The second opinion is provided at no cost to the member.

OUT-OF-NETWORK PRACTITIONERS
If a member requires services unavailable from a qualified network practitioner, the decision to authorize an out-of-network practitioner is based on the continuity of care, availability, and location of an in-network practitioner of the same specialty and expertise, and complexity of the case. Network practitioners are prohibited from making referrals for designated health services to healthcare entities with which the practitioner or a member of the practitioner's family has a financial relationship.

NEW TECHNOLOGY REVIEW
In determining benefit coverage and medical necessity of new and emerging technologies, the new application of existing technologies, or the application of technologies for which no InterQual Criteria exists, the Health Plan's Medical Director first consults the Health Plan's available Medical Policy Statements. The Clinical Policy Committee (CPC) develops these statements.

The CPC is responsible for evaluating new technologies or new applications of existing technologies for inclusion as medical necessity criteria. The CPC develops, disseminates, and at least annually updates medical policies related to:

- Medical procedures,
- Behavioral health procedures,
- Pharmaceuticals and
- Devices.

The CPC or assigned designee reviews appropriate information to make medical necessity decisions, including published scientific evidence, applicable government regulatory body information, CMS's National and Local Coverage Decisions database/manual, and input from relevant specialists and professionals with expertise in the technology. Practitioners are notified in writing through the provider newsletters and the practitioner web portal (as applicable) of new technology determinations made by the Health Plan. As with standard UM criteria, the treating practitioner may, at any time, request the medical policy criteria pertinent to a specific authorization by contacting the PHCO department or may discuss the UM decision with the Health Plan Medical Director.

PREVENTIVE & CLINICAL PRACTICE GUIDELINES
While clinical practice guidelines are not used as criteria for medical necessity determinations, the Medical Director and UM staff make UM decisions consistent with guidelines distributed to network practitioners. Our recognized resources are American Medical Association (AMA), American Diabetes Association (ADA), American Heart Association (AHA), American Lung Association (ALA), Center for Disease Control (CDC), and Agency for Healthcare Research and Quality (AHRQ). Such guidelines include, but are not limited to,

- Adult Preventive Health
- Asthma
- Congestive heart failure
- Depression
- Diabetes
- Hypertension

PRACTITIONER ACCESS TO CRITERIA
At any time, treating practitioners may request UM criteria pertinent to a specific authorization request by contacting the Health Plan's PHCO department or may discuss the UM decision with the Health Plan Medical Director. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the PHCO department. The manual also outlines the Health Plan's PHCO policies and procedures.

INTERRATER RELIABILITY
At least annually, the CMO and VPPH assess the consistency with which Medical Directors and other UM staff make clinical decisions and apply UM criteria in decision-making. The assessment is performed as a periodic review by the VPPH or designee to compare how staff members manage the same case or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. UM staff are required to complete inter-rater reliability annual testing successfully. When an opportunity for improvement is identified through this process, the Health Plan's PHCO leadership takes corrective action.

COMMUNICATION
Members and practitioners can access UM staff through a toll-free number at least eight hours a day during regular business hours for inbound or outbound calls regarding UM issues or questions about the UM process. Inbound and outbound communications may include directly speaking with practitioners and members or faxing, electronic or telephone communications (e.g., sending emails or leaving voicemail messages). After regular business hours and on holidays, calls to the UM department are automatically routed to the after-hours team.

Plan PHCO departments are available to coordinate services for members with urgent and emergent care, including ambulance services, to promote timely access to and delivery of necessary health services. As part of the triage process, UM/CM staff may direct the member, as appropriate, to their PCP or Emergency Department. Under no circumstances does the PHCO staff offer medical advice.

SIGNIFICANT LACK OF AGREEMENT
When there is a significant need for more agreement between the Health Plan PHCO staff and the health care practitioner regarding the appropriateness of authorization during the review or appeal process, additional information may be requested. "Significant lack of agreement" means the PHCO employee has:

- Tentatively determined that a service cannot be authorized
- Referred the case to the Medical Director for review; and
- Spoken to or attempted to speak to the health care practitioner regarding additional information.

ACCESS TO PHYSICIAN REVIEWER
The Health Plan Medical Director or appropriate practitioner reviewer (behavioral health practitioner, pharmacist, etc.) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Practitioners are notified of the availability of an appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, new practitioner orientation, and/or the practitioner newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision and how to contact a reviewer for specific cases is also provided verbally and/or in the written notification at the time of an adverse determination. the Health Plan Medical Director may be contacted by calling the Health Plan's main toll-free phone number and asking for the Health Plan Medical Director. A Health Plan Care Manager may also coordinate communication between the Health Plan Medical Director and requesting practitioner.

REQUESTING COPIES OF MEDICAL RECORDS
PHCO staff do not routinely request copies of medical records for all members reviewed. During the prospective and concurrent telephonic review, copies of medical records are only required when a difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay. In those cases, only the necessary or pertinent sections of the record are required. Medical records may also be requested to complete an investigation of member grievances or when a potential quality of care issue is identified through the UM process. Confidentiality of information necessary to conduct UM activities is always maintained. Unless modified by state code and/or federal regulations, healthcare practitioners are not reimbursed for the reasonable costs of providing medical information in writing, including copying and transmitting any requested patient records or other documents. Members requesting a copy of a designated record set are not charged for the copy.

SHARING INFORMATION
Plan PHCO staff share all clinical and demographic information on individual members among various departments (e.g., authorization, discharge health planning, transition of care, care management) to avoid duplicate requests for information from members or practitioners.

PRACTITIONER-MEMBER COMMUNICATION
Health Plan's PHCO staff in no way prohibits or otherwise restricts a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a member who is their patient for the following:

- The member's health status, medical care, or treatment options, including any alternative treatments that may be self-administered.
- Any information the member needs to decide on all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The member's right to participate in the decision(s) regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions.

TIMELINESS AND NOTIFICATION OF UM DECISIONS
Utilization Management decisions and notifications are made promptly to accommodate the situation's clinical urgency and minimize any disruption in the provision of health care. Established timelines are in place for practitioners to notify the Health Plan of a service request and for the Health Plan to make UM decisions and subsequent notifications to the member and practitioner.

For all pre-scheduled services requiring prior authorization, the Practitioner must notify the Health Plan within (5) days before the requested service date. Prior approval is not required for emergent or urgent care services. Facilities are requested to notify the Health Plan of all inpatient admissions within one (1) business day following the admission.

Standard Organization Determinations
The Health Plan makes determinations for standard, non-urgent, pre-service prior authorization requests within 14 calendar days of receipt of the request or as required by the Health Plan's Contract. Both the member and the provider are notified of the determination:
- Approval: Written notification or verbal member notification/voicemail
- Denial: Written notification and verbal member notification/voicemail

Expedited Organization Determinations
Expedited prior authorization requests should be made verbally. The Health Plan makes determinations for expedited preservice prior authorization requests within 72 hours of receipt of the request. Both the member and the provider are notified of the decision:
- Approval: Written notification (refer to letter grid for letter name) or verbal member notification/voicemail.
- Denial: Written notification (refer to letter grid for letter name) and verbal member notification/voicemail.

The Health Plan accepts requests for expedited determinations if the member, or the member's physician, believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy. The Health Plan does not require authorization for emergent or urgent procedures.

DENIAL OF SERVICES
A denial of services, also called an adverse benefit determination as defined above, of any service is based on medical necessity or benefit limitations. Upon any adverse determination for health care services made by the Health Plan Medical Director or other appropriately licensed health care professional (as indicated by case type), a written notification is communicated to the member and requesting practitioner. The written notification is easily understandable and includes the specific reason/rationale for the determination, specific criteria, and availability of the criteria used to make the decision, process, and timeframes for appeal of the decision. Practitioners can discuss any medical UM denial decisions with a physician or appropriate reviewer.

Following denial of a request for an expedited initial determination, plans must:
- Transfer the request to the standard initial determination process
- Give the member prompt verbal notice of the denial to expedite the request; and
- Deliver a written notice within three calendar days of the verbal notice of the denial to expedite the request.

REQUEST FOR RECONSIDERATION
A written or verbal request received from a member or a physician acting on behalf of a member that an initial organization determination is reconsidered based on the initial evidence and findings or other evidence submitted or obtained by the parties.

APPEAL OF UM DECISIONS
A request to change or reverse a previous clinical decision is considered an appeal. Appeals may be requested for the benefit and/or medical necessity adverse determinations. Members, their authorized representatives (with written consent from the member as dictated by CMS or State, or legal representatives of a deceased member's estate may appeal adverse determinations regarding their care. A healthcare practitioner with knowledge of the member's medical condition, acting on behalf of the member and with the member's written consent, may file an appeal. Expedited appeals are available to

members for any urgent care requests. Punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

Members have sixty (60) calendar days from the initial pre-service denial to file an appeal. The content of an appeal, including all clinical care aspects involved, is thoroughly investigated and documented. Members can submit comments, documentation, records, and other information relevant to the appeal in person or writing. A physician or other appropriate clinical peer of a same-or-similar specialty, not involved in the initial adverse determination, must evaluate medical necessity decisions for adverse appeal decisions.

SATISFACTION WITH UM PROCESS

The Health Plan provides an explanation of the Medicaid grievance and appeal process, external review, and/or Fair Hearing process to newly enrolled members upon enrollment and annually after that. The process is explained in the Evidence of Coverage and Provider Manual and may also be highlighted in member newsletter articles, member educational flyers, and postings at provider offices. Complaints or grievances regarding potential quality of care issues are referred to the Health Plan Quality Improvement Department for investigation and resolution and reported as a grievance defined by Medicaid.

Annually, the Health Plan evaluates members' and providers' satisfaction with the UM process. Mechanisms of information gathering may include but are not limited to member satisfaction survey results (CAHPS), member/provider complaints and appeals that relate specifically to UM, provider satisfaction surveys with specific questions about the UM process and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates that there are areas of dissatisfaction, the Health Plan develops an action plan and interventions to improve the areas of concern, including staff retraining and member/provider education.

EMERGENCY SERVICES

It is the Health Plan's policy that a member may access emergency services when an Emergency Medical Condition exists (reference NC Medicaid Health Plan contract).:
Emergency Medical Condition: 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, for 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.

The Health Plan does not require members to obtain a referral or prior authorization before receiving emergency services.

Post-Stabilization Services

The Health Plan provides coverage for any services performed until the Provider, whether in or out of the network service area, has stabilized the patient. The Health Plan covers services subsequent to stabilization:

- That were pre-approved by the Health Plan.
- That were not pre-approved by the Health Plan because the Health Plan did not respond to the provider of post-stabilization care services' request for pre-approval within one (1) hour after the request was made.
- If the Health Plan could not be contacted for pre-approval.
- If the Health Plan and the treating physician cannot reach an agreement concerning the Health Plan member's care and a network physician is not available for consultation. In this situation, the Health Plan gives the treating physician the opportunity to consult with a network physician and the treating physician may continue with the care of the member until:
    - a Health Plan physician with privileges at the treating hospital assumes responsibility for the member's care.
    - a Health Plan physician assumes responsibility for the member's care through transfer.
    - the Health Plan representative and the treating physician reach an agreement concerning the member's care.
    - the member is discharged.

Refer to WNC.UM.07, Emergency and Post-Stabilization Services Policy.

BEHAVIORAL HEALTH MANAGEMENT

Management of the behavioral health program (as covered by each Plan) may be delegated to managed behavioral health organizations (MBHO). The MBHO is responsible as a delegate to provide all aspects of behavioral health care utilization

management services to plan members and coordinate behavioral health care with plan practitioners, including evaluating behavioral health sites/services.

The Health Plan UMAC reviews and approves the Behavioral Health Utilization Program Description for the overall UM Program, which includes integrating behavioral health with physical health. As part of the delegation oversight, the Health Plan reviews utilization reports from the MBHO, which summarize the utilization of services for Health Plan members.

TRIAGE AND REFERRAL FOR BEHAVIORAL HEALTH

Plan members calling for assistance in accessing behavioral health or substance abuse services are immediately referred to the appropriate care setting and treatment resources. Behavioral health care managers assist members with locating a network behavioral health provider to meet their clinical needs. Members accessing outpatient care with contracted providers do not require a referral from their PCP. Such decisions are made by appropriately licensed staff utilizing clinically based triage and referral protocols that are in keeping with currently acceptable practices for behavioral health care service delivery. These protocols are reviewed and revised, at a minimum, every two years.

DISEASE MANAGEMENT

Disease management is a multidisciplinary, continuum-based approach to healthcare delivery that proactively identifies populations with, or at risk for, chronic medical conditions. Disease management is a system of coordinated healthcare interventions and communications for people in situations where member self-care efforts are significant. Disease management programs generally are offered telephonically, involving interaction with a trained nursing professional, and require an extended series of interactions, including a vital educational element. The Health Plan's disease management programs emphasize prevention, and members are expected to play an active role in managing their diseases.

- Pharmaceutical claims data.
- HRA results.
- Laboratory reports.
- Data from UM/CM processes.
- New member welcome calls.
- Member self-referral.
- Physician referral.

Based on the data received during the identification phase, members are stratified into risk groups that guide the care coordination interventions provided. Members are stratified into low, moderate, or high-risk categories. Definitions for each risk category are program specific and are outlined in the program's description document. Members may change between risk groups based on data retrieved during each reporting period and through collaboration/interaction with the member or PCP.

Members enrolled in a disease management program receive some level of intervention, which may include, but is not limited to:

- Identification.
- Assessment.
- Disease-specific education.
- Reminders about preventive/monitoring services.
- Assistance with making needed appointments and transportation arrangements.
- Referral to specialists as required.
- Authorization for services and/or medical equipment, coordination of benefits.
- Coordination with community-based resources.

Education is a crucial component of the disease management program. Education is presented to members and their treating physicians and may be provided through mailings, telephone calls, or home visits.

Moderate and high-risk members are referred to the Health Plan's Care management program to develop an individualized care plan. The member/family and the physician are included in the development of the care plan. Including the member/family in developing the individualized goals and interventions promotes ownership of the program and stimulates a desire for success. Care plan goals and interventions are reviewed routinely, and the Health Plan of care is adjusted as necessary by the care coordinator to ensure the best possible outcomes for the member.

COMPLEX CARE/CARE MANAGEMENT

Care management or care coordination is a collaborative process of assessment, planning, coordinating, monitoring, and evaluating the services required to meet an individual's needs. Care management serves as a means for achieving member wellness and autonomy through advocacy, communication, education, identification of service resources, and service

facilitation. Care Management's goal is to provide quality health care along a continuum, decrease care fragmentation across settings, enhance the member's quality of life, and efficiently utilize patient care resources. The CM helps identify appropriate providers and facilities throughout the continuum of services while ensuring that available resources are being used promptly and cost-effectively. Care Management services are offered to all members to optimize the outcome for all concerned. They include an initial and annual Health Risk Assessment (HRA) as well as member-centric integrated care team (ICT) meeting and individual care plan (ICP). The care manager ensures direct communication between the CM, the member, and appropriate service personnel while maintaining the member's privacy, confidentiality, health, and safety through advocacy and adherence to ethical, legal, accreditation, authorization, and regulatory standards or guidelines.

The managing physician maintains responsibility for the patient's ongoing care needs. The Health Plan's Care Management Team supports the physician by tracking compliance with the Care management plan and facilitating communication by actively linking the member to the PCP and other members of the Care Management Team where support services are needed. The Care Management Team also facilitates referrals and linkages to community practitioners such as local health departments, school-based clinics, and social and other support services where needed.

PROGRAM EVALUATION

The UM Program is evaluated annually, and modifications are made as necessary. The Chief Medical Officer and VPPH assess the impact of the UM program by using the following:

- Member complaint, grievance, and appeal data
- The results of member satisfaction surveys
- Practitioner complaint and practitioner satisfaction surveys
- Relevant UM data
- Practitioner profiles
- Drug Utilization Review (DUR) profiles (where applicable)

The evaluation covers all aspects of the UM Program. Problems and/or concerns are identified, and recommendations for removing barriers to improvement are provided. The review and proposals are submitted to the QIUMC or the Health Plan's UMAC for review, action, and follow-up. The final document is then submitted to the BOD/Governing Body for approval.

DELEGATION

The Health Plan may elect to delegate various UM activities to entities that demonstrate the ability to meet the Health Plan's UM standards and standards for delegation, as outlined in the UM Plan and policies and procedures. The Health Plan conducts ongoing oversight and annual review of each delegate's UM program as outlined in the Oversight of Delegated UM policy. Delegation is dependent upon the following factors:

- A pre-delegation review is necessary to determine the ability to accept delegation.
- Once the delegate is determined to be capable of fulfilling the responsibilities of delegation, a Delegation Agreement is executed with the organization to which the UM activities have been delegated, clarifying the responsibilities of the delegated group and the Health Plan. This agreement specifies the standards of performance to which the contracted group has agreed.
- The delegated group must conform to the Health Plan's UM standards; including timeframes outlined in the Health Plan's policy and procedure Timeliness of UM Decisions and Notifications.
- The delegated group is responsible for providing The Health Plan with a written UM Program Description/Plan for annual review and approval by the Health Plan's QIC.
- The delegated group is responsible for submitting utilization reports, including monthly utilization summaries, high-cost days, and quality assurance/improvement issues.

The Health Plan retains accountability for any functions and services delegated and, as such, monitors the performance of the delegated entity through the following vehicles:

- Annual approval of the delegate's UM program (or portions of the program that are delegated), as well as any significant program changes that occur in between
- Routine reporting of key performance metrics that are required and/or developed by the Health Plan's Chief Medical Officer and the QIUMC.
- Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to Plan standards and state program requirements.

If the delegate is NCQA accredited, the Health Plan may assume that the delegate is carrying out responsibilities per NCQA standards and revise the annual audit or evaluation per state or CMS contract requirements. At the time of pre-delegation, the Health Plan must evaluate the compatibility of the delegate's UM Program with the Health Plan UM Program. Once the delegation is approved, the Health Plan requires that the delegate provide the appropriate reports as determined by the

Health Plan to monitor the delegate's continued compliance with the needs of the Health Plan. The Health Plan annually reviews ongoing accreditation status.

REFERENCES:
North Carolina Medicaid RFP/Contract
WNC.UM.17, Clinical Coverage Guidelines Policy
WNC.QI.03, Clinical Practice Guidelines Policy
WNC.UM.07, Emergency and Post-stabilization Services Policy
42 CFR 438.210(d)
42 C.F.R. § 438.210(a)(5)(ii)
42 C.F.R. § 438.114
42 CFR 438.10
42 CFR § 422.584

ATTACHMENTS: NA

ROLES & RESPONSIBILITIES:
The Utilization Management Team is responsible for this policy.

REGULATORY REPORTING REQUIREMENTS:
All Policies and Procedures ("Documents") are required to be reviewed at least annually, unless required more frequently by state regulation or contractual obligation. The review includes collaboration with Stakeholders and may also require regulatory or state approvals. Upon completion of the review, the Documents must be approved and published in RSA Archer to be valid. To facilitate this timing, reviews should commence 90 days prior to one calendar year from the current New, Reviewed or Revised date.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
New Policy Document	New Policy	02/27/2022
Ad Hoc Review	Transitioned to Centene policy template and format with present, active tense language, and reformatting.	02/27/2022
Annual Review	Updated staff title and responsibilities, added concurrent review responsibilities with discharge planning, and formatting changes; added definition for emergency services and adverse benefit determination, updated language throughout to align with corporate policy including language in the Emergency Services, Concurrent Review Process, and Medically Necessary Services section; clarified use of InterQual in the absences of state clinical policies	03/14/2023
Ad Hoc Review	Added Medicaid contract language from V.C.1.e. Benefits and Care Management	06/19/2023

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.