ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	UM-001
Policy Name	Utilization Management Program
Department Name	Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Line(s) of Business	Medi-Cal, Group Care
Effective Date	11/02/2004
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

I. Alameda Alliance for Health ("The Alliance") ensures appropriate utilization of all healthcare services including mental health and substance use disorders for members, and compliance with the applicable State and Federal regulations.

II. The Alliance UM Program will be compliant and consistent with State and Federal regulations including but not limited to CA Health and Safety Code 1367.01 and 42 CFR 438.900(d).

III. The Alliance Quality Improvement Health Equity Committee (QIHEC) oversees the development, implementation, and effectiveness of the Quality Improvement Health Equity (QIHE) Program and is accountable to the Alliance Board of Governors. The QIHEC oversees subcommittees including the Utilization Management Committee. The QIHEC is chaired by the Chief Medical Officer (CMO) and vice-chaired by the Medical Director of Quality.

IV. The Alliance reviews/revises the Utilization Management (UM) Program and UM policies at least annually to ensure requirements and guidelines are adequately described for UM activities to facilitate appropriate utilization of health services including behavior health and substance use disorders.

a. The UM Program Description, Program Evaluation and Workplan are reviewed and updated at least annually and submitted for review and approval through the Utilization Management Committee (UMC,) Quality Improvement Health Equity Committee (QIHEC,) and the Board of Governors (BOG.) Significant program changes may also be reflected in a revised Program Description/Workplan during the year.

b. UM policies and procedures are reviewed and revised at least annually and as needed to reflect new policies/procedures in response to new APLs, other regulatory requirements, or business needs. They are submitted for review and approval through the Utilization Management Committee (UMC,) Quality

Improvement Health Equity Committee (QIHEC,) and the Board of Governors, (BOG.)

V. The Alliance UM program shall include the following elements:

a. Authorization is not required prior to the provision of emergency services and care needed to stabilize a Member's emergent medical condition.
b. The Alliance covers all emergency room services and does not deny any emergency room claims.
c. Qualified staff will be responsible for the UM program including development, implementation, and medical policy including the designation of a physician to be involved in the UM Program implementation and a designated behavior health practitioner involved in the behavior health aspects of the UM program.
d. All UM decisions involving medical, surgical, behavior health or substance use disorders are based on medical necessity, appropriateness of care and services, by reviewing either/or clinical notes from the requesting provider, or adjunct clinical information obtained by using medical records, or labs available to the Alameda Alliance for Health, and the Member's covered services.
e. There is separation of medical decisions from fiscal and administrative management to assure that those medical decisions will not be unduly influenced by fiscal and administrative management:

    i. The Alliance distributes an affirmative statement to all practitioners, providers, staff, and members regarding incentives to ensure appropriate utilization and discourage underutilization.
    ii. The Alliance does not use incentives to encourage barriers to care and service.
    iii. The plan will ensure that a Medical Director's authorization decisions avoid any conflict of interest situations.

f. Second opinions from a qualified health professional are at no cost to Medi-Cal or fee-for service health plan in accordance with the AAH policy and procedure for Second Opinion (UM-005)
g. The Alliance and its delegates will maintain evidence-based criteria and a hierarchal criteria process for approving, modifying, deferring, and denying requested services.

    i. The hierarchal criteria process:

        1. Regulatory and contractual requirements
            - Regulatory requirements include WPATH guidelines for Transgender Care
            - Regulatory requirements include LOCUS/CALOCUS, CASII/ECSII/ASAM for Mental Health and Substance Use Disorders.
        2. Evidence based guidelines.
        3. Alliance specific guidelines
        4. National medical association consensus
        5. Medical necessity/medical judgment

ii. Documentation will be maintained evidencing the use of providers involved in the development and or adoption of specific criteria utilized by the UM program.

iii. Criteria are applied in conjunction with considering individual needs, such as:

1. Age
2. Co-morbidities
3. Complications
4. Progress of Treatment
5. Psychosocial situations, and
6. Home environment

h. The Alliance and its delegates shall communicate to health care practitioners the procedures and services that require prior authorization, concurrent review or retrospective review and ensure that contracting health care practitioners are aware of the procedures and timeframes necessary to obtain prior authorization for these services.

i. The Alliance will ensure the integration of UM activities into the Quality Improvement System, including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modification to the appropriate QI staff.

VI. The Alliance and its delegates will ensure medical necessity determinations of mental health and substance use disorders services use current generally accepted standards of mental health and substance use disorder care and rules of conduct for Plan medical personnel by the following:

a. Medical decisions are rendered by qualified medical personnel and that only a qualified actively licensed health care practitioner with an active, unrestricted California license or, in the case of behavioral health decisions, a California Department of Health Care Services approved qualified licensed behavioral practitioner.

b. Decisions to modify, deny or authorize an amount, duration or scope of a service that is less than what was requested will be made by a qualified health care professional with appropriate clinical expertise or who is competent to evaluate the specific clinical issues using appropriate clinical guidelines in treating the condition or disease. Appropriate clinical expertise may be demonstrated by appropriate specialty training, experience, or certification by the American Board of Medical Specialties. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions.

c. Qualified health professionals supervise medical necessity review processes and documentation as described in Section II in the procedure section of this policy and procedure.

d. Qualified physicians and pharmacists with unrestricted licenses oversee UM decisions and sign all denials that are made, whole or in part, based on medical necessity.

VII. Personnel Responsible for aach level and type of UM Decision Making

a. Medical Healthcare UM Decisions

UM Personnel	Responsibilities
UM/BH Coordinator	• Administrative Decisions: Qualified non-clinical staff may make non-medical necessity decisions for non-eligibility. • Receives and initially processes authorization requests to include eligibility and benefit verification. • Approves services using criteria included in the UM scope of practice. • Forwards all other requests to the UM/BH Reviewer or Medical Director/Doctoral Behavioral Health Practitioner, as appropriate. • Collects clinical information pertinent to the authorization request as directed by the UM/BH Reviewer/Medical Director/Doctoral Behavioral Health Practitioner. • Sends Notice of Action (NOA) letters when UM decision to approve, modify or deny a service has been rendered.
UM Reviewer/ BH Reviewer	• Hold a current unrestricted California Nursing or Behavioral Health License. • Review authorization requests processed by the Coordinators under their scope of practice. • Use evidence-based criteria or clinical guidelines to review and approve authorization requests.

UM Personnel	Responsibilities
	• May make non-medical necessity benefit denial decisions. • Forward to the Medical Director/designee/Doctoral Behavioral Health Practitioner authorization requests that require physician medical necessity review and/or are potential denials or modifications
Medical Directors / Doctoral Behavioral Health Practitioner	• The Chief Medical Officer (CMO) is board certified and holds a current unrestricted California License. • The Associate Medical Director / Doctoral Behavioral Health Practitioner holds a current unrestricted California license. • Use evidence-based criteria or clinical guidelines to review and approve, modify, or deny authorization requests. • Consult resources/guidelines available from appropriate national specialty professional boards or associations. • Identify cases with potential conflicts of interest sent for review and refer the cases to another Medical Director/Doctoral Behavioral Health Practitioner or the external reviewer for medical necessity review for a decision.

b. Supervision
   i. The Board of Governors delegates oversight of Utilization Management functions to the CMO and the Quality Improvement Health Equity Committee (QIHEC,)

ii. A Medical Director/Doctoral Behavioral Health Practitioner must review any authorization request that may result in a denial due to medical necessity.

iii. The Supervisor of Utilization Management provides day to day supervision of the UM Coordinator and UM Nurse staff:

1. The Manager of Utilization Management provides oversight and day to day supervision of any Licensed Vocational Nurse (LVN) functioning in the department, ensuring that LVNs do not make medical necessity decisions.
2. Consistently available to staff, either in on site or by telephone
3. Ensures consistent criteria application, e.g., Inter-Rater Reliability testing.
4. Provides staff training as needed.
5. Monitors documentation adequacy.

c. Behavioral Health Care UM Decisions

i. Specialty Mental Health (SMHS)/Behavioral healthcare services for Medi-Cal Members are carved out to and delivered by Alameda County Behavioral Health Care Services (ACBHCS) providers. Mild to Moderate mental/behavioral healthcare services for MediCal Members are delivered through the AAH Behavioral Health department.

ii. Behavioral healthcare services for the Group Care line of business is delivered through the Behavioral Health department.

iii. Inpatient medical necessity non-coverage decisions may only be made by a behavioral health clinical peer reviewer.

1. Board certified clinical psychiatrist with a current unrestricted license.

iv. Outpatient medical necessity non-coverage decisions may only be made by a behavioral health clinical peer reviewer (as described above) or a doctoral level clinical psychologist who has:

1. Competency to review the case within their scope of practice.
2. Current unrestricted California license.

v. AAH collects utilization management statistics, on at least a quarterly basis, to assess potential areas of under- or over-utilization of services.

1. These data are reviewed by the Utilization Management Committee (UMC), which oversees the process for appropriate utilization of services.
2. Findings are reported at both UMC and QIHEC meetings to ensure quality oversight of utilization activities.
3. Detailed analysis may be conducted to determine root cause of identified trends.
4. Interventions are developed and approved at UMC and QIHEC and are carried out by AAH, including collaboration with ACHBCS as indicated.

d. Pharmacy Prior Authorization/UM Decisions: See policy RX-002 Prior Authorization Review Process.

e. All decisions, including those for appeals, are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services. In addition, all decisions are clearly documented.

f. Mechanisms to detect both under and over utilization of healthcare services including by delegated entities and include encounter and internal reporting mechanism to detect member utilization patterns.

VIII. The Alliance and its UM maintains current policies and procedures covering UM activities for all health services including behavioral health and substance use disorders as may be required by regulations, and contract including:

a. There is no difference in limitations on services, including Non-Quantitative Treatment Limitations (NQTLs) between Medical Surgical, Behavioral Health and Substance Use Disorder, ensuring parity in medical and behavioral service processes and practices.
b. UM or utilization review policies and procedures are available to Members and Providers upon request at no cost.

IX. The Alliance shall monitor and evaluate the care and services provided to Alliance members by delegates to ensure consistency with State and Federal regulations and NCQA standards.

X. The Alliance processes requests for a service/care that has already been rendered by the provider as retrospective reviews:

a. **Prior Authorization Review:** Submissions received prior to the Date of Service will be reviewed for medical necessity.
b. **Retrospective Authorization Review**: Submissions received up to 90 days from the date of service.
c. **Post-Retrospective Authorization Review:** Submissions received more than 90 days from the date of service will be denied for not obtaining prior authorization. **Post-Stabilization Review following a Emergency Department admission:** Non-notification in accordance with the Alliance's notification policy and applicable law may result in an administrative denial.

i. If retrospective services are administratively denied by the Alliance because of not requesting a prior authorization for services that require pre-approval or for non- notification for post-stabilization services, a NOA will be sent with appeal rights.
ii. The provider may appeal through the appropriate medical necessity or provider payment dispute appeal process. If the provider believes that the exceptions were met for medical necessity review, they may submit medical records for review. The Alliance will review for medical necessity on appeal if the medical records show evidence that the exceptions were met.

d. Exceptions include member eligibility issues and if the services were emergent/urgent. If the exceptions are met, then the submission will be reviewed for medical necessity regardless of when it was received.

XI. In the event of a Presidential or Gubernatorial emergency or major disaster declaration or an announcement of public health emergency by the secretary of HHS requirements for authorization/pre- notification will be waived as directed by DHCS.

PROCEDURE

1. The Alliance maintains a full-time physician as medical director, with an active, unrestricted California license, whose responsibilities include, but are not limited to:
   a. Ensuring that:
      i. Medical care provided meets the standard for acceptable medical care.
      ii. Medical protocols and rules of conduct for plan medical personnel are followed.
   b. The Alliance and its delegates will ensure that medical decisions:
      i. Are rendered by qualified medical personnel and
      ii. Including those by delegated entities and rendering Providers, are not unduly influenced by fiscal and administrative management.
      iii. To deny, modify, delay, or terminate are reviewed by a qualified physician with an active, unrestricted California license (or in the case of behavioral health care decisions, a California Department of Health Care Services approved qualified license non-physician doctoral level psychologist)
   c. Developing and implementing the Utilization Management program and medical policy
   d. Active participation in the function of Alameda Alliance's grievance procedures and resolving Appeals clinical grievances related to medical quality of care.
   e. Direct involvement in the implementation of Quality Improvement activities

2. The Alliance UM manages:
   a. Services that allow direct access (services exempt from prior authorization)
      i. Prior authorization shall not be applied to emergency services, family planning services, preventive services, basic prenatal care in-network, sexually transmitted disease services, HIV testing, COVID 19 vaccines or therapeutics, or biomarker testing for members with advanced cancer stage 3 or 4.
      ii. Direct access to contracted in-network obstetrics and gynecology specialties for obstetrical care and well woman exams.

iii. Direct access to services that do not require prior authorization, including

in network physician to physician referrals. Please see attachment D Prior Authorization Grid

b. Services that require authorization
    i. Processes for processing prior authorization, concurrent, and retrospective requests for authorization, including determination of medical services include, but are not limited to:
        1. Prior authorization and referral management
        2. Inpatient concurrent review, discharge planning, and care management
        3. Retrospective requests

c. In collaboration with the Case Management department, Continuity of Care processes for outpatient to inpatient case management and vice versa, including processes for specialty/comprehensive case management, targeted case management and Transitional Care Services

3. Information sources used to make determinations are based on benefit coverage and Medical Necessity.
    i. Criteria, based on sound clinical evidence, are used to make determinations for approval, deferral, modification, and denial of service request.
        1. Criteria are reviewed on an annual and as needed basis and updated as necessary.
        2. Criteria is made available to its Practitioners or Members upon request. Practitioners or Members may call or fax their request. Reviewer contact information is included in the practitioner and provider correspondence for each denial decision.
        3. Evaluation of the consistency with which the health care professional involved in Utilization Review apply the Criteria in decision making is done through Inter-Rater Reliability testing, at least annually and upon hire
        4. Member benefits are described in the Member's Evidence of Coverage
4. Timeliness of review decisions, are consistent with state, federal and Department of Managed Health Care (DMHC) regulations
5. Processes for review of experimental and investigational referrals are described in UM-007 New or Experimental Technology Review Process.
6. Processes for review of second opinion are described in UM- 005 Second Opinions and are at no cost to the Medi-Cal Member
7. Processes for written notifications of determination through a Notice of Action Letter (NOA) to Providers and Members, includes information for Providers and Members to Appeal a determination, consistent with state, federal and DMHC regulations including the additional state requirements for Medi-Cal Members which can be found in UM-054 Notice of Action
8. The Alliance UM department:
    a. Identifies individuals who may need or who are receiving services from out of plan Providers and/or programs to ensure coordinated service delivery and efficient and effective joint case management for services, and

b. Facilitates care coordination and meet the mandatory interface with the state and community-based organizations/programs including but not limited to the following linked and carved-out programs:
    i. Specialty Mental Health
    ii. Alcohol and Substance Abuse Treatment Service
    iii. Services for Children with Special Health Care Needs
    iv. California Children Services (CCS)
    v. Services for Persons with Developmental Disabilities
    vi. Early Intervention Services
    vii. School Linked CHDP Services
    viii. Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Home and Community Based Services Waiver Programs
    ix. Dental
    x. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)
    xi. Women, Infants, and Children (WIC) Supplemental Nutrition Program

9. The Alliance UM provides oversight of delegated entities' compliance with state and federal regulations and Alameda Alliance's delegated UM activities, which includes, but not limited to, annual, focused, and supplemental audits/file reviews, and other types of audits, such as continuous monitoring, medical record/document/log reviews and data analysis.

DEFINITIONS / ACRONYMS

1. **Administrative Decisions:** Qualified non-clinical staff may make non-medical necessity denial decisions (example: not eligible with the Alliance).
2. **Appeal** means a formal request by a Member or Member Representative on behalf of a Member about a Utilization Review decision to deny, modify, delay, or terminate health care services.
3. **Behavioral Healthcare Practitioner (BHP)** is a physician or other health professional who has advanced education and training in the behavioral healthcare field and /or behavioral health/substance abuse facility and is accredited, certified, or recognized by a board of practitioner as having special expertise in that clinical area of practice.
4. **Benefits Determination:** A denial of a requested service that is specifically excluded from a Member's benefit plan and is not covered by the organization under any circumstances. A benefit determination includes denials of requests for extension of treatments beyond the limitations and restrictions imposed in the Member's benefit plan, if the organization does not allow extension of treatments beyond the number outlined in the benefit plan for any reason.
5. **Conflict of Interest:** A conflict of interest is a set of circumstances that creates a risk that professional judgment or actions of a person regarding the primary interest might be unduly influenced by a secondary interest. The existence of a conflict of interest is not, in and of itself, evidence of wrongdoing. In fact, for many professionals, it is virtually impossible to avoid having conflicts of interest from time to time. But a conflict of interest can become an issue if not disclosed or if the individual tries and/or succeeds in influencing the outcome of a decision, for personal benefit.

6. **Criteria** means systemically developed, objective, and quantifiable statements used to

assess the appropriateness of specific health care decisions, services, and outcome.

7. **Denial** means non-approval of a request for care or service based on either medical appropriateness or benefit coverage. This includes denials, any partial approvals or modifications, delays and termination of existing care or service to the original request.

8. **Medical Necessity:** Determinations on decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits; and care or service that could be considered either covered or non-covered, depending on the circumstances.

9. **Medically Necessary (Group Care Program):** Those covered health care services or products which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician or licensed, qualified provider to be consistent with the medical condition; and (c) furnished at the most appropriate type, supply, and level of service which considers the potential risks, benefits, and alternatives to the patient; (d) reasonable and necessary to protect life, prevent illness, or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. (See current EOC)

10. **Medically Necessary (Medi-Cal Program):** means those reasonable and necessary services, procedures, treatments, supplies, devices, equipment, facilities, or drugs that a medical Practitioner, exercising prudent clinical judgment, would provide to a Member for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms to protect life, to prevent significant illness or significant disability, or to alleviate severe pain that are:

    a. Consistent with nationally accepted standards of medical practice:

        i. "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer• reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas and any other relevant factors.

        ii. For drugs, this also includes relevant finding of government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia consulted in pharmaceutical determinations.

        iii. For purposes of covered services for Medi-Cal Members, the term "Medically Necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury and

        iv. When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the requirements applicable to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services and EPSDT Supplemental Services as defined in Title 22, 51340 and 51340.1. and the most recent APL.

11. **Medical Necessity Determination** means UM decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits; and care or service that could be considered either covered or non-covered, depending on the circumstances.
12. **Medically Necessary Mental Health and Substance Use Disorders** means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:
    a. In accordance with the current generally accepted standards of mental health and substance use disorder care.
    b. Clinically appropriate in terms of type, frequency, extent, site, and duration.
    c. Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.
13. **Member** means any eligible beneficiary who has enrolled in the AAH and who has been assigned to or selected AAH.
14. **National Committee for Quality Assurance (NCQA**) is a non-profit organization committed to evaluating and public reporting on the quality of health plans and other health care entities.
15. **Non-Contracted Provider** is a provider of health care services who is not contractually affiliated with AAH.
16. **Over Utilization of Healthcare** is the provision of services that are not medically necessary, or the provision of services that are medically necessary, but either in excessive amounts or in a higher-level setting than is medically indicated.
17. **Post Service** is defined as utilization review determinations for medical necessity/benefit conducted after a service or supply is provided to a member.
18. **Prior Authorization**: A type of Organization Determination that occurs prior to services being rendered.
19. **Provider** means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.
    a. NCQA considers a Provider to be an institution or organization that provides services for Members where examples of provides include hospitals and home health agencies. NCQA uses the term Practitioner to refer to the professionals who provide health care services, but recognizes that a "Provider directory" generally includes both Providers and Practitioners and the inclusive definition is more the more common usage of the word Provider.
20. **Qualified Health Care Professional** is a primary care physician or specialist who is acting within his or her scope of practice and who possesses a clinical background.
21. **Second Opinion** is an alternate medical opinion provided by a physician of like or greater expertise than the physician providing the initial opinion and where the second physician is considered to be reasonably independent from the first serves to evaluate

and determine the medical necessity for any proposed or continued treatment or other treatment options for the member's condition.

22. **Under Utilization of Healthcare** means failure to provide appropriate or indicated services or provision of an inadequate quantity or lower level of services than required.
23. **Utilization Management (UM)** means the process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.

AFFECTED DEPARTMENTS/PARTIES

- All Departments

RELATED POLICIES AND PROCEDURES

QI-101 Quality Improvement Program
UM-005 Second Opinions
UM-007 New and Experimental Technology Review Process
UM-054 Notice of Action
UM-057 Authorization Request Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- Prior Authorization Grid

REVISION HISTORY

11/30/2006, 3/15/2007, 1/1/2008, 9/22/2008, 10/31/2008, 1/16/2009, 4/4/2011, 10/18/2011, 12/30/2011, 4/27/2012, 10/18/2012, 12/12/2012, 05/06/2013, 08/21/2013, 09/24/2013, 10/14/2013, 12/16/2013, 3/13/2014, 5/01/2014, 7/14/2014, 8/6/2014, 8/18/2014, 9/2/2014, 12/1/2014, 10/07/2015, 10/15/2016, 12/15/2016, 12/20/2017, 01/04/2018, 11/15/2018, 7/18/2019, 1/16/2020, 1/21/2021, 5/20/2021, 6/28/2022, 2/21/2023, 6/20/2023, 04/19/2024

REFERENCES

1. DHCS Contract, Exhibit A, Attachments 5, 9, 13
2. Title 22, Section 51159
3. 28 CCR, §1300.51 (d)(I-6)
4. Health & Safety Code, Section 1367.01
5. 42 CFR 438.900(d)

MONITORING

1. Delegated Medical Groups
    a. The Alliance continuously monitors the utilization management functions of its delegated groups through periodic reporting and annual audit activities.

b. The Alliance reviews reports from delegated groups of all authorized specialty and inpatient services that are the Alliance's financial responsibility.

2. Internal Monitoring
   a. The Utilization Management Department, on a routine basis, reviews:
      i. Results from the quarterly authorization audit conducted by the Alliance Compliance Department. The Department audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.
      ii. Complaints and grievances to identify problems and trends that will direct the development of corrective actions plans to improve performance.
      iii. Quarterly reports of authorizations and claims for non-network specialty referrals.
   b. Inter-Rater Reliability - At least annually and upon hire, the Alliance evaluates the consistency of decision making for those health care professionals involved in applying UM Criteria requiring at a 90% pass rate. The Alliance will immediately provide remediation if the passing threshold is not met. New staff require testing prior to conducting utilization review without supervision.