POLICY AND PROCEDURE

DEPARTMENT: ~~Medical Management~~Population Health Clinical Operations	**DOCUMENT NAME:** Appropriate UM Professionals
PAGE: 1 of 9	**REPLACES DOCUMENT:**
APPROVED DATE: Sept 2011	**RETIRED:**
EFFECTIVE DATE: Jan 2012, 12/15	**REVIEWED/REVISED:** 1/14, 9/15, 7/16, 7/17, 5/18, 9/18, 7/25/19, 10/19, 11/19, 5/20, 5/21, 11/21, 10/22
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.UM.04

SCOPE:
Louisiana Healthcare Connections (Plan) Population Health Clinical Operations Department.

PURPOSE:
To ensure qualified licensed health professionals assess the clinical information used to support Utilization Management (UM) decisions.

POLICY:
Appropriately licensed, qualified health professionals supervise the UM process and all medical necessity decisions. A Louisiana licensed physician must make final determination on all medical necessity denials of healthcare services offered under the Plan's medical and behavioral health benefits. The physician shall attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise. (Model Contract 2.12.5.2.1~~Emergency contract 8.1.17~~)
Appropriate practitioners include:

- Physicians – for all types of denials
- Behavioral health practitioners, including psychiatrists, doctoral level clinical psychologists or certified addiction medicine specialists – for behavioral healthcare denials
- Chiropractors – for chiropractic denials
- Dentists – for dental denials
- Pharmacists – for pharmaceutical denials
- Physical therapists – for physical therapy denials

The Plan shall ensure that staff consistently and correctly apply authorization criteria and make appropriate determinations, including a process to ensure staff performing below acceptable thresholds on inter-rater reliability tests are not permitted to make independent authorization determinations until such time that the staff member can be retrained, monitored, and demonstrate performance that meets or exceeds the acceptable threshold. (Model Contract 2.12.5.3)

The physician(s) making these determinations shall have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital,

governmental agency or unit, or regulatory body that raise a substantial question as to the physician's' physical, mental, ~~professional~~professional, or moral character. Physician must have active unencumbered Louisiana license in accordance with State laws and regulations and is not designated to serve in any other non-administrative position. (Model Contract 2.12.5.4)~~Emergency Contract 8.1.16~~)

Qualified licensed health professionals, who are appropriately trained in the principles, procedures, and standards of utilization and medical necessity review, will conduct authorization and/or concurrent reviews utilizing generally accepted evidenced-based clinical criteria and may approve services. Licensed supervisory staff such as the Vice President of Population Health and Clinical Operations (PHCO) or UM Directors/Managers/Supervisors:

- Provide supervision of assigned UM staff
- Participate in staff training
- Monitor for consistency in the application of criteria by UM staff for each level and type of UM decision
- Monitor documentation for accuracy and appropriateness
- Are available to UM staff on site or via telephone

Non-licensed staff may collect non-clinical data and structured clinical data for preauthorization and concurrent review, under the supervision of appropriately licensed health professionals. They may also have the authority to approve, but not to deny, services for which there are explicit criteria. Non-licensed staff do not conduct any activities requiring evaluation or interpretation of clinical information. All non-licensed staff are supervised by licensed staff and have qualified licensed staff available to them for assistance at all times.

PROCEDURE:

Appropriate staffing will be determined based on membership and Plan requirements. Personnel employed by or under contract with the Plan to perform utilization review are appropriately trained, qualified and currently licensed in the State as applicable or based upon accrediting or federal regulations.

The Plan shall provide staff specifically assigned to Specialized Behavioral Health Services (SBHS) and Permanent Supportive Housing (PSH) to ensure appropriate authorization of tenancy services. (Model Contract 2.12.5.5.1-2)

POLICY AND PROCEDURE

DEPARTMENT: ~~Medical Management~~Population Health Clinical Operations	**DOCUMENT NAME:** Appropriate UM Professionals
PAGE: 3 of 9	**REPLACES DOCUMENT:**
APPROVED DATE: Sept 2011	**RETIRED:**
EFFECTIVE DATE: Jan 2012, 12/15	**REVIEWED/REVISED:** 1/14, 9/15, 7/16, 7/17, 5/18, 9/18, 7/25/19, 10/19, 11/19, 5/20, 5/21, 11/21, 10/22
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.UM.04

1. Licensed Health Professionals

a) Chief Medical Officer/Medical Director (CMO/MD)

The CMO oversees care management and is responsible for the proper authorization and provision of care benefits and services to members. The CMO is also significantly involved in the Quality Improvement (QI) Program including grievance and appeals and is the Chair of the QI Committee. The CMO is a full-time physician (32 hours/week) with an active unencumbered Louisiana license in accordance with State laws and regulations and is not designated to serve in any other non-administrative position.

Based on the needs of the Plan, a Medical Director, Behavioral Health Practitioner or Associate Medical Director(s) may also be involved in medical review. The CMO, Medical Director and Associate Medical Directors will be licensed physicians and hereafter collectively referred to as 'Medical Director'.

The Medical Director is a physician with an active unencumbered Louisiana license in accordance with state laws and regulations and is required to supervise all medical necessity decisions and conducts Level II medical necessity reviews. Only the Medical Director or other licensed clinical professionals with appropriate clinical expertise in the treatment of an ~~member's~~ enrollee's condition or disease and training in the use of any required assessments shall make an adverse determination or authorize a service in an amount, duration or scope that is less than requested based on medical necessity. (Model Contract 2.12.5.2~~Emergency contract 8.1.15 and 8.4.2.3)~~

The CMO and Medical Director's job descriptions are held by the Human Resource Department.

b) Behavioral Health Provider

A behavioral health provider is involved in implementing, monitoring, and directing the behavioral health care aspects of the UM program. The behavioral health provider may be a clinical director, a network practitioner, or a behavioral health delegate.

A physician, appropriate behavioral health practitioner (i.e. doctoral-level clinical psychologist or certified addiction-medicine specialist), or pharmacist, as appropriate, reviews any behavioral health care denial of care based on medical necessity.

c) Board-Certified Clinical Consultant
In some cases, the clinical judgment needed for UM decisions is specialized. In these instances, the Medical Director may consult with a board-certified physician from the appropriate specialty for additional or clarifying information when making medical necessity determinations or denial decisions. Appropriate documentation of their clinical judgment will be provided. (LA.UM.04.02.)

Clinical experts outside the Plan may be contacted, when necessary, to avoid a conflict of interest. The Plan defines conflict of interest to include situations in which the practitioner, who would normally advise on a UM decision, made the original request for authorization or determination or is in, or is affiliated with the same practice group as the practitioner who made the original request or determination.

d) Service Consultants
In some cases, the UM staff must call upon service experts outside the Plan to assist in making authorization determinations for specialty services. In these instances, a licensed/certified service consultant specializing in the area of service in question will be contacted. Specialty Service Consultants may include but are not limited to: Occupational Therapists, Physical Therapists, Speech Therapists, Physician Assistants, Certified Nurse Practitioners, Psychiatrists, Psychologists, etc. As noted above, only appropriate practitioner types specified in this policy can review denials of care based on medical necessity applicable to their scope of practice.

e) Vice President/Director of Population Health and Clinical Operations (VPPHCO)
The VPPHCO is a registered nurse, physician's assistant or physician with an active unencumbered Louisiana license and with experience in UM activities. The VPPHCO is responsible for overseeing the day-to-

day operational activity of the Plan's Physical Health (PH) UM Program and care management staff. ~~.~~ The VPPHCO, in collaboration with the CMO, assists with the development of the UM strategic vision in alignment with Corporate and Plan objectives, policies and procedures.

f) ~~*Centene Advanced*~~ *Behavioral Health Vice President of UM/Clinical Operations*

The ~~Centene Advanced~~ Behavioral Health ~~(CABH)~~ Vice President (VP) of UM/Clinical Operations is a licensed Doctorate or Masters' Level Licensed Clinicians with experience in utilization management activities. The Vice President of UM/Clinical Operations is responsible for overseeing the day-to-day operational activities of the UM Program

~~f)~~g) Utilization Management Director/Manager

The PH UM Director/Manager is a registered nurse and coordinates the activities of the UM Department including supervision of the referral specialist staff, prior authorization, UM clinical reviewers and correspondence unit staff. The UM Director/Manager reports to the VPPHCO and works in conjunction with the Care Management Director to execute the strategic vision in conjunction with Corporate and Plan objectives and attendant policies and procedures and State contractual responsibilities.

h) UM Leaders

The ~~CABH~~BH UM leaders are Doctorate or Masters' Level Licensed Clinicians. The Utilization Management Directors/Managers direct and coordinate the daily activities of the department, including supervision of the licensed and non-licensed UM staff, and in conjunction with the ~~CABH~~BH UM VP of UM/Clinical Operations, assists with the development of the UM strategic vision in conjunction with the company objectives, policies, and procedures.

~~g)~~i) Prior Authorization/Concurrent Review (PA/CCR) Staff or Licensed Mental Health Professionals (LMHP)

PA/CCRs are nurses or LMHPs with clinical and preferably UM experience. UM clinical reviewers 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 UM Director/Manager. LMHPs are specifically assigned to specialized behavioral health services, Inpatient psychiatric hospital and CCR utilization reviews to ensure appropriate authorization and utilization of behavioral health services. At any level, UM clinical reviewers or LMHPs are prohibited from making adverse medical necessity determinations. When a request for authorization of services does not meet the standard UM criteria, the case is referred to the Medical Advisor for a medical necessity review. The Plan shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the ~~member's~~ enrollee's health condition made by the provider.(Model Contract 2.12.8.5 & 2.12.6.3.2~~Emergency Contract 8.4.5.1 & 8.5.3.2~~)

A Level I review is conducted on covered medical benefits by a UM clinical reviewer who has been appropriately trained in the principles, procedures, and standards of utilization and medical necessity review. A Level I review is conducted utilizing applicable medical policies, ~~or~~ McKesson's InterQual® criteria or ASAM criteria, while taking into consideration the individual ~~member~~ enrollee needs and complications at the time of the request, in addition to the local delivery system available for care. At no time shall a Level I review result in a reduction, denial, or termination of service. Adverse determinations can only be made by a Medical Director, or qualified designee, during a Level II review. The adverse determination letter to the provider will be provided within the timeframes as noted in LA.UM.05 Timeliness of UM Decisions and Notifications policy and will also include a copy of the criteria used to make the decision. (HB 424/Act 330)

2. Non-Licensed UM Staff

~~a)~~ Referral Specialists (RS)

Referral Specialists are individuals with significant administrative experience in the health care setting. Experience with ICD-10 and CPT

coding is preferred. RS collect demographic data necessary for preauthorization and may also have the authority to approve specific services for which there are explicit criteria or algorithms. RS cannot make clinical determinations, referring all clinical decisions to a UM clinical reviewer. RS may also have the authority to approve specific services for which there are explicit criteria or algorithms. RS report to and are supervised by a Supervisor or qualified designee.

3. Affirmative Statement About Incentives

All individuals involved in the UM decision making process at the Plan, attest annually, via an Affirmative Statement about Incentives, acknowledging that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care, and that the Plan shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any ~~member~~ enrollee in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42CFR §422.210. Staff must attest to this upon employment and annually thereafter. The Affirmative Statement about Incentives module may be found in Centene University – NCQA Affirmative Statements about Incentives. (Model Contract 2.12.5.1~~Emergency Contract 8.1.21~~)

REFERENCES / ASSOCIATED PROCESSES

LA MCO ~~RFP Amendment 11- Section 8 Utilization Management~~
~~LA MCO RFP Amendment 11 Section 4 Staff Requirements and Support Services.~~ Model Contract
Louisiana Administrative Code Title 37 Part XIII
Louisiana House Bill 424 – Act 330
Current NCQA Health Plan Standards and Guidelines
CC.UM.04.02 Use of Board-Certified Consultants
LA.UM.04.02 Use of Board-Certified Consultants
LA.UM.04.01 Affirmative Statement About Incentives
LA.UM.01 UM Program Description
LA.UM.07 Adverse Determination (Denial) Notices

ATTACHMENTS

POLICY AND PROCEDURE

DEPARTMENT: ~~Medical Management~~Population Health Clinical Operations	**DOCUMENT NAME:** Appropriate UM Professionals
PAGE: 8 of 9	**REPLACES DOCUMENT:**
APPROVED DATE: Sept 2011	**RETIRED:**
EFFECTIVE DATE: Jan 2012, 12/15	**REVIEWED/REVISED:** 1/14, 9/15, 7/16, 7/17, 5/18, 9/18, 7/25/19, 10/19, 11/19, 5/20, 5/21, 11/21, 10/22
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.UM.04

DEFINITIONS:

Permanent Supportive Housing (PSH) – Consists of deeply affordable, community-integrated rental housing combined with supportive services that are designed to assist households in gaining and maintaining access to safe, good quality housing. In PSH, the service beneficiary is the tenant and lessee. Tenancy is not contingent upon continued receipt of services.

Specialized Behavioral Health Services (SBHS) – Mental health services and substance use services that are provided outside of primary care, unless furnished in an integrated care setting, and include, but are not limited to, services provided by a psychiatrist, LMHP, and/or mental health rehabilitation provider.

REVISION LOG	DATE
Updated reference to 2013 NCQA Health Plan Standards and Guidelines.	11/13
Reviewed. No changes.	1/14
Removed references to Case Management, Program Coordinators and Program Specialists. Added reference to LMHP to Licensed Health Professionals Section.	9/15
Change to current NCQA instead of date.	9/15
Section A-5, changed denial/appeals staff to correspondence/appeals staff.	7/16
Changed Chief Medical Director (CMD) to Sr. Vice President for Medical Affairs/Medical Director (SVP-MA/MD. Change RFP 8.1.10 to RFP 8.1.10 – 8.1.10.2..	**7/17**
Revised definitions for Licensed Health and Non-Licensed UM Staff according to 2018 UM Program Description. Changed reporting of VPMM to Senior Vice President of Clinical Operations. Revised Affirmative Statement About Incentives according to 2018 UM Program Description. Removed "Clinical Peer" term and definition. Changed LA CCN-P Contract to MCO RFP Amendment 11. Changed CCL.202 to EPC.UM.202. Added LA.UM.01 Program Description to References.	**5/18**
Removed Reference for EPC.UM.202 Qualifications of UM Personnel	**9/18**
Retired to follow CC.UM.04 with LA Addendum	**7/25/19**
Reinstate LA policy with the following changes: Added what Appropriate practitioners include Added that Physician must have active unencumbered Louisiana license in accordance with State laws and regulations and is not designated to serve in any other non-administrative position. Added appropriate RFP references. Added duties of licensed supervisory staff. Added that staffing is based upon accrediting or federal regulations Added Psychiatrists, Psychologists to service consultants.	**10/19**

POLICY AND PROCEDURE

DEPARTMENT: ~~Medical Management~~Population Health Clinical Operations	**DOCUMENT NAME:** Appropriate UM Professionals
PAGE: 9 of 9	**REPLACES DOCUMENT:**
APPROVED DATE: Sept 2011	**RETIRED:**
EFFECTIVE DATE: Jan 2012, 12/15	**REVIEWED/REVISED:** 1/14, 9/15, 7/16, 7/17, 5/18, 9/18, 7/25/19, 10/19, 11/19, 5/20, 5/21, 11/21, 10/22
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.UM.04

Added that RS may approve specific services with explicit criteria. Replaced all references of PA/CCR Nurse with UM clinical reviewer Added that attestation is done annually	
Added Behavioral Health Practitioner as being involved in medical reviews.	**11/19**
Added specific reference to Emergency contract 8.1.15, 8.1.17, 8.4.2.3, 8.5.3.2 and HB 424-Act 330 Added policy references Grammar Changes	**5/2020**
Changed MM to PHCO Changed SVPMA to CMO Added Behavioral Health Provider section Changed denials to correspondence unit Changed Medical Director to Advisor Changed Cornerstone to Centene University	**5/2021**
No Revisions	**11/2021**
Changed Department from Medical Management to PHCO Added ASAM criteria Added BH Leadership Grammatical changes Changed member to enrollee Updated Contract references Added contract language for staff assigned to SBHS and PSH	**10/2022**

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer is considered equivalent to a physical signature.

Sr. VP, Population Health _____Electronic Signature on File_____
Chief Medical Officer:_____Electronic Signature on File_____