POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Clinical Decision Criteria and Application
PAGE: 1 of 7	**REPLACES:**
APPROVED DATE: 9/11	**RETIRED:**
EFFECTIVE DATE: 1/12, 2/15, 12/15	**REVIEWED/REVISED:** 07/13, 11/13; 4/14, 11/14, 6/15, 9/15, 5/16, 4/17, 4/18, 4/19, 8/19, 10/19
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.UM.02

SCOPE:
Louisiana Healthcare Connections (Plan) Medical Management Department

PURPOSE:
To ensure clinical decisions are made and documented using all relevant clinical information and are based on written, nationally recognized clinical decision support criteria.

POLICY:
Plan and delegated vendors (as applicable) use written clinical support criteria that are objective and

- Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field
- Consider the needs of the members
- Are adopted in consultation with contracting health care professionals
- Are reviewed annually and updated as appropriate

Criteria are used to evaluate medical necessity, level of care, and/or clinical appropriateness of select services including inpatient hospitalization and outpatient services. The Plan shall use Louisiana Department of Health (LDH) medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for medical necessity determinations. The Plan shall make medical necessity determinations that are consistent with the State's definition. (RFP 8.1.11)

PROCEDURE:

I. Clinical Criteria

A. Evidence-based, nationally recognized clinical support tools:
Plan Utilization Management (UM) staff and delegated vendors (as applicable) consult the following criteria sets when determining medical necessity, level of care, and appropriateness of physical health care:

- Most recently available written/electronic purchased version of McKesson's *InterQual*® Level of Care and Care Planning Criteria for Acute Adult, Acute Pediatric, Long-Term Acute Care, Rehabilitation, Subacute/SNF, Home Care, Outpatient Rehabilitation and Chiropractic, Durable Medical Equipment, Imaging, Behavioral Health and Adult and Pediatric Procedures (RFP 8.1.6)
- Medicare National Coverage Determinations

- Plan's Medical Management Guidelines for therapies and rehabilitation
- Local state and/or regulatory guidelines, where applicable, may also be used in making UM decisions.
- While *clinical practice guidelines* *are not* used as criteria for medical necessity determinations, the Plan's Medical Director and UM staff will ensure that UM decisions are consistent with guidelines distributed to network providers. Such guidelines will include, but not be limited to, Preventive Health (adult and child), Asthma, Prenatal Care, Diabetes, and Synagis
- Centene's Clinical Policy Committee will determine clinical policy related to new and emerging technologies and new uses for existing technologies and these clinical policies will be available to Plan Medical Director(s) (see associated policy). Clinical policies are reviewed and updated at least annually by the committee. Plan Medical Director(s) will also have access to the CMS National Coverage Decisions database/manual and the Hayes, Inc. health technology assessments on-line
- The Plan will coordinate the development of clinical practice guidelines with other LDH Plans to avoid providers receiving conflicting practice guidelines from different Plans
- American Society of Addiction Medicine (ASAM) for substance use disorders

B. Annual Review of Criteria

Updates and revisions to McKesson's InterQual® Level of Care and Care Planning Criteria are reviewed annually during the Plan's Medical Management Committee (MMC) and Quality Assurance Performance Improvement Committee (QAPIC) meetings. All clinical policies created/updated by the Clinical Policy Committee are also presented for review and adoption at the Plan MMC and QAPIC meetings. At this time, local practitioners with professional knowledge or clinical expertise in the area being reviewed have an opportunity to give advice or comment on adoption of UM criteria and on instructions for applying the criteria.

C. Availability of Criteria:

Providers are notified via the comprehensive new provider orientation, the Provider Manual, and provider newsletters of the criteria utilized by the Plan for medical necessity determinations. The Provider Manual,

newsletters, and other provider information are also available on the Plan web site. These communications include notification that treating providers may, at any time, request UM criteria pertinent to a specific authorization by contacting the Medical Management Department via the designated email box; or may discuss the UM decision with the Plan Medical Director.

Criteria will also be provided as required by HB 424-Act 330:

- With the PA denial notices by either:
    - providing instructions for accessing the applicable law, regulation, policy, procedure, or medical criteria or guideline if housed within the public domain OR
    - a copy of the applicable law, regulation, policy, procedure, or medical criteria or guideline
- Upon request from a provider via the designated email box exclusively used for Prior Authorization (PA) Criteria Requests; in which a response with criteria will be provided within twenty-four (24) hours from the time of receipt of email request (see corresponding Work Process LA.UM.02.13 Tracking Disclosure of Medical Necessity Criteria).

Members may request UM criteria pertinent to a specific authorization request by contacting the Medical Management Department.

II. Clinical Criteria Application

A. Levels of Clinical Review

Clinical criteria are applied to determine medical necessity and/or appropriate level of care for the service being requested. Two levels of UM clinical review are available for all authorization requests.

a. Level I review is conducted by a UM Clinical Reviewer (Prior Authorization Nurse, Concurrent Review Nurse, LPC, LCSW, etc.) who has been appropriately trained in the principles, procedures, and standards of utilization and medical necessity review. A Level I review is conducted utilizing the appropriate clinical criteria set or applicable medical policy, while taking into consideration the individual member 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 a service. Adverse determinations can only be made by a Medical Director, or qualified designee, during a Level II review

b. Level II review is conducted by the Plan's Medical Director, an appropriately licensed practitioner, or other health care professional as appropriate to the type of service being reviewed. All Level II reviews shall be conducted utilizing the appropriate clinical criteria set or applicable medical policy with consideration given to continuity of care, individual member needs at the time of the request and the local delivery system available for care. A board-certified consultant may also be used in making a medical necessity determination

B. Consistency in Applying Criteria:

Annual Inter-rater Reliability (IRR) testing is performed on all staff involved in UM decision making to ensure consistency in determinations and documentation is being attained. (See associated Work Process)

- All current InterQual® users will be tested at least annually. This includes all Medical Directors and UM Clinical Reviewers who use InterQual®
- All new employees must be tested within ninety (90) days of initial Interqual® training, regardless of any pre-employment test or as directed by Centene Corporation.
- Temporary staff required to use InterQual® must be tested prior to working in the live authorization system
- Staff will be kept updated related to any changes of the InterQual® system as needed based on when changes occur
- Staff will be re-trained as needed based on annual testing results. When wide-spread issues are identified as a result of IRR testing, the corrective action plan can include, but is not limited to:
    a. In-service training for all staff
    b. Modifications to on-line documentation standards
    c. Modifications to the criteria set after approval by the Clinical Policy Committee or,
    d. Development of internal checklists/guides for staff use.

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III. Oversight of Delegated Activities

A. Plan may, at their discretion, delegate UM activities, including adoption or development of utilization decision criteria, to qualified subcontracted vendors.

B. The Plan is accountable for delegated UM services and monitors performance of these services. Initial monitoring occurs through the approval of the delegate's UM program, policies and procedures (or the delegated portions of the program). Subsequent performance reviews are achieved through routine reporting and at least annual evaluation. The evaluation criteria are NCQA or Plan/State standards. The Plan also retains the right to reclaim the responsibility for performance of this function should standards not be maintained.

REFERENCES:
LA.UM.01 - Utilization Management Program Description
LA.UM.02.01 – Medical Necessity Review
LA.UM.02.05 – Inter-rater Reliability
LA.UM.02.13 Tracking Disclosure of Medical Necessity Criteria
RFP Amendment 11 Section 8.1.11
CMS National Coverage Decisions Database (online at https://www.cms.hhs.gov/mcd/overview.asp)
Current NCQA Health Plan Standards and Guidelines
Code of Federal Regulations – 42 CFR 422
House Bill 424- Act 330

ATTACHMENTS:

LA.UM.02
Attachment - InterQ

InterQual Corporate Policy Variances

DEFINITIONS:
Local Coverage Determination: An LCD, as established by Section 522 of the Benefits Improvement and Protection Act, is a decision by a fiscal intermediary or carrier whether to cover a particular service on an intermediary-wide or carrier-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the service is reasonable and necessary).
Medical Director: As used in this policy, a collective term for the Chief Medical Director (CMD), Medical Director or Associate Medical Director.

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Medically Necessary: Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary." The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing services at his discretion on a case-by-case basis. (RFP 6.1.9.1, RFP 8.1.11 The MCO shall use DHH's medical necessity definition as defined in LAC 50:I1101)

National Coverage Determinations: An NCD sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis. Medicare contractors are required to follow NCDs. If an NCD does not specifically exclude/limit an indication or circumstance, or if the item or service is not mentioned at all in an NCD or in a Medicare manual, it is up to the Medicare contractor to make the coverage decision (see LCD). Prior to an NCD taking effect, CMS must first issue a Manual Transmittal, CMS ruling, or Federal Register Notice giving specific directions to claims-processing contractors. That issuance, which includes an effective date and implementation date, is the NCD. If appropriate, CMS also changes billing and claims processing systems and issues related instructions to allow for payment. The NCD will be published in the Medicare National Coverage Determinations Manual. An NCD becomes effective as of the date listed in the transmittal that announces the manual revision.

National Coverage Policy: A policy developed by CMS that indicates whether and under what circumstances certain services are covered under the Medicare program. It is published in CMS regulations, published in the Federal Register as a final notice, contained in a CMS ruling, or issued as a program instruction.

UM Clinical Reviewer: Member of the UM department who has been appropriately trained in the principles, procedures, and standards of utilization and medical necessity review. See LA.UM.04 Appropriate UM Professionals for UM department staff titles, qualifications and reporting structure.

REVISION	DATE
Updated reference to NCQA 2013 Standards and Guidelines	11/13
Updated change in committee name from UM to MM to match change adopted in 2/14. Grammatical corrections. Updated NCQA date.	4/14
LA Procurement 2015 Policy Update, ® added to InterQual references	11/14

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Updated NCQA reference	6/15
Added CCL.246 to references	9/15
Added Behavior Health Added Utilization Management for UM Changed referrals to services Changed CM to CCR Changed testing criteria	5/16
Changed Department of Health & Hospitals to Louisiana Department of Health	4/17
Changed Department of Health & Hospitals to Louisiana Department of Health	4/18
Changed UM Designee to UM Clinical Reviewer, Updated to reflect current process. Added attachment named InterQual Corporate Policy Variances	4/19
Added new process for release of criteria as necessary per new House Bill 424- Act 330 requirement Added references to House Bill 424 and policy for Tracking Disclosure of Criteria	8/19
Updated attachment to include Discharge Planning	10/19

POLICY AND PROCEDURE APPROVAL

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

Vice President Medical Management: _____Electronic Signature on File_____
Chief Medical Director: _____Electronic Signature on File_____