POLICY AND PROCEDURE

POLICY NAME: Appropriate Utilization ManagementUM Professionals	**POLICY ID:** LA.UM.04
BUSINESS UNIT: Louisiana Healthcare Connections	**FUNCTIONAL AREA:** Utilization Management
EFFECTIVE DATE: 09/01/2011	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE: 1/14, 9/15, 7/16, 7/17, 5/18, 9/18, 7/19, 10/19, 11/19, 5/20, 5/21, 11/21, 12/22, 09/2023,, 06/03/2024	
REGULATOR MOST RECENT APPROVAL DATE(S): N/A	

POLICY STATEMENT:

All Aareas and Ddepartments within Centene Corporation and its subsidiaries must have written Policies and Procedures that address core business processes related to, among other things, compliance with laws and regulations, accreditation standards and/or contractual requirements.

PURPOSE:

The purpose of this policy is to ensure qualified licensed health professionals assess the clinical information used to support uUtilization mMmanagement (UM) decisions.

SCOPE:

This policy applies to employees of the Utilization ManagementUM Ddepartment. This includes officers, directors, consultants, and temporary workers (collectively, the "Plan").

DEFINITIONS:

Permanent Supportive Housing ~~(PSH)~~(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 Permanent Supportive Housing~~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, licensed mental health professional (LMHP), and/or mental health rehabilitation provider.

POLICY:

Appropriately licensed, qualified health professionals supervise the ~~utilization management~~UM process and all medical necessity decisions. A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials and appeals of healthcare services offered under the medical benefits~~.~~ (Model Contract 2.12.5.2).

The individual making determinations attests that no adverse determination is made regarding any medical procedure or s service outside of the scope of the individual's expertise~~.~~ (Model Contract 2.12.5.2.1).

Appropriate practitioners include:

- Physicians – for all types of denials and appeals~~.~~
- Behavioral health (BH) practitioners, including psychiatrists, doctoral level licensed ~~clinical~~ psychologists or certified addiction medicine specialists – for behavioral healthcare denials and appeals~~.~~
- Chiropractors – for chiropractic denials and appeals~~.~~
- Dentists – for dental denials and appeals
- Pharmacists – for pharmaceutical denials
    - Pharmacists are not considered appropriate appeals reviewers by National Committee for Quality Assurance (NCQA)~~.~~
- Physical therapists – for physical therapy denials and appeals~~.~~

The Plan ensures that staff consistently and correctly apply authorization criteria and make appropriate determinations, including ensuring 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 is retrained, monitored, and demonstrates performance that meets or exceeds the acceptable threshold. (Model Contract 2.12.5.3)

The individual(s) making determinations has 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 clinical peer reviewer's physical, mental, professional, or moral character. (Model Contract 2.12.5.4).

Qualified licensed health professionals, who are appropriately trained in the principles, procedures, and standards of utilization and medical necessity review, 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 dDirectors/mManagers/sSupervisors:

- 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 is 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 provides 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).

Licensed Health Professionals

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

The Chief Medical Officer (CMO) oversees clinical aspects of the UM Program and provides direct support to the UM ~~staff~~ employees in performance of their UM responsibilities. Based on the needs of the Plan, a medical director, ~~behavioral health~~BH practitioner or associate medical director(s) may also be involved in medical review. The CMO, medical director and associate medical directors are ~~licensed physicians and~~ hereafter collectively referred to as 'medical director'.

The Medical Director supervises all medical necessity decisions and conducts level II medical necessity reviews. Delegate (including wholly owned sister organizations and external delegates) staff who are appropriate practitioners (i.e., as listed above and described below) may also make denial decisions based on medical necessity as applicable to their scope of practice. Practitioners who review potential denials of care based on medical necessity must meet the following requirements of the CMO or medical director's job description which include, but are not limited to:

- Education, training, or professional experience in medical or clinical practice.
- A current, unrestricted license to practice medicine in the state unless otherwise allowed by state statutory requirements.

The M~~m~~edical D~~d~~irector is a physician with ~~an~~a current unencumbered Louisiana license in accordance with state laws and regulations and supervises all medical necessity decisions and conducts Level II medical necessity reviews (Model Contract 2.2.2.4.4.3).

Only licensed clinical professionals with appropriate clinical expertise in the treatment of an enrollee's condition or disease, and training in the use of any required assessments, make an adverse determination or authorize a service in an amount, duration or scope that is less than requested. (Model Contract 2.12.5.2).

The CMO and medical director's job descriptions are held by the Human Resource Department.

Behavioral Health Clinician

A BH~~behavioral health~~ clinician is involved in implementing, monitoring, and directing the behavioral health care aspects of the UM ~~p~~Program.

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

Pharmacists

The P~~p~~harmacist is a licensed pharmacist in the state of contract. The P~~p~~harmacist is the point of contact for ~~physicians~~ providers regarding concerns with the preferred drug list. They review pharmacy prior authorization requests that do not meet criteria and make an appropriate determination; determinations may be made in conjunction with the medical director as needed.

Board-Certified Clinical Consultant

In some cases, the clinical judgment needed for UM decisions is narrowly specialized. In these instances, the M~~m~~edical D~~d~~irector 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 is provided. Refer to policy ~~(~~LA.UM.04.02 Use of Board-Certified Consultants.~~)~~

~~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.~~

Service Consultants

In some cases, the UM ~~staff~~ employees must call upon service experts 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 is contacted. Specialty s~~S~~ervice c~~C~~onsultants may include but are not limited to~~:~~ occupational therapists, physical therapists, speech therapists, physician assistants, certified nurse practitioners, psychiatrists, psychologists, etc. (LA.UM.04.02 Use of Board-Certified Consultants). As noted above, only appropriate practitioner types specified in this policy can assign denials of care based on medical necessity applicable to their scope of practice.

Vice President of Population Health and Clinical Operations (VP or Director of PHCO) ~~(or Director of PHCO)~~

The VP of PHCO is a registered nurse or an appropriately licensed behavioral health professional with experience in ~~utilization management~~UM activities~~. The VP of PHCO is~~and is responsible for overseeing the day-to-day operational activities of the UM Program.

~~***Behavioral Health Vice President of UM/Clinical Operations***~~

~~The Bbehavioral Hhealth Vice President (VP) of UM/Clinical Operations are licensed doctorate or masters' level licensed clinicians with experience in utilization management activities.~~

Utilization Management Unit Head

The UM U~~u~~nit H~~h~~ead is a registered nurse or an appropriate licensed BH professional. The UM U~~u~~nit H~~h~~ead, such as, ~~(e.g.,~~ UM Director/Manager,~~)~~ directs and coordinates the daily activities of the department including supervision of the program coordinators, ~~referral~~ program specialists~~,~~, prior authorization, UM clinical reviewers and correspondence unit staff. The UM unit head, in conjunction with the VP of PHCO, assists with the development of the UM strategic vision in conjunction with the company objectives, policies, and procedures.

~~Reports to the VP of PHCO 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 responsible UM Leaders.~~

~~The 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 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.~~

Prior Authorization/Concurrent Review Staff or Licensed Mental Health Professionals (LMHP)

Prior authorization/concurrent review employees~~staff~~ 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 d~~D~~irector/m~~M~~anager.

UM clinical reviewers conduct level I reviews for medical necessity and have access to an appropriate licensed health care professional for consultation if needed. They apply approved UM criteria and perform reviews for requested services and for concurrent review. UM clinical reviewers 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 Director for a level II medical necessity review.

The Plan ensures that initial and concurrent inpatient psychiatric hospital utilization reviews are completed by a ~~Licensed Mental Health Professional (~~LMHP~~)~~, psychiatrist, or registered nurse with the appropriate clinical expertise for each enrollee~~.~~ (Model Contract 2.12.8.5).

The Plan does not 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 enrollee's health condition made by the provider~~.~~ (Model Contract 2.12.6.3.2).

~~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, Change Healthcare® criteria or ASAM criteria, while taking into consideration the individual 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 services. 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 is provided within the timeframes as noted in LA.UM.05 Timeliness of UM Decisions and Notifications policy and also includes a copy of the criteria used to make the decision. (HB 424/Act 330)~~

Non-Licensed UM ~~Staff~~Employees

Intake Operations Director/Manager

The Intake Operations Director/Manager directs and coordinates the activities of the department including supervision of the intake specialists, vertexers, medical records staff, and escalation specialist. The Intake Operations Director/Manager reports to the Staff VP of Intake Operations.

~~Referral~~ Intake Specialists ~~(RS)~~

~~Referral~~ Intake specialists are individuals with administrative experience in the health care setting. Experience with diagnosis and procedure coding is preferred. The intake specialists~~RS~~ are responsible for reviewing service requests for completeness of information, collecting demographic data necessary for pre-certification, and authorizing referrals to specialty providers. ~~RS~~ Intake specialist cannot make clinical determinations and are required to refer all clinical decisions to a c~~C~~are m~~M~~anager. They report to and are supervised by the UM unit head, or qualified designee.

Program Coordinators

Program coordinators (PC) are trained non-clinical employees with significant experience in a health care setting such as lab technician or medical office assistant. PCs assist the CM with administrative duties such as follow-up calls, screening assessments, obtaining tests results, coordinating home health services, and arranging transportation. They may attend marketing and outreach meetings and coordinate services with community-based organizations. They work under the direction of the CM and refer all clinical decisions to the CM.

Program Specialists

Program specialists (PS) (also known as social service specialists (SSS)) are employees with background in social services, who may or may not be licensed social workers. The PS is responsible for coordinating psychosocial services for members identified as having special needs. They assist the members with utilization of medical resources related to care management, disease management, and discharge planning. PS are authorized to make referrals and coordinate care plans. Non-licensed PS do not conduct any activities requiring evaluation or interpretation of clinical information. PS are required to refer all potential adverse determinations to the designated Medical Director.

Affirmative Statement About Incentives

All individuals involved in UM decision making, annually sign an 'a~~A~~ffirmative st~~St~~atement about i~~I~~ncentives' acknowledging that UM decisions are based on appropriateness of care and existence of coverage. The organization does not reward practitioners or other individuals for issuing denials of coverage or care. There are no financial incentives for UM decisions makers that would encourage decisions that result in underutilization of services. Refer to ~~(~~LA.UM.04.01 Affirmative Statement About Incentives.~~)~~

The Plan ensures 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 enrollee in accordance with 42 CFR §438.3(i), and 42 CFR §422.208~~.~~ (Model Contract 2.12~~.~~5.1).

REFERENCES:

~~Louisana~~Louisiana ~~LA~~ MCO Model Contract~~:~~
~~2.2.2.4.4.3~~
~~2.12.5.1~~
~~2.12.5.2~~
~~2.12.5.2.1~~
~~2.12.5.3~~
~~2.12.5.4~~
~~2.12.5.5.1-2~~
~~2.12.6.3.2~~
~~2.12.8.5~~
Louisiana Administrative Code Title 37 Part XIII
Louisiana Revised Statute~~Statue~~ (LARS) §46:460.74(B)
Current NCQA Health Plan Standards and Guidelines UM 4: Appropriate Professionals
LA.UM.04.02 Use of Board-Certified Consultants
LA.UM.04.01 Affirmative Statement About Incentives
LA.UM.01 Utilization Management~~UM~~ Program Description
~~LA.UM.07 Adverse Determination (Denial) Notices~~
42 CFR §438.3(i) ~~,~~ Physician incentive plans

42 CFR §422.208 Physician incentive plans: requirements and limitations.

ATTACHMENTS: N/A

ROLES & RESPONSIBILITIES: N/A

REGULATORY REPORTING REQUIREMENTS: LARS §46:460.54 applies to material changes for this policy.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Review	Updated reference to 2013 NCQA Health Plan Standards and Guidelines.	11/25/13
Review	Reviewed. No changes.	01/27/14
Review	Removed references to Case Management, Program Coordinators and Program Specialists. Added reference to LMHP to Licensed Health Professionals Section. Changed to current NCQA, instead of date.	09/29/15
Review	Section A-5, changed denial/appeals staff to correspondence/appeals staff.	07/25/16
Review	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..	07/24/17
Review	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.	05/24/18
Review	Removed Reference for EPC.UM.202 Qualifications of UM Personnel	09/25/18
Review	Retired to follow CC.UM.04 with LA Addendum	07/25/19
Review	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. 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	10/24/19
Review	Added Behavioral Health Practitioner as being involved in medical reviews.	11/22/19
Review	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	05/27/20
Review	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	05/27/21
Review	No Revisions	11/19/21
Review	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, Reformatted to new policy template	12/12/22
Annual Review	Updated policy statement and scope. Aligned with corporate policy/wording when not Model Contract specific. Added 2.23.5.2 language, added 2.2.2.4.4.3 reference, Added pharmacist and program specialist role. Removed BHVP and UM leaders role as not in contract or corporate policy, Updated references.Style guide changes.Removed CCR abbreviation as not approved.	09/2023
Annual Review	Grammatical and formatting edits. Updated references. Under CMO added level II review information. Updated roles and responsibilities to align with most current structure. Under UM Unit Head added BH professional. ~~.~~Added	06/03/2024

	sections for intake operations director/mgr, program coordinators, program specialists. Updated referral specialist to intake specialist. Updated BH title to doctoral level licensed psychologists.	

POLICY AND PROCEDURE APPROVAL

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