POLICY AND PROCEDURE

POLICY NAME: Appropriate UM Professionals	**POLICY ID:** LA.UM.04
BUSINESS UNIT: Louisiana Healthcare Connections~~LHCC~~	**FUNCTIONAL AREA:** Utilization Management~~PHCO~~
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	
REGULATOR MOST RECENT APPROVAL DATE(S): ~~n/a~~N/A	

POLICY STATEMENT:

All areas and departments 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.

~~This policy outlines appropriate UM professional staffing.~~

PURPOSE:

The purpose of this policy is ~~T~~to ensure qualified licensed health professionals assess the clinical information used to support Utilization Management (UM) decisions.

SCOPE:

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

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

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.

POLICY:

Appropriately licensed, qualified health professionals supervise the utilization management 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) ~~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 individual making determinations attests that no adverse determination is made regarding any medical procedure or service outside of the scope of the individual's expertise. [AB1]~~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)

Appropriate practitioners include:

- Physicians – for all types of denials and appeals.
- Behavioral health practitioners, including psychiatrists, doctoral level 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 NCQA.
- Physical therapists – for physical therapy denials and appeals.

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

The ~~physician~~individual(s) making ~~these~~ determinations ~~shall have~~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 ~~physician's'~~ clinical peer reviewer's physical, mental, professional, or moral character. (Model Contract 2.12.5.4) ~~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.~~

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~~staff.
- Participate in staff ~~training~~training.
- Monitor for consistency in the application of criteria by UM staff for each level and type of UM ~~decision~~decision.
- Monitor documentation for accuracy and ~~appropriateness~~appropriateness.
- Are available to UM staff on site or via ~~telephone~~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~~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 ~~shall~~ 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 in performance of their UM responsibilities. ~~The CMO oversees care management and is responsible for the proper authorization and provision of care benefits and services to enrollees. 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~~medical director, behavioral health practitioner or associate ~~Medical Director~~medical director(s) may also be involved in medical review. The CMO, ~~Medical Director~~medical director and associate ~~Medical Director~~medical directors ~~will be~~are licensed physicians and hereafter collectively referred to as '~~Medical Director~~medical director'.

The ~~Medical Director~~medical director is a physician with an ~~active~~ current unencumbered Louisiana license in accordance with state laws and regulations and ~~is required to~~ supervises all medical necessity decisions and conducts Level II medical necessity reviews (Model Contract 2.2.2.4.4.3).

Only ~~the Medical Director or other~~ 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, ~~shall~~ 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~~medical director's job descriptions are held by the Human Resource Department.

Behavioral Health ~~Provider~~Clinician

A behavioral health ~~provider~~ clinician 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.~~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.

Pharmacists

The pharmacist is a licensed pharmacist in the state of contract. The pharmacist is the point of contact for physicians 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 ~~Medical Director~~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~~is provided. (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 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~~is 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. (LA.UM.04.02 Use of Board-Certified Consultants) As noted above, only appropriate practitioner types specified in this policy can ~~review~~ assign denials of care based on medical necessity applicable to their scope of practice.

Vice President of Population Health and Clinical Operations (VP of PHCO) (or Director of PHCO)
The VP of PHCO is a registered nurse with experience in utilization management activities. The VP of PHCO is responsible for overseeing the day-to-day operational activities of the UM Program.

~~**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~~ [AB2]~~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.~~

Behavioral Health Vice President of UM/Clinical Operations

The behavioral health Vice President (VP) of UM/Clinical Operations ~~is a~~are licensed doctorate or masters' level licensed clinicians with experience in utilization management activities. [CLCF3]

~~The Vice President of UM/Clinical Operations is responsible for overseeing the day-to-day operational activities of the UM Program.~~[AB4]

Utilization Management ~~Director/Manager~~Unit Head

The ~~PH~~ UM ~~Director/Manager~~unit head is a registered nurse. The UM unit head (e.g., UM Director/Manager[~~CLCF5~~]) directs and coordinates the daily activities of the ~~UM~~ department including supervision of the referral specialists, ~~program specialists, program coordinators, and care managersstaff~~[CLCF6], prior authorization, UM clinical reviewers and correspondence unit staff. The UM ~~Director/Manager~~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.

~~r~~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 ~~responsibil~~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. [AB7][CLCF8]

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

Prior authorization/concurrent review staff ~~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. 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. [AB9]~~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~~(Model Contract 2.12.8.5).

~~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~~ does 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 enrollee's health condition made by the provider. (Model Contract ~~2.12.8.5 &~~ 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, ~~McKesson's InterQual~~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~~medical director, or qualified designee, during a Level II review. The adverse determination letter to the provider ~~will be~~is provided within the timeframes as noted in LA.UM.05 Timeliness of UM Decisions and Notifications policy and ~~will~~ also includes a copy of the criteria used to make the decision. (HB 424/Act 330)

Non-Licensed UM Staff

Referral Specialists (RS)

Referral specialists are individuals with significant administrative experience in the health care setting. Experience with diagnosis and procedure ICD-10 and CPT coding is preferred. The 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 cannot make clinical determinations and are required to refer all clinical decisions to a Care Manager. They report to and are supervised by the UM unit head, or qualified designee.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.

Affirmative Statement About Incentives

All individuals involved in UM decision making, annually sign an 'Affirmative Statement about Incentives' 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. (LA.UM.04.01 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

The Plan shall 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 §438.6(h3(i), and 42 CFR §422.208., (Model Contract 2.12.5.1) 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 Incentive**REFERENCES:**

LA MCO Model ContractContract:
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 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
42 CFR §438.3(i), §438.6(h),
42 CFR §422.208

ATTACHMENTS: N/A

ROLES & RESPONSIBILITIES: N/A

REGULATORY REPORTING REQUIREMENTS: HB434, Act 319 applies to material changes for this policy.
Which regulator(s) require reporting, what should be reported, when to report, and how to report/who to contact.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED

ReviewAd Hoc Review	Updated reference to 2013 NCQA Health Plan Standards and Guidelines.	11/25/13
ReviewAd Hoc Review	Reviewed. No changes.	01/27/14
ReviewAd Hoc 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
ReviewAd Hoc Review	Section A-5, changed denial/appeals staff to correspondence/appeals staff.	07/25/16
ReviewAd Hoc 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
ReviewAd Hoc 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
ReviewAd Hoc Review	Removed Reference for EPC.UM.202 Qualifications of UM Personnel	09/25/18
ReviewAd Hoc Review	Retired to follow CC.UM.04 with LA Addendum	07/25/19
ReviewAd Hoc 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
ReviewAd Hoc Review	Added Behavioral Health Practitioner as being involved in medical reviews.	11/22/19
ReviewAd Hoc 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
ReviewAd Hoc 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
ReviewAd Hoc Review	No Revisions	11/19/21
Ad Hoc 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

POLICY AND PROCEDURE APPROVAL

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