

POLICY AND PROCEDURE

POLICY NAME: Appropriate Utilization Management 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, 07/09/2024, 05/14/2025, 03/23/2026	
REGULATOR MOST RECENT APPROVAL DATE(S): Please refer to system of record – Archer	

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.

PURPOSE:

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

SCOPE:

This policy applies to employees of [Louisiana Healthcare Connections](#) in the UM Department. This includes officers, directors, consultants, and temporary workers (collectively, the “Plan”).

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 [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 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 Plan ensures that 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 determine service authorization request, denials or authorize a service in an amount, duration or scope that is less than requested \(Model Contract 2.12.5.2\)](#)

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 (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 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 the National Committee for Quality Assurance (NCQA)
- Physical therapists – for physical therapy denials and appeals

[The Plan ensures that employees consistently and correctly apply authorization criteria and make appropriate determinations, including a process to ensure employees performing below acceptable thresholds on inter-rater reliability](#)

~~tests are not permitted to make independent authorization determinations until such time that the employee can be retrained, monitored, and demonstrate performance that meets or exceeds the acceptable threshold (Model Contract 2.12.5.3). The Plan ensures that employees consistently and correctly apply authorization criteria and make appropriate determinations, including ensuring employees performing below the acceptable thresholds on inter-rater reliability tests are not permitted to make independent authorization determinations until such time that the employee 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 employee 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 employees such as the Vice President of Population Health and Clinical Operations (PHCO) or UM directors/managers/supervisors:

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

Non-licensed employees 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 employees do not conduct any activities requiring evaluation or interpretation of clinical information. All non-licensed employees are supervised by licensed employees and have qualified licensed employees 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 employees specifically assigned to SBHS and PSH to ensure appropriate authorization of tenancy services (Model Contract 2.12.5.5.1-2).

Licensed Health Professionals

Chief Medical Officer/Medical Director

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

The Medical Director supervises all medical necessity decisions and conducts level II medical necessity reviews. Delegate employees (including wholly owned sister organizations and external delegates) -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 Medical Director is a physician with 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 clinician is involved in implementing, monitoring, and directing the behavioral health care aspects of the UM Program.

A physician, appropriate BH practitioner (i.e., doctoral level licensed 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 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 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 is provided. Refer to policy LA.UM.04.02 Use of Board-Certified Consultants.

Service Consultants

In some cases, the UM 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 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 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)

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

Utilization Management Unit Head/Director/Manager of UM

The [Director/Manager of UM or Director/Manager of BH UM Unit Head](#) is a registered nurse or an appropriate licensed BH professional. The [Director/Manager of UM Unit Head, such as, UM director/manager, \(e.g., UM director/manager, care management \(CM\) director/manager, etc.\)](#) directs and coordinates the daily activities of the department including supervision of the program coordinators, program specialists, prior authorization, UM clinical review [er ers and correspondence unit](#) employees. The [Director/Manager of 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.

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

Prior authorization/concurrent review employees 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.

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 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).

Non-Licensed UM 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.

Intake Specialists

Intake specialists are individuals with administrative experience in the health care setting. Experience with diagnosis and procedure coding is preferred. The intake specialists are responsible for reviewing service requests for completeness of information, collecting demographic data necessary for pre-certification, and authorizing referrals to specialty providers. Intake specialist cannot make clinical determinations and are required to refer all clinical decisions to a care manager. They report to and are supervised by the [Intake Operations Director/Manager](#)~~UM unit head~~, or qualified designee.

Care Management Support Coordinators

Care management support coordinators (also referred to as care coordinators) are trained non-clinical employees with significant experience in a health care setting such as lab technician or medical office assistant. Care management support coordinators assist the clinical review nurse 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 refer all clinical decisions to and work under the direction of the clinical review nurse.

Care Navigators

Care navigators are employees with background in social services, who may or may not be licensed social workers. The care navigator is responsible for coordinating psychosocial services for enrollees identified as having special needs. They assist the enrollees with utilization of medical resources related to care management, disease management, and discharge planning. Care navigators are authorized to make referrals and coordinate care plans. Non-licensed care navigators do not conduct any activities requiring evaluation or interpretation of clinical information. Care navigators 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 ‘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. 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:

- Louisiana MCO Model Contract:
 - [2.12 Utilization Management](#)
 - [2.2.2.4 Key Personnel Requirements](#)
- Louisiana Administrative Code Title 37 Part XIII
- Louisiana Revised Statute (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 Program Description
- 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 sections for intake operations director/mgr, program coordinators, program specialists. Updated referral specialist to intake specialist. Updated BH title to doctoral level licensed psychologists.	07/09/2024
Annual Review	Updated Program Coordinators to Care Management Support Coordinators. Updated Program Specialist to Care Navigators. Grammatical and formatting edits.	05/14/2025
Annual Review	Updated contract language under the Policy section because of contract amendment. Updated section name Utilization Management Unit Head to Director/Manger of UM. Under the Director/ Manager of UM section updated the term UM Unit Head to Director/Manager of UM or BH. Under the Intake Specialists section updated UM unit head to Intake Operations Director/Manager. Updated references.	03/23/2026

POLICY AND PROCEDURE APPROVAL

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

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