Government Business Division
Policies and Procedures

Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management – Utilization Management	**Associates Performing Utilization Reviews – ~~Core Process –~~ LA**

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
March 27, 2015	April ~~January 7~~24, ~~20~~2019	~~May 3, 2018~~January 7, 2020	~~April 24, 2019~~January 7, 2020
Department Approval/Signature :			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid**	☐ Arkansas	☐ Indiana	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☐ California	☐ Iowa	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☐ Kentucky	☐ New York – Empire	☐ Virginia
	☐ District of Columbia	☒ Louisiana	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Maryland	☐ North Carolina	☐ Wisconsin
	☐ Georgia	☐ Minnesota	☐ South Carolina	☐ West Virginia

POLICY:

To identify requirements for ~~associates~~ individuals performing utilization review (UR) ~~(telephonic and/or onsite)~~ activities~~s~~.

Healthy Blue is required to have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines. Healthy Blue shall use the Louisiana Department of Health's (LDH's) definition of medical necessity as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for medical necessity determinations. Medical necessity determinations are consistent with the State's definition and made by qualified and trained practitioners in accordance with state and federal regulations. The qualifications of staff who determine medical necessity are identified.

Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease. The individual making these determinations shall attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise.
The individual(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 clinical peer reviewer's physical, mental, or professional or moral character.

~~In most instances the organization hires RNs to perform utilization reviews; however, other individuals may possess the qualifications, education and/or experience to successfully perform this function.~~

~~The Louisiana Health Plan will have qualified staff who will determine medical necessity.~~

~~Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.~~

~~The Louisiana Health Plan shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.~~

~~The individual(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 clinical peer reviewer's physical, mental, or professional or moral character.~~

~~The individual making these determinations is required to attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise.~~

All ~~inpatient and outpatient U~~utilization ~~M~~management (UM) denials, based on medical necessity or clinical appropriateness, are made by licensed physicians (or appropriate qualified practitioners), as appropriate to the scope of their expertise and training~~, and as consistent with state and federal regulations and state contracts~~.

UM denials based on administrative criteria may be made by qualified healthcare professionals as defined in this policy~~below~~.

Medical disciplines that may have the qualifications, education, and/or experience to successfully perform UR activities consistent with state and federal regulations include:

- Medical Doctor (MD) and Doctor of Osteopathic Medicine (DO);
- Physician's Assistant (PA);
- Advanced practice nurse (APRN);
- Registered nurse (RN);
- Licensed practical nurse (LPN) and licensed vocational nurse (LVN);
- Independently licensed behavioral health (BH) professionals – includes psychologist, licensed clinical social worker (LCSW), licensed mastered social worker (LMSW), licensed professional counselors (LPC), licensed mental health counselor (LMHC), and licensed marriage and family therapists (LMFT); and
- Licensed occupational, physical, speech and language pathologists.

DEFINITIONS:

** Denotes terms for which Healthy Blue must use the State-developed definition.*

Qualified Practitioner – An appropriately qualified practitioner who makes utilization management medical necessity denial decisions. Depending on the type of case, the qualified reviewer may be a physician, pharmacist, chiropractor, clinical psychologist, dentist, nurse practitioner, physical therapist, or other licensed and qualified practitioner type as appropriate. Licensed health care professionals will include appropriately qualified practitioners in accordance with state laws. Only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested. The individuals who make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the Medical Director or other qualified and trained professionals.

~~Behavioral Health Medical Director: who is a physician with a current, unencumbered Louisiana license as a physician, board-certified in psychiatry with at least three (3) years of training in a medical specialty. The Behavioral Health Medical Director shall devote full time (minimum 32 hours weekly) to the MCO's operations to ensure timely medical decisions, including after-hours consultation as needed. During periods when the Behavioral Health Medical Director is not available, the MCO shall have physician staff to provide competent medical direction. The Behavioral Health Medical Director will share responsibility to manage the behavioral health services delivery system with the Behavioral Health Coordinator, and shall be actively involved in all major clinical and quality management components of the behavioral health services of the MCO. This person shall meet regularly with the Chief Medical Officer. The Behavioral Health Medical Director's responsibilities shall include, but not be limited to the following:~~

~~a) Oversee, monitor, and assist with the management of psychopharmacology pharmacy benefit manager (PBM) activities, including the establishment of prior authorization clinical appropriateness of use, and step therapy requirements for the use of stimulants and antipsychotics for all enrolled members under age 18;~~

~~b) Oversee, monitor and assist with effective implementation of the Quality Management (QM) program;~~

~~c) Work closely with the Utilization Management (UM) of services and associated appeals related to children and youth and adults with mental illness and/or substance abuse disorders (SUD);~~

d) Provide clinical case management consultations and clinical guidance for contracted primary care physicians (PCPs) treating behavioral health-related concerns not requiring referral to behavioral health specialists;
e) Work within each plan to develop comprehensive care programs for the management of youth and adult behavioral health concerns typically treated by PCP's, such as ADHD and depression;
f) Develop targeted education and training for Health Plan PCP's related to commonly-encountered behavioral health issues frequently treated by PCPs;
g) Share responsibility to manage the behavioral health services delivery system with the Behavioral Health Coordinator; and
h) Shall be actively involved in all major clinical and quality management components of the behavioral health services of the MCO.

Concurrent Review Staff to conduct inpatient concurrent review. This staff shall include of a Louisiana licensed nurse, physician, or physician's assistant. The staff will work under the direction of a Louisiana licensed registered nurse, physician or physician's assistant.

Concurrenttinued Stay Review: – Utilization review conducted during a member's continued hospital stay or course of treatment also referred to as concurrent review.

Medically Necessary Services* – 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) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the beneficiary. Any such services must be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the beneficiary requires at that specific point in time. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

Licensed Mental Health Professional (LMHP) – an individual who is licensed in the state of Louisiana to diagnose and treat mental illness or substance disorder acting within the scope of all applicable state laws and their professional license. A LMHP includes individuals licensed to practice independently as:

- Medical Psychologists

- Licensed Psychologists
- Licensed Clinical Social Workers (LCSWs)
- Licensed Professional Counselors (LPCs)
- Licensed Marriage and Family Therapists (LMFTs)
- Licensed Addiction Counselors (LACs)
- Advanced Practice Registered Nurses (must be a nurse practitioner specialist in Adult Psychiatric & Mental Health, and Family Psychiatric & Mental Health or a Certified Nurse Specialists in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health, and Child-Adolescent Mental Health and may practice to the extent that services are within the APRN's scope of practice)

Medical Director/Chief Medical Officer: who is a physician with a current, unencumbered license through the Louisiana State Board of Medical Examiners. The Medical Director must have at least three (3) years of training in a medical specialty and five (5) years' experience post-training providing clinical services. The Medical Director shall devote full time (minimum 40 hours weekly) to the Louisiana Health Plan operations to ensure timely medical decisions, including after-hours consultation as needed. The physician must have achieved board certification in their specialty. During periods when the Medical Director is not available, the Louisiana Health Plan shall have physician staff to provide competent medical direction. The Medical Director shall be actively involved in all major clinical and quality management components of the Louisiana Health Plan.

Medical disciplines: that may have the qualifications, education and/or experience to successfully perform utilization reviews as consistent with state and federal regulations and state contracts:

1) Advanced Practice Nurses (titles vary)
2) Licensed Practical Nurse/Licensed Vocational Nurse (LPN/LVN)
Registered Nurse (RN)
3) Licensed occupational, physical, and speech and language pathologists

Prior Authorization Staff to authorize health care 24 hours per day, 7 days per week. This staff shall include a Louisiana licensed registered nurse, physician or physician's assistant. The staff will work under the direction of a Louisiana licensed registered nurse, physician or physician's assistant.

Precertification Review – Utilization review conducted prior to a member's hospital stay or before rendering treatment.

Post-Service/Retrospective Review: – Utilization review conducted after a member's hospital stay or after treatment has been rendered. Retrospective review does not include subsequent

review of services for which prospective or concurrent reviews for medical necessity and appropriateness were previously conducted.

Subcontractor – A person, agency, or organization with which Healthy Blue has subcontracted or delegated some of its management functions or other contractual responsibilities to provide MCO covered services to its members. A network provider is not a subcontractor by virtue of the network provider agreement with Healthy Blue.

Utilization Management (UM) – Refers to the process to evaluate the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. UM is inclusive of utilization review and service authorization.

Utilization Review (UR) – Evaluation of the clinical necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings, and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective review.
~~**Precertification Review:** Utilization review conducted prior to a member's hospital stay or before the rendering of treatment.~~

~~**The MCO shall**: have a sufficient number of LMHPs, including licensed addiction counselors (LACs), as well as a board-certified psychiatrist and a board-certified addictionologist. If an addictionologist cannot be retained full-time due to limited availability, the MCO shall contract with a qualified consultant. With the exception of the addictionologist who shall be available at least 10 hours per week, the other LMHPs shall be available 24 hours per day/7 days per week. The MCO shall provide UM staff, both experienced and specifically assigned to children, youth, adults, and older adults, and PSH.~~

~~**The Medical Director**: shall be responsible for:~~
~~a) Development, implementation and medical interpretation of medical policies and procedures including, but not limited to, service authorization, claims review, discharge planning, credentialing and referral management, and medical review included in the Louisiana Health Plan Grievance System;~~
~~a) Administration of all medical management activities of the Louisiana Health Plan;~~
~~b) Serve as member of and participate in every quarterly and phone meeting of the Medicaid Quality Committee either in person or by phone. Medical Director may designate a representative with a working understanding of the clinical and quality issues impacting Medicaid; and~~
~~b) Serve as the director of the Utilization Management committee and chairman or co-chairman of the Quality Assessment and Performance Improvement committee.~~

PROCEDURE:

2)1) The health plan Health Care Management (HCM), Call Center Clinical OperationsGovernment Business Division (GBD) Outpatient Precertification (OPC), at the National Customer Care Organization (NCC), andor the Behavioral Health (BH) UM Cclinical Lleaders are accountable for managing the hiring, training, assigningment, and monitoring, and managing of associates performing utilization reviewUR for their respective departments.

4)2) Healthcare professionals (as defined in Definitionsthis policy) must possess the education and current unrestricted licensure to perform the utilization reviewUR functions.

6)3) The appropriate HCM, OPC, NCC, or BH UM Cclinical Lleader may identify othernon-RN licensed professionals (non-RN, such as LPN/LVNs) with sufficient experience and expertise for hiring consideration, to collect data for precertification, and concurrent, and retrospective review and to approve services for which there are explicit criteria. Exceptions for hiring these individuals are based on the licensed associate meeting one (1) or more of the following criteria:

a) Documented experience conducting utilization reviewUR prior to joining the organization;
b) Certification as a Managed Care Nurse (CMCN), Certified Professional in Healthc Care Quality (CPHQ), or similar certification; and/or
c) Experience in training or instruction of UM practices and activities.

8)4) When an exception is made, the HCM, OPC, NCC, or BH UM Cclinical Lleader is responsible for ensuring:

a) That the individual is licensed, properly trained, and supervised; and
b) That the individual has an identified licensed clinicalRN resource to provide oversight and direction.

5) UM supervisors, who are licensed health care professionals, provide oversight and supervision of UM staff, including:
   a) Providing day-to-day supervision of assigned UM staff;
   b) Participating in staff training;
   c) Monitoring for consistent application of UM criteria by UM staff, for each level and type of decision;
   d) Monitoring documentation for adequacy; and
   e) Being available to UM staff on-site or by telephone.
6) Oversight of associates conducting utilization reviewUR includes, at minimum, a documented quarterly review of records by the supervisor to assess the quality, accuracy, and appropriateness of the work product.

~~10)~~

~~12)~~7) All associates conducting ~~utilization reviews~~UR participate annually in the ~~C~~company-wide Inter-Rater Reliability (IRR) program (refer to *Inter-Rater Reliability (IRR) Assessments*).

8) Health plan Medical Directors may refer a case to an outside (external) Medical Consultant to assist in making medical necessity determinations.

a) ~~(All external~~ Medical Consultants are required to be board-~~-~~certified and have an unrestricted current medical license, and may require state approval ~~in some markets)~~.

~~14)~~b) ~~External~~ Medical Consultants may be consulted for matters that include, but are not limited to:

~~a)~~i) Situations involving unusually complex cases; ~~and~~ the facts are not clearly defined, and there are alternative decisions that can be made based upon assessment of the clinical condition of the situation;

~~b)~~ii) Cases requiring special expertise in order to determine medical necessity; and expertise is not readily available within the network of credentialed practitioners to provide a non-biased and evidence-based review;

~~c)~~iii) For the most appropriate management approach or discordance between the treating provider and the health plan Medical Director about the treatment plan; or

~~d)~~iv) An appeal decision mandates an external objective opinion to ensure credibility of the process.

~~16)~~9) A list of board certified physicians is maintained by the ~~each~~ health plan and accessible by ~~health plan~~ Medical Directors for consultation on complex UM cases.

a) Corporate HCM – UM~~Clinical~~ Operations staff maintains the national list of board-certified medical consultants and contracted Independent Review Organizations (IRO) for each health plan on the MD Resource~~HCM~~ SharePoint site. The designated health plan HCM staff notifies UM~~Clinical~~ Operations of updates to their board-certified medical consultants or contracted IRO.

General Staffing Requirements

Healthy Blue shall not employ or subcontract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any federal healthcare program. All potential employees and subcontractors are screened to determine whether any of them have been excluded from participation in federal healthcare programs.

Healthy Blue shall employ sufficient staffing, be staffed by qualified persons in numbers appropriate the size of enrollment, and utilize appropriate resources to achieve contractual compliance. Resource allocation shall be adequate to achieve positive outcomes in all functional areas within the organization. Adequacy shall be evaluated based on outcomes and compliance with the requirements of the Contract, including the requirement for providing

culturally competent services. If Healthy Blue does not achieve the desired outcomes or maintain compliance with contractual obligations, non-compliance action may be employed by LDH, including but not limited to, requiring Healthy Blue to hire additional staff and the application of monetary penalties.

Healthy Blue shall conduct an annual criminal background check on all current or potential employees or subcontractors who have access to enrollee protected health information (PHI). Healthy Blue shall, upon request, provide LDH with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of the Contract.

Healthy Blue shall remove or reassign, upon written request from LDH, any employee or subcontractor employee that LDH deems to be unacceptable, and not hold LDH harmless for actions taken as a result hereto. Healthy Blue may terminate any of its employees designated to perform work or services under the Contract, as permitted by applicable law.

Key Personnel

Healthy Blue shall identify the individuals in key personnel positions included in the Contract. Unless specifically approved by LDH, all key personnel shall be full-time and based in Louisiana. An individual staff member is limited to occupying a maximum of two (2) key personnel positions unless prior approval is obtained from LDH or otherwise stated. Exceptions include the Medical Director/Chief Medical Officer (CMO) and BH Medical Director, who shall not hold another position.

Healthy Blue must inform LDH in writing within five (5) business days when an employee in a key personnel position provides notice of resignation or when the plan has terminated an employee in a key personnel position. Key staff shall be replaced with a person of equivalent experience, knowledge, and talent. The name and resume of the permanent employee should be submitted as soon as the new hire has taken place along with a revised organization chart complete with key staff time allocation. Replacement of the Medical Director/CMO or BH Medical Director shall require prior written approval from LDH.

The following UM positions are designated as key personnel and shall be located in Louisiana:

The **Medical Director/CMO** shall be a physician with a current, unencumbered license through the Louisiana State Board of Medical Examiners. The Medical Director shall have at least three (3) years of training in a medical specialty and five (5) years of experience post-training providing clinical services. The physician shall have achieved board certification in his or her specialty. The Medical Director shall be located in Louisiana and be involved in all major clinical and quality management components of Healthy Blue's activities. The Medical Director shall be

devoted full-time (minimum forty (40) hours weekly) to operations and be responsible for ensuring timely medical decisions, including after-hours consultation, as needed. During periods when the Medical Director is not available, the Healthy Blue shall have physician staff available to provide competent medical direction. The Medical Director shall serve exclusively in this position and may not function in an executive capacity for another insurance product. The Medical Director shall be responsible for:

1) Development, implementation, and medical interpretation of clinical policies and procedures, including, but not limited to, service authorization, claims review, discharge planning, credentialing and referral management, utilization management and medical review included in the Grievance System;
2) Administration of all medical management activities;
3) Coordinating with the BH Medical Director to integrate the administration and management of behavioral and physical health services;
4) Serving as member of and participating in every meeting of the Medicaid Quality Committee in person or by phone. The Medical Director may designate a representative with a working understanding of the clinical and quality issues impacting Medicaid; and
5) Serving as the chairman of the Utilization Management Committee and chairman or co-chairman of the Quality Assessment and Performance Improvement committee.

The **BH Medical Director** shall be a physician with a current, unencumbered Louisiana-license as a physician, board-certified in psychiatry with at least three (3) years of training in a medical specialty. The BH Medical Director shall be located in Louisiana and be actively involved in all major clinical and quality management components of BH services. The BH Medical Director shall be devoted full-time (minimum thirty-two (32) hours weekly) to operations to ensure timely medical decisions, including after-hours consultation, as needed. During periods when the BH Medical Director is not available, Healthy Blue shall have physician staff available to provide competent medical direction. The BH Medical Director shall serve exclusively in this position and may not also function in an executive capacity for another insurance product. The BH Medical Director shall meet regularly with the CMO. The BH Medical Director's responsibilities shall include, but not be limited to, the following:

1) Oversee, monitor, and assist with the management of psychopharmacology pharmacy benefits manager (PBM) activities, including the establishment of prior authorization, clinical appropriateness of use, and step therapy requirements for the use of stimulants and antipsychotics for all enrollees under age eighteen (18);
2) Provide clinical case management consultations and clinical guidance for contracted primary care physicians (PCPs) treating BH-related concerns not requiring referral to BH specialists;
3) Develop comprehensive care programs for the management of youth and adult BH concerns typically treated by PCPs, such as Attention-Deficit/Hyperactivity Disorder (ADHD) and depression;

4) Develop targeted education and training for PCPs to screen for mental health and substance use disorders using evidence-based tools (e.g., AUDIT-C, PHQ-9, and GAD-7), perform diagnostic assessments, provide counseling and prescribe pharmacotherapy when indicated, and build collaborative care models in their practices;
5) Coordinate with the Medical Director to integrate the administration and management of behavioral and physical health services;
6) Oversee, monitor and assist with effective implementation of the Quality Management (QM) program;
7) Work closely with managing utilization of services and associated appeals related to children and youth and adults with mental illness and/or substance use disorders (SUD); and
8) Share responsibility to manage the BH services delivery system with the BH Coordinator.

A **Medical Management Coordinator** shall be a Louisiana-licensed RN, APRN, PA, or physician if required to make medical necessity determinations; or have a master's degree in health services, healthcare administration, or business administration, if not required to make medical necessity determinations, to manage all required Medicaid management requirements under LDH policies, rules and the Contract. This position shall be located in Louisiana. The primary functions of the Medical Management Coordinator include:

1) Ensuring adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria;
2) Ensuring that appropriate concurrent review and discharge planning of inpatient stays is conducted;
3) Developing, implementing and monitoring the provision of care coordination, disease management and case management functions;
4) Monitoring, analyzing and implementing appropriate interventions based on utilization data, including identifying and correcting over- or under-utilization of services; and
5) Monitoring prior authorization functions and assuring that decisions are made in a consistent manner based on clinical criteria and meet timeliness standards.

A **Behavioral Health Coordinator** shall meet the requirements for an LMHP and have at least seven (7) years' experience in managing behavioral healthcare operations. The BH Coordinator shall have responsibility for clinical program development and oversight of staff and services related to the delivery of covered mental health and addiction services to children/youth, adults with serious mental illness and/or with substance use disorders in compliance with federal and state laws and the requirements set forth in the Contract, including all documents incorporated by reference. The BH Coordinator will share responsibility to manage the specialized BH services delivery system with the BH Medical Director. The BH Coordinator shall regularly review integration performance, performance improvement projects, and surveys related to integration and shall work closely with the Performance/Quality Improvement Coordinator and QM Coordinator and BH QM Coordinator. This position shall be based in Louisiana.

An **Addictionologist or Addiction Services Manager (ASM)** shall meet the requirements of a licensed addiction counselor (LAC) or LMHP with at least seven (7) years of clinical experience with addiction treatment of adults and children experiencing substance use problems and disorders. The ASM shall be responsible for oversight and compliance with the addiction principles of care and application of American Society of Addiction Medicine (ASAM) placement criteria for all addiction program development. The ASM will work closely with the Chief Operating Officer, the BH Coordinator, the QM Coordinator, and the BH Medical Director in assuring quality, appropriate utilization management, and adequacy of the addiction provider network. This position shall be located in Louisiana.

Additional Staff Required

Healthy Blue shall have sufficient number of qualified staff with sufficient experience and expertise to meet both physical health services and BH services responsibilities, and shall provide dedicated staff where necessary to meet this obligation including all required timeframes and geographic coverage outlined in the contract, and comply with additional staffing requirements. Healthy Blue must maintain at least fifty percent (50%) of its staff within the state of Louisiana.

In addition to the key personnel requirements, Healthy Blue must have these additional UM staff:

Prior Authorization Staff to authorize health care twenty-four (24) hours per day, seven (7) days per week. This staff shall include a Louisiana licensed registered nurse, advanced practice registered nurse, physician or physician's assistant. The staff will work under the direction of a Louisiana-licensed RN, APRN, PA or physician.

Concurrent Review Staff to conduct inpatient concurrent review. This staff shall include and work under the direction of a Louisiana licensed RN, APRN, PA or physician.

Licensed Mental Health Professionals to perform evaluations for adult mental health rehabilitation services. Whether through subcontract or direct employment, Healthy Blue shall maintain appropriate levels of LMHP staff to ensure adequate local geographic coverage for in field face-to-face contact with enrollees. LMHP staff must be trained to determine the medical necessity criteria as established by the State. LMHPs shall be certified in administering the Level of Care Utilization System (LOCUS).

- Healthy Blue shall have a sufficient number of LMHPs, including LACs, as well as a board-certified psychiatrist and a board-certified addictionologist. If an addictionologist cannot be retained full-time due to limited availability, Healthy Blue shall contract with a qualified consultant. With the exception of the addictionologist who shall be available at least ten (10) hours per week, the other LMHPs shall be available twenty-four (24) hours per day,

seven (7) days per week. Healthy Blue shall provide UM staff, both experienced and specifically assigned to children, youth, adult, and older adult specialized behavioral health services, and permanent supportive housing (PSH) to ensure appropriate authorization of tenancy services.

- Healthy Blue shall ensure that inpatient psychiatric hospital and concurrent utilization reviews are completed by an LMHP for each enrollee referred for psychiatric admissions to general hospitals. Healthy Blue shall comply with the requirements set forth in state administrative rules.
- Healthy Blue shall ensure LMHPs are included in the team responsible for certification and recertification of PRTF services in Louisiana. This shall include a face-to-face assessment by an LMHP or a telephonic/video consultation with an LMHP who has had a face-to-face interview with the child/youth, in addition to the recommendations of the team specified at 42 CFR §441.156.

Major Subcontracts/Subcontractors

Prior to contracting with a major subcontractor, Healthy Blue shall evaluate the prospective major subcontractor's ability to perform the activities to be subcontracted. Healthy Blue shall request prior approval of all major subcontracts, amendments, and substitutions from LDH.

Notwithstanding any relationship Healthy Blue may have with a subcontractor, including major subcontractors, Healthy Blue shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the Contract. No subcontractor will operate to relieve the Contractor of its legal responsibilities under the Contract. As required by 42 CFR §438.3(k), §438.230(a) and § 438.230(b)(1),(2), Healthy Blue shall be responsible to oversee all subcontractors' performance and shall be held accountable for any function and responsibility that it delegates to any subcontractor.

EXCEPTIONS:

Requests for exceptions to mandatory staffing requirements must be submitted in writing to LDH for prior approval. Healthy Blue must address the reason for the request, the organization's ability to furnish services as contractually required with the exception in place, and duration of exception period requested. Healthy Blue shall provide and have an LDH-approved staffing plan that describes how the staffing level will be maintained to ensure the successful accomplishment of all duties including specialized behavioral health related functions. Healthy Blue may propose to LDH a staffing plan that combines positions and functions outlined in the Contract with other positions, provided it describes how staffing roles delineated in the Contract will be addressed.

REFERENCES:

Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management – Utilization Management	**Associates Performing Utilization Reviews – Core Process – LA**

CFR Title 42
Clinical Staff Conflict of Interest Policy
Concurrent Review (Telephonic and On-Site) – LA
Healthcare Management Denial – LA
Health Care Management – Clinical Training Compliance
Inter-Rater Reliability (IRR) Assessments
Louisiana State Contract
NCQA Accreditation Standards and Guidelines
Precertification of Requested Services – LA
Prohibiting the Use of Financial Incentives When Making Medical Necessity Determinations
Retrospective Review – LA
Staff Availability – Core Process
Use of Board Certified Consultants (Medical/Behavioral Health) – LA
Utilization Management Clinicians Responsibilities (Health Plan/Region)
Utilization Management Support Staff
Utilization Management Training

~~Clinical Criteria for Utilization Management Decisions – Core Process~~
~~Governance of Utilization Management Practice~~
~~HB 4290, 28 TAC §19.1703(32) and TIC §4201.305~~
~~Healthcare Management Services Denial – Core Process~~
~~Inter-Rater Reliability (IRR) Assessments~~
~~NCQA Accreditation Standards and Guidelines: Appropriate Professionals, Elements: Licensed Health Professionals, Use of Practitioners for UM Decisions, and Use of Board-Certified Consultants~~
~~Use of Board Certified Consultants (Medical/Behavioral Health) – Core Process~~
~~Utilization Management Training~~

RESPONSIBLE DEPARTMENTS:

Primary Department: ~~–~~Health Care Management – ~~Health Plan~~Utilization Management

Secondary Department(s): Behavioral Health, Government Business Division Outpatient Precertification, National Customer Care Organization

REVISION HISTORY:

Review Date	Changes
03/27/2015	• New~~:~~. ~~C~~created LA-specific version of corporate document~~.~~
02/15/2016~~5~~	• Early annual/~~O~~off cycle review

	• Procedures section update to include updated contract language
05/23/2017	• For annual review • Definitions placed in alphabetical order • References placed in alphabetical order
05/03/2018	• For annual review • Under procedure section duplicative information removed
04/24/2019	• For annual review • No changes
01/07/2020	• Off cycle review; revised for new LA Emergency Contract • Edits to policy, definitions, procedure sections, and references • Exception language added • Secondary departments added for Behavioral Health, Government Business Division Outpatient Precertification, National Customer Care Organization