POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Appropriate UM Professionals
PAGE: 1 of 8	**REPLACES DOCUMENT:**
APPROVED DATE: Sept 2011	**RETIRED:**
EFFECTIVE DATE: Jan 2012, 12/15	**REVIEWED/REVISED:** 1/14, 9/15, 7/16, 7/17, 5/18, 9/18, 7/25/19, 10/19, 11/19, **5/20**
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.UM.04

SCOPE:
Louisiana Healthcare Connections (Plan) Medical Management Department.

PURPOSE:
To ensure qualified licensed health professionals assess the clinical information used to support Utilization Management (UM) decisions.

POLICY:
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 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.
(Emergency contract 8.1.17)
–Appropriate practitioners include:

- Physicians – for all types of denials
- Behavioral health practitioners, including psychiatrists, doctoral level clinical psychologists or certified addiction medicine specialists – for behavioral healthcare denials
- Chiropractors – for chiropractic denials
- Dentists – for dental denials
- Pharmacists – for pharmaceutical denials
- Physical therapists – for physical therapy denials

The physician(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 physician's' physical, mental, professional or moral character. 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. (~~RFP~~ **Emergency Contract** 8.1.16)

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 Medical Management or UM Directors/Managers/Supervisors:

- Provide supervision of assigned UM staff
- Participate in staff training
- Monitor for consistenc~~t~~y 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 will be 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.

1. **Licensed Health Professionals**

a) Sr. Vice President for Medical Affairs/Medical Director (SVP-MA/MD)
The SVP-MA oversees care management and is responsible for the proper authorization and provision of care benefits and services to members. The SVP-MA is also significantly involved in the Quality Improvement (QI) Program including grievance and appeals and is the Chair of the QI Committee. The SVP-MA 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, Behavioral Health Practitioner or Associate Medical Director(s) may also be involved in medical review. The SVP-MA, Medical Director and Associate Medical Directors will be licensed physicians and hereafter collectively referred to as 'Medical Director'.
The Medical Director is a physician with an active unencumbered Louisiana license in accordance with state laws and regulations and is required to supervise all medical necessity decisions and conducts Level II medical necessity reviews. Only the Medical Director or other licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall make an adverse determination **or authorize a service in an amount, duration or scope that is less than requested** based on medical necessity. **(Emergency contract 8.1.15 and 8.4.2.3)**

The SVP-MA and Medical Director's job descriptions are held by the Human Resource Department.

b) Board-Certified Clinical Consultant
In some cases, the clinical judgment needed for UM decisions is 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 will be provided. (LA.UM.04.02.)

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.

c) 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 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. As noted above, only appropriate practitioner types specified in this policy can review denials of care based on medical necessity applicable to their scope of practice.

d) Vice President/Director of Medical Management (VPMM)
The VPMM is a registered nurse, physician's assistant or physician with an active unencumbered Louisiana license and with experience in UM activities. The VPMM is responsible for overseeing the day-to-day operational activity of the Plan's UM Program and care management staff. The VPMM reports to the Senior Vice President of Clinical Operations. The VPMM, in collaboration with the SVP-MA, assists with the development of the UM strategic vision in alignment with Corporate and Plan objectives, policies and procedures.

e) Utilization Management Director/Manager
The UM Director/Manager is a registered nurse and coordinates the activities of the UM Department including supervision of the referral specialist staff, prior authorization, UM clinical reviewers and denials staff. The UM Director/Manager reports to the VPMM 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 responsibilities.

f) Prior Authorization/Concurrent Review (PA/CCR) Staff or Licensed Mental Health Professionals (LMHP)
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. 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. 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 Director for a medical necessity review. **The Plan shall 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 member's health condition made by the provider.**(~~RFP~~ **Emergency Contract** 8.4.5.1 **& 8.5.3.2**)

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 or McKesson's InterQual® criteria, while taking into consideration the individual member needs and complications at the time of the request, in addition to the local delivery system available for care. At no time shall a Level I review result in a reduction, denial, or termination of service. 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 will be provided within the timeframes as noted in LA.UM.05 Timeliness of UM Decisions and Notifications policy and will also include a copy of the criteria used to make the decision. (HB 424/Act 330),**

2. Non-Licensed UM Staff

a) Referral Specialists (RS)

Referral Specialists are individuals with significant administrative experience in the health care setting. Experience with ICD-10 and CPT coding is preferred. 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.

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3. 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 Plan shall ensure 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 member in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42CFR §422.210. Staff must attest to this upon employment and annually thereafter. The Affirmative Statement about Incentives module may be found in the Cornerstone Learning Center (Cornerstone on Demand) – NCQA Affirmative Statements about Incentives. (~~RFP~~ **Emergency Contract** 8.1.21)

REFERENCES / ASSOCIATED PROCESSES
LA MCO RFP Amendment 11- Section 8 Utilization Management
LA MCO RFP Amendment 11 Section 4 Staff Requirements and Support Services.
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

ATTACHMENTS

DEFINITIONS:

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REVISION LOG	**DATE**
Updated reference to 2013 NCQA Health Plan Standards and Guidelines.	11/13
Reviewed. No changes.	1/14
Removed references to Case Management, Program Coordinators and Program Specialists. Added reference to LMHP to Licensed Health Professionals Section.	9/15
Change to current NCQA instead of date.	9/15
Section A-5, changed denial/appeals staff to correspondence/appeals staff.	7/16
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..	**7/17**
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.	**5/18**
Removed Reference for EPC.UM.202 Qualifications of UM Personnel	**9/18**
Retired to follow CC.UM.04 with LA Addendum	**7/25/19**
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	**10/19**
Added Behavioral Health Practitioner as being involved in medical reviews.	**11/19**
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**	**~~5~~06/2020**

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POLICY AND PROCEDURE APPROVAL

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

Sr. VP, ~~Medical Management:~~Population Health _____Electronic Signature on File_____

~~Sr. VP, Medical Affairs~~Chief Medical Officer:_____Electronic Signature on File_____