

POLICY AND PROCEDURE

DEPARTMENT: Medical Management	DOCUMENT NAME: Appropriate UM Professionals
PAGE: 1 of 7	REPLACES DOCUMENT: CC.MEDM.UM.09 Medical/Dental Consultant (12/04)
APPROVED DATE: 3/2006	RETIRED:
EFFECTIVE DATE: 3/2006	REVIEWED/REVISED: 1/12; 1/13; 1/14; 08/14; 01/15; 01/15; 11/15
PRODUCT TYPE: Medicaid, Medicare and HIM	REFERENCE NUMBER: CC.UM.04

SCOPE: Corporate and Plan Medical Management Departments

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 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 of healthcare services offered under the Plan's medical benefits. Appropriate practitioners include:

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

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.

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 does not conduct any activities requiring evaluation or interpretation of clinical information. All non-licensed staff are supervised by licensed staff and have qualified licensed staff available to them for assistance at all times.

PROCEDURE:

Appropriate staffing is determined based on membership and Plan requirements. Personnel employed by or under contract with the Plan to

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perform utilization review are appropriately trained, qualified and currently licensed in the State as applicable.

A. Licensed Health Professionals

1. Chief Medical Officer/Medical Director

The Chief Medical Officer (CMO) oversees clinical aspects of the Utilization Management Program and provides direct support to the UM staff in performance of their UM responsibilities. Based on the needs of the Plan, a Medical Director or associate Medical Director(s) may also be involved in medical review. CMO, Medical Director and Associate Medical Directors, hereafter collectively referred to as “Medical Director”.

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

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

The CMO and Medical Director job descriptions are held by the Human Resource Department.

2. Behavioral Health Provider

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A behavioral health provider 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. Management of the behavioral health program (as covered by each Plan) may be delegated to Cenpatico or other subcontracted vendor.

A physician, appropriate behavioral health practitioner (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.

3. Pharmacists

The Plan Pharmacist is a licensed pharmacist in the state of contract. The Pharmacist is the point of contact for Plan physicians regarding concerns with the preferred drug list. The Pharmacist reviews pharmacy prior authorization requests that do not meet criteria and makes an appropriate determination in conjunction with the Plan Medical Director. Management of the pharmacy benefit (as covered by each Plan) may be delegated to the Pharmacy Benefit Manager (PBM) US Script or other subcontracted vendor.

4. Board-Certified Clinical Consultants

In some cases, the clinical judgment needed for UM decisions are sufficiently 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/denials. Appropriate documentation of their clinical judgment will be provided (*CC.UM.04.02 – Use of Board Certified Consultants*).

5. 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.

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Specialty Service Consultants may include but are not limited to: Chiropractors, Dentists, Occupational Therapists, Physical Therapists, Speech Therapists, Physician Assistants, Certified Nurse Practitioners, etc., (*CC.UM.04.02 – Use of Board Certified Consultants*). 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.

6. Vice President of Medical Management (VPMM) (or Director of Medical Management if Plan does not have a VPMM)
The VPMM is a registered nurse with experience in utilization management activities. The VPMM is responsible for overseeing the day-to-day operational activities of the Plan's UM Program.

7. Utilization Management Unit Head
The Utilization Management Unit Head (UMUH) is a registered nurse. The Utilization Management Unit Head (e.g. Utilization Management Director/Manager, Care Management Director/Manager, etc.) directs and coordinates the daily activities of the department, including supervision of the Referral Specialists, Program Specialists, Program Coordinators, and Care managers. The Utilization Management Unit Head, in conjunction with the Medical Management Department Head, assists with the development of the UM strategic vision in conjunction with the corporate and Plan objectives, policies and procedures.

8. Care Managers
Care Managers (CM) are nurses with clinical and preferably utilization management experience. There are several levels or types of CMs within the organization and as such may be referenced with alternate titles such as: Prior Authorization Nurse, Concurrent Review Nurse, Concurrent Review/Care manager, Hospital Care manager, Complex Care manager, Catastrophic Care manager, Disease Care manager, Care Manager I, Care Manager II, Utilization Manager, etc. Care Managers report to and are supervised by the UMUH or a qualified designee.

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Care Managers 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. Care Managers 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. Care managers are also responsible for the daily coordination of the care management and specialty programs including high-risk conditions and disease specific cases.

B. Non-Licensed UM Staff

1. Referral Specialists/(Marketplace Coordinator for Ambetter)
Referral Specialists (RS) are individuals with administrative experience in the health care setting. Experience with Diagnosis and CPT coding is preferred. The Referral Specialists are responsible for reviewing service requests for completeness of information, collecting demographic data necessary for pre-certification and authorizing referrals to specialty providers. Referral Specialists cannot make clinical determinations and are required to refer all clinical decisions to a Care Manager. Referral specialists report to and are supervised by the UMUH, or qualified designee.

2. Program Coordinators/(Marketplace Coordinator for Ambetter)
Program Coordinators (PC) are highly trained non-clinical staff with significant experience in a health care setting such as lab technician or medical office assistant. PCs assist the Care Manager with administrative duties such as follow-up calls, screening assessments, obtaining tests results, coordinating home health services, and obtaining transportation. They may attend marketing and outreach meetings and coordinate services with community base organizations. They work under the direction of the Care Manager and refer all clinical decisions to the Care Manager.

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3. Program Specialists

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

C. 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. (CC.UM.04.01 - See Affirmative Statement About Incentives).

REFERENCES / ASSOCIATED PROCESSES

UM.01 - Utilization Management Program Description
UM.04.01 – Affirmative Statement About Incentives
UM.04.02 – Use of Board Certified Consultants
NCQA 2016 MCO Standards and Guidelines
TruCare Training Manual

ATTACHMENTS

DEFINITIONS:

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REVISION LOG

REVISION	DATE
Updated References to reflect 2012 NCQA Standards.	1/25/12
Annual Review: Removed reference to Vice President Medical Affairs (VPMA) updating to reflect Chief Medical Officer (CMO); minor formatting changes; updated reference to NCQA 2013 Standards; updated approver title.	1/12/13
Annual Review; Removed revision history prior to 2010; Updated reference to NCQA for 2014; Removed reference to "specialty service consultants" in "4."; Updated Approval titles; added "physical therapist" to listing of practitioners under "Policy" section; Added #3. Pharmacy; Deleted reference to URAC; updated "A.8." and "B.1 & 2." to reflect applicable Ambetter titles.	01/01/14
Updated "Product Type" from "All" to "Medicaid, Medicare and HIM"	08/12/14
Annual review; Updated reference for NCQA to current year; Removed revision history prior to 2012; Removed "Financial incentives for UM decision makers do not encourage decisions that result in underutilization." from "C." and added "There are no financial incentives for UM decisions makers that would encourage decisions that result in underutilization of services."	01/07/15
Removed reference to "ICD-9" code in "B.1" and substituted "diagnosis" in preparation for ICD-10.	01/26/15
Annual review, replaced "case manager" with "care manager"; "case management" with "care management", no substantive changes	11/15
Added detail regarding appropriate practitioners other than physicians who can make denial decisions within their scope of practice. Clarified these practitioner types may be staff of Plan delegates.	4/2016

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.

Sr. Manager, Medical Management Operations: Approval on File
 Director, Medical Management Operations: Approval on File
 Corporate Vice President, Medical Management Operations: Approval on File