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

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
07/19/2005	03/26/2020	03/26/2020	03/26/2020
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 performing utilization review (telephonic and/or onsite) activity.

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.

All inpatient and outpatient Utilization Management (UM) denials, based on medical necessity or clinical appropriateness, are made by licensed physicians (or appropriate 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 below.

DEFINITIONS:

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) Independently Licensed Behavioral Health Professionals – Includes Licensed Clinical Social Workers (LCSW), Licensed Mastered Social Worker (LMSW), Psychologists, Licensed Professional Counselors (LPC), Licensed Mental Health Counselors (LMHC), and Marriage and Family Therapists (LMFT)
3) Licensed Practical Nurse/Licensed Vocational Nurse (LPN/LVN)
4) Medical Doctor/Doctor of Osteopathy (MD/DO)
5) Registered Nurse (RN)
6) Licensed occupational, physical, and speech and language pathologists

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

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.

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

PROCEDURE:

1) The health plan Health Care Management (HCM), Call Center UM Operations at The GBD Outpatient Precert (OPC), National Customer Care (NCC) Intake team or the Behavioral Health (BH) Clinical Leaders are accountable for managing the hiring, training assignment and monitoring of associates performing utilization review for their respective departments.

2) Healthcare professionals (as defined in Definitions) must possess the education and current unrestricted licensure to perform the utilization review function.

3) The appropriate HCM, The GBD Outpatient Precert (OPC), National Customer Care (NCC) Intake team or BH Clinical Leader may identify licensed health care professionals such as LPN/LVNs with sufficient experience and expertise for hiring consideration to collect data for precertification and concurrent review and to approve services for which there are explicit criteria. Exceptions for hiring these individuals are based on the licensed associate meeting one or more of the following criteria:
   a) Documented experience conducting utilization review prior to joining the organization
   b) Certification as a Managed Care Nurse, Certified Professional in Health Care Quality (CPHQ) or similar certification, and/or
   c) Experience in training or instruction of UM practices and activities

4) When an exception is made, the HCM, The GBD Outpatient Precert (OPC), National Customer Care (NCC) Intake team or BH Clinical Leader is responsible for ensuring:
   a) The individual is licensed, properly trained and supervised and
   b) This individual has an identified independently licensed clinical resource to provide oversight and direction

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5) Oversight of associates conducting utilization review includes, at minimum, a documented quarterly review of records by the supervisor to assess the quality, accuracy and appropriateness of the work product.

6) UM Supervisors who are licensed health care professionals (as defined in Definitions) provide oversight and supervision to the 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 UM decision
   d) Monitoring documentation for adequacy
   e) Being available to UM staff on site or by telephone

7) All associates conducting utilization reviews participate annually in the Company-wide Inter-Rater Reliability program per policy.

8) Health plan Medical Directors may refer a case to an outside Medical Consultant to assist in making medical necessity determinations. (Medical Consultants are required to be board-certified and have an unrestricted current medical license and may require state approval in some markets). Medical Consultants may be consulted for matters that include but are not limited to:
   a) 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) 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) For the most appropriate management approach or discordance between the treating provider and the health plan Medical Director about the treatment plan; or
   d) An appeal decision mandates an external objective opinion to ensure credibility of the process.

NCQA does not consider it delegation if a board-certified consultant reviews cases and makes recommendation for medical necessity determinations, if the health plan makes the final determination. If the consultant makes the final determination, NCQA considers this to be delegation.

9) A list of board-certified physicians is maintained by each health plan and accessible by health plan Medical Directors for consultation on complex UM cases.
   a) Corporate HCM - UM Operations staff maintains the national list of board-certified medical consultants and contracted Independent Review Organization (IRO) for each health plan on the MD Resource SharePoint site. The designated health plan HCM staff

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notifies UM Operations of updates to their board-certified medical consultants or contracted IRO.

REFERENCES:

Florida AHCA Contract # FP068
Florida Healthy Kids 2020-03 Medical Services and Coverage Simply Executed Contract
HB 4290, 28 TAC §19.1703(32) and TIC §4201.305
Indiana Hoosier Care Connect, Exhibit 1.G, Section 7.3.1; Hoosier Healthwise, Exhibit 1.C, Section 6.3.2; and Healthy Indiana Plan, Exhibit 2.C, Section 9.3.2.
Iowa Health Link Contract 11.1.2
Kentucky Medicaid Managed Care Contract section 21.2
Kentucky Revised Statute 304.17A-607(1) (a) (b), 304.17A-005
NCQA Accreditation Standards and Guidelines: Appropriate Professionals, Elements: Licensed Health Professionals, Use of Practitioners for UM Decisions, and Use of Board-Certified Consultants
WA Apple Health Managed Care Contract K2724 §11.2
WA Integrated Managed Care Contract K2729 §11.2

Related Policies or Procedures:
Associates Performing Utilization Reviews - Core Process - LA
Associates Performing Utilization Reviews - TN
Clinical Criteria for Utilization Management Decisions - Core Process
Governance of Utilization Management Practice
Health Care Management Denial - Core Process
Health Care Management Denial - TX
Inter-Rater Reliability (IRR) Assessments
Use of Board Certified Consultants (Medical/Behavioral Health) - Core Process
Utilization Management Training

RESPONSIBLE DEPARTMENTS:

Primary Department:
Health Care Management

Secondary Department(s):
Behavioral Health
National Customer Care Organization

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EXCEPTIONS:

Kentucky:
The health plan or private review agent will not provide or perform utilization reviews without being registered with the Department.

The health plan will have available the services of sufficient numbers of registered nurses, medical records technicians, or similarly qualified persons supported by licensed physicians with access to consultation with other appropriate physicians to carry out its utilization review activities. The health plan will ensure that only licensed physicians make a utilization review decision to deny, reduce, limit, or terminate a health care benefit or to deny or reduce payment for a health care service because that service is not medically necessary, experimental, or investigational except in the case of a health care service rendered by a chiropractor or optometrist where the denial will be made respectively by a chiropractor or optometrist duly licensed in Kentucky. The health plan will ensure that only licensed physicians supervise qualified personnel conducting case reviews.

The Medical Director and BH Director shall supervise the UM program and shall be accessible and available for consultation as needed. Decisions to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, must be made by a physician who is of the same specialty and subspecialty, when possible, as the ordering provider, has appropriate clinical expertise in treating the Member's condition or disease and is consistent with state and federal regulations and state contracts.

REVISION HISTORY:

Review Date	Changes
10/14/2013	• Rebranded for VA Medicaid Migration. Remove company specific references.
01/01/2014	• Added Kentucky health plan.
04/01/2014	• Add WI as applicable market and remove NM.
04/30/2014	• Annual Review
11/13/2014	• Changes made to reflect the 2015 Louisiana contract requirements
03/27/2015	• Off-cycle edit to remove LA as applicable market, remove LA exception and update primary department from Healthcare Management Services to Health Care Management
12/03/2015	• Off-cycle edit to add Iowa as an applicable market. Approved by Iowa DHS 12/03/2015 for use effective 04/01/2016.
01/28/2016	• Annual review by PPOC and MOC • Added CA, TX & VA MMP as applicable markets

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	• Add LMSW to definition of medical disciplines • Add UM Supervisor oversight and supervision responsibilities • Add exceptions for FL, NJ, NV, TX, TN & WA
10/20/2016	• Off-cycle edit to add WV as an applicable market
11/17/2016	• Off-cycle edit to add KY exception language
12/22/2016	• Annual review by PPOC and MOC. Added NYW as an applicable market; added licensed associate language; wordsmithing; added KS & NY exception language.
01/23/2017	• Off-cycle edits to add IA contract reference and exception language
02/02/2018	• Annual review • Removed VA MMP as an applicable market • Revised #9 of Procedure • Revised References • Added IN exception language; revised IA, NJ & TN exception language
07/20/2018	• Off-cycle edit for addition of FL exception language to facilitate adoption by the Simply/Amerigroup/Clear Health Alliance FL Plans
08/10/2018	• Off-cycle edit to add MN as an applicable market. Exception added to notate market go-live of 12/1/18.
10/08/2018	• Off cycle review • Few minor edits to procedure section • WA exception section language updated for contract amendment 7/1/18
10/23/2018	• Off cycle review • FL exception language updated
12/13/2018	• Off-cycle edit to add DC as an applicable market. Update MN go-live date to 1/1/19.
01/14/2019	• Off-cycle edits to add AR as an applicable market and add AR
02/28/2019	• Annual review • Removed KS as an applicable market • Revised IN contract reference; add KY contract references • Added DC & MD exception language; revised NY & TN exception language; removed KS & MN exception language
03/26/2020	• Annual Review • Added NC as an applicable market • Minor update to Policy Section • Revised Procedure and References • Revised IA, KY, NY/NYW and TX exceptions

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