POLICY

	Policy No: HCS-364
	Policy Title: Appropriate Professionals Making UM Decisions
	Department: Healthcare Services (HCS) **Sub-Department:**
Entity: Molina Healthcare, Inc. **State(s): AZ, CA, FL, ID, IL, KY, MA, MI, MS, NE, NM, NV, NY, OH, SC, TX, UT, VA, WA, WI**	**Effective Date:** 5/5/2013
Name: Liz Miller **Title:** SVP, Clinical Operations	**Signature**: Liz Miller

Lines of Business:

☒ All ☐ Medicare ☐ Marketplace

☐ Medicaid ☐ Medicare-Medicaid Programs (MMP) ☐ Other: _____

I. PURPOSE

The purpose of this policy is to provide Healthcare Services (HCS) with a procedure to ensure that qualified licensed health professionals assess the clinical information used to support Utilization Management (UM) decisions.

II. POLICY

Molina Healthcare requires appropriate licensed health professionals to supervise all medical necessity decisions and specifies the type of personnel responsible for each level of UM decision making. Licensed nurses conduct and approve all services requiring assessment of clinical information and/or the application of all medically necessary criteria. Molina Healthcare medical directors are responsible for the review of cases regarding medical necessity and/or appropriateness that HCS staff cannot approve.

Molina Healthcare has written job descriptions with qualifications for practitioners (e.g., physicians, behavioral health practitioners and pharmacists) who review denials of care, including medical and behavioral healthcare, based on medical necessity. Practitioners are required to have:

A. Education, training, or professional experience in medical or clinical practice.

B. Current license to practice without restriction.

C. License free of any sanctions, including free of any sanctions from Medicaid or Medicare.

Molina Healthcare utilizes board-certified consultants to assist in making medical necessity determinations.

III. SCOPE

Clinical Management and Policy; Healthcare Services (HCS); MHI Chief Medical Officer (CMO) Policy and Benefit; Molina Clinical Services (MCS)

IV. AREA(S) OF RESPONSIBILITY

Healthcare Services (HCS)

V. DEFINITION(S)

Medical necessity – services or supplies for diagnosing, evaluating, treating, or preventing an injury, illness, condition, or disease, based on evidence-based clinical standards of care. Medically necessary services are accepted health care services and supplies provided by health care entities, appropriate to evaluation and treatment of disease, condition, illness, or injury and consistent with the applicable standards of care. Determination of medical necessity is based on specific criteria.

VI. REFERENCE(S)

42 CFR 422.112(a)(6)(ii), 42 CFR 422.562(a)(4), 42 CFR 422.566(d), 42 CFR 422.629(k)(3)

42 CFR 438.210(b)(3)

Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (Effective July 19, 2024), Sections 10.4.2, 40.9.

Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans (Updated August 2022), Section 40.9.a.

NCQA UM 4

HCS-364.01 Appropriate Professionals Making UM Decisions Procedure

VII. VERSION CONTROL

Version No	Date	Revision Author/Title	Summary of Changes
1	04/13/2022	J. Cruz/VP Clinical Operations	Annual review, new P&P template (previous revision dates- 06/17/2013, 12/11/2014, 02/01/2016, 12/05/2016, 12/04/2017, 04/23/2020, 06/28/2021)
2	05/08/2023	J. Cruz/VP Clinical Operations	Annual review, added NE, updated references
3	12/12/2023	J. Cruz/VP Clinical Operations	Conversion from Medicaid/MP to All LOB; Added TX (for Medicare); Supersedes and replaces EMU-UM-002; Added Office of CMO to Scope; Updated definitions (added medical necessity, removed benefit determination and medical necessity determination); Added references to CFR, Part C Guidance, and connected procedure.
4	11/13/2024	Christa Ross/AVP Clinical Operations	Annual Review; II.: reworded for clarity (minor); Scope: Office of CMO replaced with Clinical Mgmt. and Policy, MHI CMO Policy and Benefit, and MCS; References: updated version date of Parts CD Guidance and added links to CMS documents

PROPRIETARY- Molina policies/procedures apply to all subsidiaries where applicable to the subsidiaries' business.

PROCEDURE

	Procedure No: HCS-364.01
	Procedure Title: Appropriate Professionals Making UM Decisions
	Department: Healthcare Services (HCS) **Sub-Department:**
Entity: Molina Healthcare, Inc. **State(s): AZ, CA, FL, ID, IL, KY, MA, MI, MS, NE, NM, NV, NY, OH, SC, TX, UT, VA, WA, WI**	**Effective Date:** 5/5/2013
Name: Liz Miller **Title:** SVP, Clinical Operations	**Signature**: Liz Miller

Lines of Business:

☒ All ☐ Medicare ☐ Marketplace
☐ Medicaid ☐ Medicare-Medicaid Programs (MMP) ☐ Other: _____

I. PURPOSE

To provide Healthcare Services (HCS) with a procedure to ensure that qualified licensed health professionals assess the clinical information used to support Utilization Management (UM) decisions.

II. PROCEDURE

Molina Healthcare's Human Resource staff verifies state licensure of physicians, pharmacists, and licensed nurses through the state-specific licensing boards via the Internet. Results are documented. All healthcare professional licenses are verified at the time of hire, on an annual basis and upon expected date of license renewal. Verification must be free of open formal complaints, disciplinary action, and/or restrictions.

All staff receiving requests for services and staff reviewing care have been trained regarding the levels and limitations of their responsibilities, the denial process, and the appropriate decision-making levels of responsibility.

A physician, pharmacist, or appropriate behavioral healthcare practitioner (i.e., doctoral-level clinical psychologist or certified addiction medicine specialist) reviews all denials based on medical necessity, depending on the type of service and clinical appropriateness. Behavioral health services denials must be rendered by board-certified or board-eligible psychiatrists or by a clinician licensed with the same or similar specialty as the behavioral health services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist.

All requests for services and UM decisions are forwarded to the appropriate decision-maker. The process of ongoing UM review is to verify that the appropriate decision-maker was used for all decisions.

Levels of decision-making responsibilities are described as follows:

A. Governing Body for Molina Healthcare Inc. and State Plan Board of Directors

The Molina Healthcare corporate and state plan Board of Directors are responsible for the governing body oversight of Molina Healthcare's adherence to implementation of the HCS Program. Specific responsibilities of the Board of Directors include but are not limited to:

1. Strategic planning and direction; and
2. Budget approval and staff allocation approval.

B. Health Care Services Committee (HCSC)

The HCSC is chaired by the Chief Medical Officer (CMO) or designated Medical Director and Vice President (VP) HCS with standing physician membership representing various specialties from within the plan and from the contracted network.

Other members may include but may not be limited to the Associate Vice President (AVP) HCS, Director HCS, Medical Director, Behavioral Health Medical Director, Regional Director Pharmacy, Director QI Compliance, or designee, and/or Manager for Network/Provider Services who is selected to represent primary care, high volume specialists, and delegated provider groups. Ad hoc members include representatives from other areas in Molina Healthcare and medical experts on as-needed basis.

Functions of the HCSC include:

1. Review and approve the HCS Program Description, Quality Improvement (QI)/HCS Work Plan and Annual HCS Work Plan Evaluation;
2. Annual review of clinical criteria used to determine medical necessity;
3. Review and approve all clinical policy;
4. Update coverage for items such as: medical, surgical, and diagnostic services;
5. Review and assess Care Management (CM) interventions and outcomes;
6. Recommend actions based on CM findings;
7. Review and analyze data on outcomes and trend studies;
8. Monitor utilization trends and identify opportunities for improvement;
9. Monitor consistency of medical necessity decisions which includes Inter-Rater-Reliability (IRR) studies;
10. Review and analyze compliance metrics;
11. Monitor compliance with external regulatory and accreditation bodies; and
12. Evaluate provider and member satisfaction with the HCS Program.

C. Corporate and State Plan Chief Medical Officer (CMO)

The CMO is responsible for the activities of the HCS department. The CMO reports to the Chief Executive Officer (CEO). Responsibilities of the CMO include but are not limited to:

1. Represent the HCS Program throughout the organization and report to the Molina Healthcare Board of Directors and the Plan President;
2. Responsible for the outcomes of the HCS department;
3. Implementation of the HCS Program on a daily basis;
4. Chair the HCSC, Credentialing Committee and participate in the Pharmacy and Therapeutics (P&T) Committee;
5. Implement Clinical Practice Guidelines and evidence-based medical practice protocols;
6. Lead role in the evaluation of new technology;
7. Utilize information technology and data analytics to develop tools to report, monitor and improve UM and to identify potential under- and over-utilization trends;
8. Evaluate HCS Program satisfaction on an annual basis and ensure corrective actions;
9. Engage and interact with network, group providers, and nursing/behavioral health clinicians regarding utilization practices, guideline usage, pharmacy utilization and effective resource management;

10. Authority, responsibility, and accountability for denial determinations when acting as a clinical reviewer;
11. Evaluate the IRR of physician reviewers.

D. Medical Director/Associate Medical Director

The Medical Director/Associate Medical Director is responsible for the outcomes of the HCS department. The Medical Director reports to the CMO. Responsibilities of the Medical Director/Associate Medical Director include but are not limited to:

1. Review quality referred issues, focused reviews and recommend correct actions;
2. Attend or chair committees required such as HCS, Credentialing Committee, P&T and others as directed by the CMO;
3. Consultation to HCS personnel;
4. Actively participate in staff development;
5. Conduct medical necessity reviews following UM protocols and accountability for denial determinations;
6. Monitor appropriateness of care and services through the continuum among hospitals, skilled nursing facilities and home care to ensure quality, cost-efficiency, and continuity of care;
7. Participate in CM and Interdisciplinary Care Team (ICT) meetings to ensure the highest level of evidenced-base practice and clinical outcomes in care;
8. Engage and interact with network, group providers, and nursing/ behavioral health clinicians regarding utilization practices, guidelines usage, pharmacy utilization and effective resource management.

E. Pharmacy Director

The Pharmacy Director is responsible for clinical, administrative, financial, and regulatory management of corporate pharmacy services. The Pharmacy Director reports to the CMO. Responsibilities of the Pharmacy Director include but are not limited to:

1. Represent Pharmacy Services components of the HCS Program throughout the organization;
2. Participate in the implementation of the HCS Program;
3. Serve as consultant to HCS personnel;
4. Chair the P&T Committee;
5. Serve as member of the HCS and Quality Improvement Committee (QIC);
6. Participate in individual case reviews;
7. Serve as a peer reviewer to practitioners to discuss potential denials;
8. Initiate denials when serving as a clinical reviewer;
9. Participate in evaluation of new technology if applicable for pharmacy;
10. Assist with evaluation of satisfaction with the HCS program as needed.

F. Vice President (VP)/Associate Vice President (AVP)/Director

The HCS VP/AVP/Director is responsible for the management of the clinical operations of HCS departmental processes related to UM (prior authorization, inpatient review) and CM (health management, transitions of care, and/or member assessment). The position works collaboratively with the CMO/Medical Director at the local State Plans and/or the corporate colleagues. Responsibilities of the VP/AVP/Director include but are not limited to:

1. Implement and maintain HCS systems including prior authorization, referral management, inpatient review, discharge planning, retrospective review, transitions of care and care management;
2. Direct all activities related to the clinical nursing and behavioral health review of ambulatory medical services and hospital/facility admissions;
3. Coordinate activities required to effectively interface with regulatory agencies, accrediting bodies, corporate representatives, community agencies, regional leadership, the local management team, and other departments outside HCS;
4. Facilitate, establish, and achieve the HCS Program's annual goals associated with served populations;
5. Manage fiscal and human resources within the HCS department;
6. Oversee the development, implementation and propose updates to HCS department policies and procedures;
7. Provides ongoing clarification of policy and procedure issues on a daily basis;
8. Oversee the development and implementation of education and training programs for internal staff and external audiences;
9. Oversee the audit outcomes of program, implement performance improvement plan and report findings to HCS compliance for compliance and quality oversight;
10. Participate in the oversight of delegated Behavior Health, Operations, QIC, and HCSC.

G. HCS Manager

The HCS Manager is responsible for the operational management of the integrated HCS teams including inpatient and outpatient utilization, concurrent review, and care management. The Manager reports to the Director of HCS. Responsibilities of the HCS manager include but are not limited to:

1. Coordinate daily operations and supervision of respective staff, ensure adequate staffing and service levels, monitor, and maintain staff productivity and other performance indicators;
2. Report on UM key performance indicators including plan utilization, staff productivity, cost effective utilization of services, management of targeted member population;
3. Lead role in identifying opportunities for continuous improvement of department processes;
4. Ensure staff adheres to state and federal regulatory and accreditation standards inclusive of department and company policies;
5. Perform and promote interdisciplinary/multidisciplinary integration and collaboration to enhance continuity of care including consultation of the Medical Director, pharmacy team, Behavioral Health and coordination with community-based providers and services;
6. Provide clinical oversight for ICT meetings;
7. Ensure completion of staff quality review audit reviews and oversee performance improvement plans and delivery of feedback to staff;
8. Identify opportunities for training and ensure team compliance with required staff training.

H. HCS Supervisor

The HCS Supervisor reports to the HCS Manager and is responsible for daily HCS activities. Responsibilities of the HCS Supervisor include but are not limited to:

1. Oversee an integrated UM team responsible for prior authorizations, inpatient/outpatient medical necessity/utilization, and/or other UM activities to provide Molina Healthcare members with the right care at the right time;

2. Function as a hands-on supervisor, coordinate and monitor clinical and non-clinical team activities to facilitate integrated, proactive utilization management, and ensure compliance with regulatory and accrediting standards;
3. Manage and evaluate team members in the performance of various UM activities, provide coaching, counseling, employee development;
4. Perform and promote interdepartmental integration and collaboration to enhance the continuity of care including Behavioral Health and Long-Term Care (LTC) for Molina Healthcare members;
5. Ensure adequate staffing and service levels and maintain customer satisfaction to implement and monitor staff productivity and other performance measures;
6. Collate and report on UM statistics;
7. Complete staff quality audit reviews, evaluate outcomes, and recommend enhancements/ improvements;
8. Maintain professional relationships with provider community and internal and external customers while identifying opportunities for improvement.

I. RN or LVN/LPN and Care Management (Clinical Case Managers and Complex Case Managers)

The **RN or LVN/LPN** report to the HCS Manager. Responsibilities of the RN, LVN/LPN and Clinical/Complex Case Mangers include but not limited to:

1. Management and/or supervision of member care within departmental guidelines using clinical judgment, appropriate criteria, and as directed by management;
2. Perform clinical assessments of members to determine individualized acuity level based on stratification guidelines and clinical judgement;
3. Collaborate with member to develop, update, and share their individualized care plan using program protocols based on the member's needs and preferences;
4. Update care plan to document progress toward goal achievement;
5. Use targeted outreach methods including telephonic, face-to-face within community, or home visits as required;
6. Integrate services for members including utilization and preservice needs, behavioral health care and long-term services and supports to enhance continuity of care for Molina Healthcare members;
7. Facilitate member ICT meeting and informal ICT collaboration, as appropriate;
8. Use motivational interviewing techniques, Molina Healthcare clinical guideposts and clinical practice guidelines to educate, support self-management and motivate change during member contacts;
9. Assess barriers to care, provide patient care coordination and assistance to address member concerns;
10. Address biopsychosocial needs of members including physical health, behavioral health, functional and cognitive needs; and
11. Participation in departmental quality initiatives.

J. HCS Care Review Clinicians (CRCs)

The HCS CRCs report to the HCS Manager and/or Supervisor. Responsibilities of HCS CRCs include but are not limited to:

1. Analyze clinical service requests from members or providers against evidence-based clinical guidelines to ensure optimum outcomes, cost effectiveness, and compliance with state and federal regulations and guidelines;
2. Appropriately licensed staff assess inpatient services for members to ensure optimum outcomes, cost effectiveness and compliance with all state and federal regulations and guidelines;
3. Review benefit and eligibility criteria for requested treatments and/or procedures;
4. Process requests within required contractual and regulatory timelines;
5. Understanding of the parameters and limitations of position responsibilities, knowledge about when to seek the direction of Manager, Director and/ or Medical Director;
6. Refer to pharmacy for coordination and consultation; and makes appropriate referrals to other clinical programs;
7. Promotion of all decisions ensuring for the continuity of care and an individual treatment plan for each member;
8. Collaborates with interdisciplinary teams to promote Molina Healthcare's Integrated Care Management program;
9. Adhere to HCS policies and procedures;
10. Participation in departmental quality initiatives.

K. HCS Care Review Processors (CRPs)

The HCS CRPs report to the HCS Manager and/or Supervisor. Responsibilities of HCS CRPs include but are not limited to:

1. Work with requesting providers to enter necessary information into the HCS information system;
2. Provide approval of requests for selected services, according to specified approval lists that are reviewed and updated by the HCSC;
3. Make coverage determinations -both approvals and denials- in limited circumstances. A CRP can make benefit determinations for lack of member eligibility and in response to services requested that are specifically excluded from a member's benefit plan, which the plan is not required to cover under any circumstances.

L. Medical Advisory Board

Medical Advisory Board member qualifications include but are not limited to:

1. Valid Medical License;
2. Credentialed with Molina Healthcare, Inc.;
3. Board Certified in their area of specialty.

Board certified specialty physicians are consulted for determinations of appropriateness of services *and Medical Necessity* related to their field of specialty. The Medical Advisory Board consists of but is not limited to the following specialties:

1. Allergy/Rheumatology
2. Cardiology
3. Endocrinology
4. Family Practice
5. Gastroenterology
6. General Surgery

7. Hematology
8. Internal Medicine
9. Nephrology
10. Neurology
11. Obstetrics & Gynecology
12. Oncology
13. Pain Management
14. Pediatric
15. Urology

III. SCOPE

Clinical Management and Policy; Healthcare Services (HCS); MHI Chief Medical Officer (CMO) Policy and Benefit; Molina Clinical Services (MCS)

IV. AREA(S) OF RESPONSIBILITY

Health Care Services (HCS)

V. DEFINITION(S)

Medical necessity – services or supplies for diagnosing, evaluating, treating, or preventing an injury, illness, condition, or disease, based on evidence-based clinical standards of care. Medically necessary services are accepted health care services and supplies provided by health care entities, appropriate to evaluation and treatment of disease, condition, illness, or injury and consistent with the applicable standards of care. Determination of medical necessity is based on specific criteria.

VI. REFERENCE(S)

42 CFR 422.112(a)(6)(ii), 42 CFR 422.562(a)(4), 42 CFR 422.566(d), 42 CFR 422.629(k)(3)

42 CFR 438.210(b)(3)

Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (Effective July 19, 2024), Sections 10.4.2, 40.9

Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans (Updated August 2022), Section 40.9.a.

NCQA UM 4

HCS-364 Appropriate Professionals Making UM Decisions Policy

VII. VERSION CONTROL

Version No	Date	Revision Author/Title	Summary of Changes
1	04/13/2022	J. Cruz/VP Clinical Operations	Annual review, new P&P template (previous revision dates- 06/17/2013, 12/11/2014, 02/01/2016, 12/05/2016, 12/04/2017, 04/23/2020, 06/28/2021)
2	05/08/2023	J. Cruz/VP Clinical Operations	Annual review, added NE, updated references
3	12/12/2023	J. Cruz/VP Clinical Operations	Conversion from Medicaid/MP to All LOB; Added TX (for Medicare);

			Supersedes and replaces EMU-UM-002.01; Added Office of CMO to Scope; Updated definitions (added medical necessity, removed benefit determination and medical necessity determination); added references to CFR, Part C Guidance, and connected policy.
4	11/13/2024	Christa Ross/AVP Clinical Operations	Annual Review; II. 3rd paragraph: added sentence for BH service denials; Scope: Office of CMO replaced with Clinical Mgmt. and Policy, MHI CMO Policy and Benefit, and MCS; References: updated version date of Parts CD Guidance and added links to CMS documents; minor formatting and grammatical changes

STATE ADDENDUM

Procedure No: MHT-HCS 364.01	**Addendum No:** 14a
Procedure Title: Appropriate Professionals Making UM Decisions	**Health Plan (State):** TX
Name: Rebecca Stokes, RN BSN **Title:** AVP HCS UM	**Si**  **Date:** 02/19/2025
Corporate Policy: HCS-364 Appropriate Professionals Making UM Decisions Policy.pdf	**Corporate Procedure:** HCS-364.01 Appropriate Professionals Making UM Decisions Procedure.pdf

I. PURPOSE

To identify state specific requirements that differ from MHI procedure for compliance with Federal and/or State regulatory or contractual requirements applicable to Appropriate Professionals Making UM Decisions.

II. SCOPE

Health Care Services (HCS); Molina Clinical Services (MCS)

III. STATE VARIANCES REFERENCE TABLE

Procedure Citation	Requirement	Variance for Texas Medicaid/CHIP	Source of Decision

II	MHI document does not address	PA and concurrent review determinations are made and supervised by formally educated and currently licensed medical professionals with same or similar specialty as the ordering provider, such as physicians, nurses, or therapists, who have subject area knowledge and relevant patient care experience; and that these medical professionals work and supervise others only within the scope of their education and licensure.	Uniform Managed Care Contract 8.1.8 Utilization Management
II. D.	MHI document does not address. Add #9	Participate in individual case review; which may include consultation with external Texas licensed physicians.	Texas Administrative Code Chapter 19, Subchapter R, Division 1 Rule 19.1706 Requirements and Prohibitions Relating to Personnel
II. D.	MHI document does not address.	Prior Authorization (PA) determinations to deny or limit services are made by physicians licensed in Texas working under the direction of the medical director.	42 CFR 422.566(d)
II. I.	RN or LVN/LPN and Care Management (Clinical Case Managers and Complex Case Managers)	RN or LVN/LPN, Therapists (PT/OT/ST), Behavioral Health LPC, and Care Management (Clinical Case Managers and Complex Case Managers)	Utilization Management Program Description
V.	Definitions not in MHI document	**Request for experimental or investigational procedures** – Because each case is unique and the classification of a procedure or treatment as "experimental" or "investigational" can be a matter of interpretation with differing opinions between the organization and the treating practitioner, a medical necessity review is required of such requests unless the requested service or procedure is specifically listed as an exclusion in the member's benefit plan.	Texas Administrative Code Chapter 19, Subchapter R, Division 1 Rule 19.1703
VI.	References	Uniform Managed Care Contract (UMCC): 4.02 MCO's Key Personnel and 8.1.8 Utilization Management Texas Administrative Code (TAC) Title 28 Part 1 Chapter 19, Subchapter R, Rule §19.1706 Texas Insurance Code (TIC): Title 14, Chapter 4201, Subchapter D and Subchapter F Texas Insurance Code (TIC): Title 4, Subtitle I, Chapter 533, Sec. 533.0073.	

IV. VERSION CONTROL

Version No	Date	Revision Author/Title	Summary of Changes

1		Rebecca Stokes, RN BSN AVP HCS UM	Added statement that reviews and determinations are made by staff with knowledge in the area of service requested. Added MD may consult with physicians outside Molina. Added denials and limitations of service are determined by MD. Added therapists and behavioral health clinicians. Added definition for experimental or investigational procedures. Added state specific references.
1.1	02/19/2025		Approved through Texas Health Care Services Committee