KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Appropriate Non-Licensed Utilization Management Staff and Licensed Professionals	**Policy #**	30.55-P
Policy Owner	Utilization Management	**Original Effective Date**	8/15/2023
Revision Effective Date		**Approval Date**	01/28/2025
Line of Business	☒ Medi-Cal ☐ Medicare	☐ Corporate	

I. PURPOSE

To ensure staff ratios are evaluated on an ongoing basis and at least annually to ensure Kern Health Systems (KHS) can meet the member's medical (non-behavioral), behavioral, and social needs.

II. POLICY

A. KHS Utilization Management (UM) Department will complete an assessment of the staffing plan to ensure appropriate staffing ratios are met to complete care coordination and coverage determination needs.

B. The staff ratios and organizational chart are based on the health plan's needs, workflows, technology, and are accommodated by the UM Program activities to ensure sufficient employees and/or contractors, or has plans to hire sufficient staff, as required, in a timely manner for all members through its staffing plan to facilitate the following:

1. Complete member assessments
2. Care coordination needs.
3. Handle care coordination oversight, monitoring, and quality assurance activities.
4. Organization and coverage determinations

III. DEFINITIONS

TERMS	DEFINITIONS
N/A	

IV. PROCEDURES

A. Staffing Plan

The staffing plan will include, but is not limited to the following:

1. The staff needed for each role/function.
2. The tasks that are required to be performed and approximate range of hours.
3. Critical functions or areas of potential risk for compliance.
4. Contingency plan or unexpected activities (e.g., increase in membership resulting in volume of workload, termination, or provider network, or membership plan transfer).

B. Appropriate UM Staffing

1. KHS's UM staff will have the appropriate education and experience to meet requirements, and the service needs of the members.
2. KHS requires that only qualified licensed health professionals will:

    a. Assess the clinical information used to support UM decisions.
    b. Supervise all medical necessity decisions; and
    c. Review denials of care based on medical necessity.

3. The UM staff will include licensed health care professional performing and supervising Utilization Management functions to:

    a. Provide day-to-day supervision of assigned UM staff.

        i. UM staff who are not qualified health care professionals may approve services when they meet explicit UM auto-authorization guidelines under the supervision of a licensed professional.

    b. Participate in staff training.
    c. Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
    d. Monitor documentation for adequacy of relevant clinical information to support non-behavioral, behavioral, and/or pharmacy UM decision making.
    e. Are available to UM staff on site or by telephone.

4. The following UM staff may approve services:
    a. Licensed health care professionals such as Licensed Vocational Nurses (LVN's) and Registered Nurses (RN's).

    b. Staff who are not qualified health care professionals and are under the supervision of appropriately licensed health professionals, when there are explicit UM criteria, and no clinical judgment is required.

    c. A non-licensed staff may:

i. Review an authorization request against the UM auto approval matrix where no clinical judgment is warranted. If clinical review is warranted, it is routed to the nurse reviewer and to a physician reviewer when further review is needed.

5. Staff members who are not qualified health care professionals may collect data for preauthorization and concurrent review for medical necessity determinations under the supervision of appropriately licensed health professionals. They may also have the authority to approve (but not to deny) services based on medical necessity for which there are explicit criteria.

6. The Human Resources Department will validate licensure and education specific to each job description requirements (i.e., match person to job requirements). The job description will include the qualifications that are required, including but not limited to:

    a. Education level (Masters, Doctoral, etc.)
    b. Training or professional experience in medical or clinical practice.
    c. A current license to practice without restriction.

7. Per the Vocational Nursing Practice Act, section 2518.5 Scope of Vocational Nursing Practice, LVNs manage cases under the direct supervision of the RN Managers, RN Supervisors, RN Medical Management Director, or the Medical Director.

    a. The scope of practice for LVN – The licensed vocational nurse performs services requiring technical and manual skills, which include the following:
        i. Uses and practices basic assessment (data collection), participates in planning, executes interventions in accordance with the care plan or treatment plan, and contributes to the evaluation of related individualized interventions.

8. The health care professionals who provide medical necessity review will have the education, training or professional experience in medical or clinical practice, including knowledge of Medi-Cal and Medicare coverage criteria, as well as, other evidence-based criteria, and shall be required to have a current, unrestricted license to practice in the state of California without restriction, and all medical directors and physician reviewers or consultants who make UM decisions for pre-service, concurrent, post-service and retrospective claims have been credentialed by KHS.

9. KHS uses only licensed health care professionals to make UM decisions that require clinical judgment.

    a. KHS may only use a physician or other appropriate health care professional to review any non-behavioral healthcare denial based on medical necessity. A physician may make medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.

    b. KHS may only use a physician or appropriate behavioral healthcare practitioner to review any behavioral healthcare denial of care based on medical necessity.

10. A licensed physician with a current, unrestricted license to practice in the state of California to practice will review any clinical, non-behavioral health denial based on medical necessity for covered services such as:

    a. Decisions about covered medical benefits defined by the organization, including hospitalization and emergency services in the Certificate of Coverage or Summary of Benefits.
    b. Decisions about care or services that could be considered either covered or not covered, depending on the circumstances, including decisions on requests for care that the organization may consider experimental.
    c. Decisions about dental procedures that are covered under the member's medical benefits.
    d. Decisions about medical necessity for "experimental" or "investigational" services.
    e. Decisions about pharmacy-related requests regarding step-therapy or prior authorization cases.

11. A behavioral health practitioner or medical physician reviewer will review any behavioral healthcare denial of medical stabilizing care based on medical necessity.

12. Board certified physician consultants may be used, as needed, to assist in making medical necessity determinations, such as:
    a. Pharmacists: Pharmaceutical denials.
    b. Dentists: Dental denials.
    c. Chiropractors: Chiropractic denials.
    d. Physical therapists: Physical therapy denials.

13. UM Staff will be supervised by a licensed practitioner with appropriate clinical experience (e.g., pharmacist, physician, RN, NP, or other appropriately licensed UM staff). Licensed doctoral-level clinical psychologists may oversee behavioral healthcare UM decisions.

14. The UM staff or behavioral health care professional responsible for making a determination for approval, benefit or administrative denial or medical necessity denial must be clearly documented by use of initials, unique electronic identifier, signature, or notation in the electronic record.

15. Compensation for individuals who review service requests will not contain incentives, direct or indirect practitioners, providers and staff who make utilization related decisions and those who supervise them must annually affirm the following:
    a. Medical decisions, including those by sub-delegated entities and rendering providers, are not unduly influenced by fiscal and administrative management.
    b. UM decision-making is based only on appropriateness of care and service and existence of coverage.

c. The organization does not reward practitioners or other individual's for issuing denials of coverage.
d. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

16. KHS will annually distribute a statement to all practitioners, providers and employees who make UM decisions affirming the above information.

17. KHS does not use incentives to encourage barriers to care and service, these affirmative statements will be distributed by the affiliates annually to all members, staff, providers, and practitioners involved with UM determinations.

    a. Distribution may include but not limited to:

        i. Mailings
        ii. Newsletters
        iii. Email
        iv. Published on the Intranet/Internet
        v. Included in provider/member handbooks/manuals.

C. Evaluation of Staff Planning

1. The staffing plan will be reviewed to identify opportunities for staff realignment, process improvements, adding additional staff, or adding temporary staff under the guidance of medical management leadership.

V. ATTACHMENTS

Attachment A:	N/A

VI. REFERENCES

Reference Type	Specific Reference
Other	NCQA (National Committee for Quality Assurance) Standards and Guidelines- "Appropriate Professionals"
Regulatory	Health and Safety Code 1367.01(a), (b), (c), (e)

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Created	8/15/2023	The policy was created to align with State & Federal regulations, and NCQA Standards.	C.P. UM
Revised			

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Chief Executive Leadership Approval *		
Title	**Signature**	**Date Approved**
Chief Executive Officer		
Chief Medical Officer		
Choose an item.		
Choose an item.		
*Signatures are kept on file for reference but will not be on the published copy		

KERN HEALTH SYSTEMS

Policy and Procedure Review

KHS Policy & Procedure: 30.55-P Appropriate Non-Licensed UM Staff and Licensed Professionals

Reason for creation: The policy was created to align with State & Federal regulations, and NCQA Standards.

Director Approval		
Title	**Signature**	**Date Approved**
Christine Pence Senior Director of Health Services		
Dr. Maninder Khalsa Medical Director of Utilization Management		
Amanda Gonzalez Director of Utilization Management		

Date posted to public drive: _____

Date posted to website ("P" policies only): _____