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SCOPE:

This purpose of this policy is to provide guidelines on the inpatient concurrent review process for acute inpatient hospital admissions for behavioral health and non-behavioral health issues.

DEFINITIONS AND ACRONYMS:

- **Concurrent Request** - A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.
- **Current Procedure Terminology (CPT)**
- **Inpatient** – An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient services.
- **MCG** – is an evidence based first level screening tool to assist in determining if the proposed services are clinically indicated and provided in the appropriate level or whether further evaluation is required. MCG can be applied in a wide range of clinical settings.

POLICY:

A. **Inpatient concurrent review-** Inpatient concurrent review process for all inpatient admissions will begin on day one of the admission. Inpatient concurrent review will focus on:
   - Review of all admissions to acute inpatient facilities.
   - Assessing the medical necessity of admissions and continued stays, the medical appropriateness and cost-effectiveness of the setting, level of care, services and length of stay.
   - Discharge planning and case management referral for targeted members.
   - Identify and refer potential quality of care issues to quality management department.
   - Monitoring services to see that they are appropriate and provided timely and efficiently.
   - Collaborate with providers of care, the patient or authorized patient's representative to arrange for alternative care of post- discharge needs.

B. **Inpatient level of care** -The following factors should be considered by the provider for inpatient admission:
   - The severity of the signs and symptoms exhibited by the patient.

- The medical predictability of something adverse happening to the patient.
- Complexity of other chronic or acute diseases in addition to the presenting problem
- The need for diagnostic services that appropriately are outpatient services to assist in assessing whether the patient should be admitted.
- The availability of diagnostic procedures at the time when and at the location where patient presents.

C. Documentation required for determining appropriateness of Inpatient stay:

- Physician's orders for inpatient admission.
- Admission history, physical exam and progress notes pertinent to inpatient care.
- Any other pertinent clinical information such as diagnostic, ancillary testing reports and treatments preformed.
- A rationale or criteria such as intensity of service and severity of illness used in clinical justification of inpatient care.
- Notification is required for all hospital admissions within one business day. Maternity and newborn admissions require notification at the time of delivery.

D. Inpatient concurrent review staff is required to obtain the following information at the time of request:

- Member's name, date of birth, sex, and plan ID number,
- Name of member's attending physician.
- Requesting or treating provider's name, address, phone and fax number,
- Diagnosis and the associated ICD-10 code,
- Requested services and associated Current Procedure Terminology (CPT) code, and
- Supporting clinical information such as history of presenting problem, family history, operative and pathological reports, treatment plans and progress notes, rehabilitation evaluations, special patient characteristics noted by the provider, laboratory and imaging studies.

E. Inpatient concurrent review function consists of:

- Evaluating concurrent review requests using the MCG criteria.
- Evaluation of information regarding benefits for services or procedures.
- Requests that do not clearly meet MCG criteria and or benefits are sent to medical director or designee for review for a determination.
- Issuing an authorization notice that includes a reference number, a date range for when the services are to be provided, maximum number of units, and how to request additional services if the request is approved.
- In the event the medical director or his designee does not approve a requested service, the provider will be provided with instructions on the process to initiate an appeal.
- Ensures the notice of action is sent timely to the member and the provider within one business day.

F. Inpatient concurrent review requests are reviewed and determination made, within the following time frames:

Pursuant to individual plan regulations.

The utilization management nurse reviews the applicable clinical criteria and if the patient does not meet criteria, the nurse refers the case to the medical director or designee for review. Medical director or his designee will be available to perform a timely review and render a decision regarding services that do not clearly meet clinical criteria. The utilization management nurse will inform the provider's team that the request is being referred for a medical director review.

The health plan affords board certified consultants based on the possible issuance of an adverse determination, an opportunity for a peer-to-peer discussion. The peer-to-peer discussion of a potential denial, must include the clinical basis for the health plan physician reviewer's thoughts about the case, the appropriateness of the medical necessity documentation presented, and identify any evidence-based criteria and/or guidelines used by the health plan's physician reviewer. Once an adverse decision has been communicated to the peer, which is part of his/her area of expertise, the original reviewing physician is not allowed to make any reconsideration to his/her decision. Any dissatisfaction by the member regarding the health plan's action supports the member's right to initiate an appeal with the health plan. The member has the right to designate through a written notification to the health plan an authorized representative such as a family member, the provider of record or a member advocate to appeal on their behalf.

REFERENCES:

- Medicare Benefit Policy Manual, Chapter 1, Inpatient Hospital Services Covered Under Part A
- NCQA 2020 Standards, UM 4, Element F, UM 5, UM 6, Element A

RELATED DOCUMENTS:

None

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1/27/20

Nancy Horstmann
Chief Executive Officer Health Plans

Date

1/27/20

David Engleking, M.D.
Medical Director Health Plans

Date

REVISION HISTORY:

Revision	Date	Description of Change	Committee
New	03/04/2016	Initial Release	Board of Directors
A	03/04/2016	Yearly review – updated to current template. Updated Definitions and Acronyms. Removed ICD-9.	Board of Directors
B	06/01/2017	Annual Review. Update for NCQA standards Changed signatory from Anita Leal, Executive Director to Nancy Horstmann, CEO.	Board of Directors
C	03/08/2018	Updated from Interqual to Milliman, and chief medical officer to medical director or designee. Updated Definitions and Acronyms.	Executive Leadership
D	09/20/2018	Annual review - timeframe and product lines updated.	Executive Leadership
E	01/16/2020	Annual review. Updated References. Updated from Milliman to MCG.	Executive Leadership