Louisiana Department of Health and Hospitals
Bayou Health Informational Bulletin 12-28
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Issue: General Provider Information for Concurrent Review

Concurrent Review Turnaround Time: Bayou Health Plans are required to respond to concurrent review requests with an approval or denial in a timely manner. The Health Plans are required to respond to:

- **Ninety five (95) percent of provider requests within one (1) business day; and**
- **One hundred (100) percent of all requests must be answered within two (2) business days.**

Response times are measured from the time the Health Plan receives all necessary clinical information to make a decision. The following are tips for providers regarding Health Plan notification, initial request for precert and concurrent review.

- **Notification of Admission:**

  Notification of admission to the Health Plan is the essential first step for the provider in the precertification process. Often the areas receiving either notification or clinical information have no contact with the other and may even be in different states. Notification of admission to the Plan by the provider triggers a "case" to be built in their system. Without the case, the clinical cannot be reviewed. It is important to remember that the notification step is separate from the submission of clinical for review.

- **Submission of Clinical Information:**

  Providers should only fax clinical information to the number specified for receipt of clinical information by the Plan; this is not necessarily the same number as that designated for notification of admission.

- **Inpatient Criteria**

  Bayou Health Plans utilize InterQual or Milliman for their inpatient criteria. The Plans review clinical at admission for Severity of Illness and Intensity of Service. Providers are required to submit clinical from the date and time of admission to certify as an inpatient. The Plans certify extensions on both Severity of Illness and Intensity of Service. This is the standard for commercial plans as well.

  Due to limitations in our current MMIS system, Legacy Medicaid is not capable of reviewing clinical at admission for Severity of Illness and Intensity of Service. The initial length of stay for Legacy Medicaid is assigned by the TR fiftieth (50^{th}) percent for the admitting diagnosis submitted on the PCF01 and therefore no clinical is required. Length of stay extensions in Legacy Medicaid are certified on Intensity of Service only.

- **Adequate Clinical Information**

  It is important to remind all providers it is the provider's responsibility to submit all clinical information necessary to justify both Severity of Illness and Intensity of Service to the nurse reviewer at the Health Plan. If the clinical submitted is inadequate, the Health Plan may deny your request or request additional information. When submitting additional documentation, Providers should fax only the pertinent clinical information needed to justify Severity of Illness and Intensity of Service. When the Health Plan requests additional information, **the turnaround time clock for concurrent review does not start until the Health Plan receives all necessary clinical information to make the decision to approve or deny initial or continued inpatient stay.**

- **Post Service Authorizations**

  In some cases, notification and/or initial clinical is sent on the day of discharge and sometimes after discharge. These cases **do not** fall into the concurrent review category. They fall into the category of post service authorization as the services have already been provided and the Health Plan has no ability to impact the stay. The turnaround time for post service authorization specified in the contract is 30 (thirty) days.

  Normal deliveries, vaginal or C-section, do not fall into concurrent review. The inpatient days for these stays are authorized by federal guidelines. It is important to note that notification of admission for delivery is required by all plans except Community Health Solutions Health Plan.