Work Process

DEPARTMENT: Population Health Clinical Operations	**DOCUMENT NAME:** Concurrent Review
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APPROVED DATE: 11/2014	**RETIRED:**
INITIAL EFFECTIVE DATE: 2/1/15	**REVIEWED/REVISED:** 11/2014, 6/15, 3/16, 8/16, 2/17, 1/18, 1/19, 1/20, 10/20, 07/22
REVISED EFFECTIVE DATE:	
Product Type: Medicaid	**REFERENCE NUMBER:** LA.UM.01.07

SCOPE:
Louisiana Healthcare Connections (LHCC) Population Health Clinical Operations

PURPOSE:
1) To ensure a timely and accurate concurrent review process with appropriate documentation.
2) To ensure members in inpatient and residential settings receive appropriate services in a suitable setting. This includes observation stays when authorization is required for this service.
3) To ensure appropriate referrals to Case Management (CM).
4) To describe how LHCC Utilization Management (UM) work collaboratively with a multidisciplinary team to initiate the discharge planning process at the time of admission and maintain continued reassessment throughout hospitalization. The multidisciplinary discharge team may include, but is not limited to, the member, family and/or caregiver, primary practitioner, hospital Case Manager, LHCC Care Manager, and ancillary service providers, as applicable. The discharge plan will be tailored to the individual member and family/caregiver's needs.

WORK PROCESS:

Concurrent Review
1) The practitioner or facility notifies LHCC that a member has been admitted to an inpatient or observation[CLCF1] setting.
2) The UM Clinical Reviewer assigned to that hospital/residential facility contacts the facility to obtain clinical information on the member, as well as the level of care the facility is requesting. This may be accomplished via onsite review, fax, electronic medical record (EMR), or web portal (where available).
3) The UM Clinical Reviewer will receive an Inpatient Daily Census report and/or a discharge list from the facilities, if applicable. The hospital census and/or LHCC Inpatient Daily Census report will be compared to the authorization in TruCare to ensure accuracy of authorization information.

(Refer to the TruCare Training Manual for instruction on authorization creation, documentation, etc.)

a) After reviewing the Inpatient Daily Census report, discharge list, and inpatient task list, the UM Clinical Reviewer will identify members who require initial and continued stay reviews for that day.
For onsite facility reviews the UM Clinical Reviewer will follow guidelines from individual facilities regarding identification/sign-in, on-site review process and procedures (~~e.g.~~e.g., scheduling in advance as necessary). Onsite staff is required to follow all facility policy and procedures, as indicated. When doing onsite reviews documentation should be entered onsite at the time of review.

b) All admissions are reviewed for current eligibility and Coordination of Benefits (COB). Any other coverage (~~e.g.~~e.g., primary insurance, workman's compensation) must be documented in a "COB" note type in TruCare. All potential COBs will be worked in accordance with *LA.UM.01.05 - Coordination of Benefits/Subrogation Work Process*.

c) All admissions must be reviewed and determined within the timeliness guidelines outlined in *LA.UM.05 - Timeliness of UM Decisions and Notifications*.

d) Discharge planning must be initiated and documented within the review or within a discharge planning note in TruCare.
- If discharge can be confirmed at the time of the initial request/notification of the admission, post-service review time frames may be applied, if allowed per state requirement and/or facility contract in accordance with LA.UM.05.01 *Retrospective Review for Services Requiring Authorization*. If a discharge date/time cannot be confirmed at the time of the initial request/~~notification~~notification, then the concurrent review time frames must be applied.

e) Requests for clinical information are documented in the TruCare authorization Request for Information hyperlink. All requests for

information should include contact name, department specific information requested and a due date and time for the clinical information to be received. It is also necessary to document "clinical information requested". Clinical information should be requested within one (1) business day of the authorization request date.

- At least one attempt must be made (and documented in TruCare) to obtain necessary clinical information by phone, fax or email within the initial one calendar day of the request/notification of admission.

f) The target discharge date (TDD) indicates the anticipated length of stay (LOS). The TDD must be reviewed and accurately documented on admission, and with each subsequent review or change in member status. The TDD will be based on the InterQual® benchmark (for physical health LOC) /Prospective Day Guidelines length of stay for initial reviews and will be adjusted with each concurrent review based on clinical information related to current member condition and treatment

g) All hospitalized members must be reviewed based upon clinical information obtained from the facility.

h) Prospective Day Guidelines

- Adult/Pediatric: Three (3) to five (5) ~~Up to four (4)~~ prospective days may be given with each review. Additional prospective days may be given at the direction of a Medical Advisor.
- NICU Cases:
  - Admits
    - -Less than 32 weeks or less approve 21 days of life (3 weeks)
    - Greater than 32 weeks but less than 34 weeks approve up until 34 weeks gestational age
    - Greater than 34 up to 36 weeks approve 7 days at a time
    - 36 weeks approve 5 days
    - 37 weeks or older approve 3 days
  - Concurrent:
    - Less than 32 weeks approve until gestational age 32 weeks

- At 32 weeks but less than 34 weeks approve until 34 weeks
- At 34 weeks approve every 5 days
- ~~Less than 32wks or less approve 14 days~~
- ~~32-37wks approve 7 days~~

- ~~37wks or older approve 3 days NICU cases Concurent Review~~
  - ~~Less than 34 weeks approve 10 days~~
  - ~~34-37wks approve 7 days~~
  - ~~34 weeks or older approve 3-5 days~~
  - ~~Oncenippling, in open crib, and on room air approve 2 days for rooming in~~

- LTAC, Rehab, SNF: A min of 6) prospective days may be given with each review
- PEC Behavioral Health (BH) admission approve 3 days may be given for initial review
- The frequency of reviews for the extension of initial determinations or continued stays is based on severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.

i) The UM Clinical Reviewer applies medical necessity criteria using the information received during the review. Clinical inpatient criteria and level of care criteria are assessed during the review. InterQual®/American Society of Addiction Medicine (ASAM) clinical criteria reviews must be completed with every review.
   - For initial review, the clinical review for Episode Day 1 will be populated within the Review Summary in TruCare.
   - For concurrent reviews, the last Episode day of the date range being reviewed will be populated within the Review Summary in TruCare).
     - Documentation for each date is required.
   - Clinical review notes must be reflective of each day reviewed.
   - Document all requests and receipt of additional clinical information received for the review in the Request for Information hyperlink within the clinical review.
- InterQual® (IQ) reviews will populate into the Review Summary section of the clinical review within TruCare for each line item

entered. All selected criteria points should be supported with a comment that included the date and what clinical information was used to support the selected criteria point.

- Review notes for all reviews that meet IQ criteria must include an admission diagnosis, a current diagnosis if different than the admission diagnosis, a history of present illness, discharge planning notes, and the next review date.
- Review notes for all reviews that do not meet IQ/ASAM criteria and are being referred for secondary review must include the admission diagnosis, the current diagnosis if different than the admitting diagnosis, information of events leading to the admission, current assessment with treatments, and assessment of discharge planning needs.
- Rationale for all authorizations that meet InterQual®/ASAM criteria should include the determination (~~ie~~i.e.. met and approved), the utilized version of InterQual® (~~ie~~i.e.. InterQual® 2018.2), or the ASAM Ebook with the ASAM template and the InterQual® subset used to make the determination. The rationale should also include any policies that were used to make the determination.
- Rationale for all authorizations that do not meet InterQual®/ASAM criteria should include the InterQual®/ASAM criteria points that were not met and a brief overview of any extenuating circumstances that might warrant consideration.
- Other medical necessity criteria, such as a Centene, Medicaid Covered Guidelines or Plan-level clinical policy, may be utilized in the absence of, or in addition to, applicable InterQual® or ASAM criteria.

j) If the requested days meet InterQual®/ASAM criteria, the UM Clinical Reviewer acknowledges approval, notifies the facility of the approved days, and documents in TruCare.

- When notifying a provider of an approval, staff will give the authorization number; authorized dates, level of care, date of anticipated next review with request for updated clinical information to support a continued length of stay.

- When notifying a provider verbally, the following "disclaimer" is to be read:
  - *"Authorization is not a guarantee of benefits or payment. Payment of benefits is subject to any subsequent review of medical information or records, patient's eligibility on the date the service is rendered and any other contractual provisions of the plan."*
- When notifying a provider by fax, staff must document that the approval letter was faxed to the facility CM within the phone notification section of the TruCare notification screen.

k) For reviews of neonatal ~~admissions~~admissions, the UM CR should complete an SSFB NICU admission admit note within seven calendar days of admission.

l) If the requested days do not meet InterQual®/ASAM criteria, the UM Clinical Reviewer will contact the hospital/facility ~~-~~Case Manager to obtain any additional clinical information available to support medical necessity and will document this attempt within the request for information hyperlink.

m) If the request does not meet criteria for medical necessity and/or level of care after an attempt to obtain additional clinical information the UM Clinical Reviewer will refer the authorization to the Medical Advisor for secondary review.
- The Medical Advisor will then review the case and make a determination based on the clinical information documented in the Clinical Review and attached to the ~~authorization, or~~authorization or contact the attending physician for more information.
- If the line item is *approved* as requested, the Medical Advisor documents the decision in the rationale section of the Advisor Review in TruCare and the UM Clinical ~~Reviewer documents~~Reviewer documents the determination and notification will be processed as outlined in *LA.UM.05 – Timeliness of UM Decision and Notifications.*

- If the line item is *denied*, the Medical Advisor documents the decision in the rationale section of the Advisor Review in TruCare and the determination and notification will be processed by the Correspondence Unit (CU) as outlined in *LA.UM.07 – Adverse Determination (Denial) Notices* policy.
- If the Medical Advisor recommends an alternative level of care, the Medical Advisor documents the determination in the rationale section of the Advisor Review in TruCare in accordance with *LA.UM.02.02 – Leveling of Care*. The facility UM staff is notified by the CU nurse of level of care at which, the member will be approved. The nurse documents the date, time, and person who informed the change.

n) If the request for authorization is approved, the UM CR or CU provides electronic notification of the approval to the requesting practitioner, not to exceed the original time frame. The facility or other treating provider is also notified, as applicable. The facility and attending/servicing practitioner must be notified of approved days and levels of care, and date of next anticipated review (telephonic/onsite) with updated clinical information to support a continued length of stay, as necessary.

o) All discharge documentation must be completed within one (1) business day of the receipt of discharge information. Discharge documentation must include discharge needs and how these needs will be managed.

p) During the course of the hospitalization, the UM Clinical Reviewer will identify members who can benefit from physical health case management (CM) that have a PH Outreach indicator of No on the daily census and will create a referral in TruCare and task it to the appropriate CM queue in TruCare.
   - All members admitted to an inpatient behavioral health or residential level of care will automatically be assigned to a BH Care Coordinator (CC) or Community Health Service Rep (CHSR) for post discharge outreach through the Follow-up After Hospitalization process

q) Other referrals identified may include the following:
- Cases identified with Quality Improvement (QI) concerns or Potential Preventable Health Events (PPHE) will be referred to the QI Coordinator via email, with a brief description included.

REFERENCES:
TruCare Training Manual
Current NCQA HP Standards and Guidelines
LA.UM.01 – UM Program Description
LA.UM.01.05 - Coordination of Benefits/Subrogation Work Process
LA.UM.02.02 – Leveling of Care
LA.UM.05 – Timeliness of UM Decision and Notifications
LA.UM.05.01 – Retrospective Review For Services Requiring Authorization
LA.UM.07 – Adverse Determination (Denial) Notices

ATTACHMENTS:

DEFINITIONS:
Medical Advisor: MD or PhD member of the Medical Affairs team

REVISION LOG

REVISION	DATE
LA Procurement 2015 Policy Update Revised to ~~utilized~~utilize LA specific policies	11/14
Removed ~~72 hour~~72-hour references and replaced with 1 business day Changed language to match rfp: “verbally or as expeditiously as the member’s health condition requires but not more than” Changed calendar day to business day Updated NCQA reference	6/15
Added - unless otherwise given prospective days (no more than 2) based upon clinical judgment and clinical information obtained from the facility. Deleted – deleted authorization and replaced it with authorized. Deleted – number of units. Grammar corrections	3/16

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Calendar days changed to business days for LA requirements; "The Plan" changed to LHCC; grammar corrections	3/16
Added- Start Smart for Your Baby Neonate Admissions and Leveling of Care dated 8/6/2014 the prospective approval guidelines for NICU cases.	8/16
Updated prospective day guidelines Updated CM referrals Grammar corrections	2/17
Update Punctuation within the policy Added statement of where to locate clinical notes	1/18
Removed language no longer relevant to current process.	1/2019
Added Residential setting Changed CCRN to UM Clinical Reviewer Changed Medical Director to Medical Advisor Added Policy title to LA.UM.05.01 Removed telephonic review Added PEC prospective day guidelines Grammatical Changes	1/2020
Added residential facility Added documentation of clinical requested Added must make 1 attempt for clinical information Removed reviews received on Friday to be sent to MA Added change in member's status to update the TDD and IQ benchmarks are only for PH LOC Added documentation of SSFB note Added approval notification to provider Added definition of Medical Advisor Updated CM referral process Formatting changes	10/2020
Changed Medical Management to PHCO Updated NICU cadence for review based on Neonate path to home Added a min of 6 days for PAC LOC in case we auth more	07/2022

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Added observation level of care Updated Adult/Peds review cadence Updated NICU review cadence	10/22

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer is considered equivalent to a~~n actual~~ physical signature ~~on paper~~.