POLICY AND PROCEDURE

POLICY NAME: Concurrent Review	**POLICY ID:** LA.UM.36
BUSINESS UNIT: Louisiana Healthcare Connections	**FUNCTIONAL AREA:** Utilization Management
EFFECTIVE DATE: 02/01/2015	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE: 11/14, 6/15, 3/16, 8/16, 2/17, 1/18, 1/19, 1/20, 10/20, 7/22, 1/23, 09/2023, 06/05/2024	
REGULATOR MOST RECENT APPROVAL DATE(S): Please refer to system of record – Archern/a	

POLICY STATEMENT:

All Aareas and Ddepartments within Centene Corporation and its subsidiaries must have written Policies and Procedures that address core business processes related to, among other things, compliance with laws and regulations, accreditation standards and/or contractual requirements.

PURPOSE:

The purpose of this policy is to describe how Pplan prior authorization (PA), concurrent review, behavioral health (BH) review and clinical review staff employees work collaboratively to ensure appropriate extension of current course of outpatient treatment or addressing the needs of our enrollees during an inpatient event throughout an inpatient hospitalization.

SCOPE:

This policy applies to employees of the Utilization Management (UM) dDepartment. This includes officers, directors, consultants, and temporary workers (collectively, the "Plan").

DEFINITIONS:

Concurrent / Clinical Review: Any utilization review conducted during an enrollee's course of treatment or hospitalinpatient stay, including an extension of a previously approved ongoing course of treatment over a period of time or number of treatments. Concurrent reviews are typically associated with inpatient care or ongoing ambulatory care.

Concurrent review may include any request made while the enrollee is in the process of receiving care, whether previously approved or not. Examples of requests considered as concurrent review:

- A specified course of allergy injections.
- A series of chemotherapy treatments.
- A continued stay review for an inpatient facility stay..-
- A new admission to a facility when the plan is notified after the admission has occurred, but before the enrollee has been discharged.

Post Service Review (Retrospective Review): Any utilization review performed after services have been rendered.

Pre-service Authorization Review: Authorization reviews requested in advance of the enrollee obtaining medical care or services. Preauthorization and pre-certification are pre-service organization reviews.

~~**Post Service Review (Retrospective Review):** Any utilization review performed after services have been performed.~~

Review Criteria: Objective, quantifiable guidelines used to assess the appropriateness of specific health care decisions and services (See LA.UM.02 Clinical Decision Criteria and Application).~~Medical Necessity criteria as denoted in the state specific Medicaid contract, InterQual Criteria, ASAM criteria, State Medicaid Provider Handbooks, as appropriate, State Statutes, Laws and Regulations, and Federal Statutes.~~

Urgent Care: Any request for medical care or treatment with respect to which the application of time periods for making nonurgent care determinations could result in the following circumstances:

- Could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, based on a prudent layperson's judgment, or
- In the opinion of a ~~practitioner~~ provider with knowledge of the enrollee's condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

POLICY:

The medical necessity and level of care for each inpatient day is assessed when the cost of that stay may be impacted by the level of care provided. This is influenced by contract and reimbursement structure (i.e., per diem reimbursement

facilities). Please refer to the Plan process to determine how the reimbursement methodology guides the medical necessity review and/or leveling of care process.

In performing reviews, ~~the PA and clinical~~ the ~~-~~review ~~staff~~employees:

- Ensures a timely and accurate concurrent review process with appropriate documentation.
- Ensures enrollees in acute/subacute care settings receive appropriate services in the appropriate setting. This includes observation stays, where authorization is required for this service.
- Evaluates a continued inpatient hospital stay for medical appropriateness utilizing national recognized clinical criteria.
- Implements timely and efficient transfer to lower levels of care when clinically indicated and appropriate.
- Ensures appropriate referrals to ~~C~~care ~~M~~management (CM) and ~~D~~disease ~~M~~management (DM), when applicable.

~~These r~~Review criteria are utilized as guidelines and decisions that take into account the enrollee's medical condition and co-morbidities. The review process is performed under the direction of the Plan Medical Director.

The Plan does not deny continuation of higher-level services (e.g., inpatient hospital or psychiatric residential treatment facilities (PRTF)) for failure to meet medical necessity unless the Plan can provide the service through an in-network or out-of-network provider at a lower level of care (Model Contract 2.12.8.2).

PROCEDURE:

Outpatient Concurrent Review

The Plan ~~may~~ conducts medical necessity reviews for continuation/extension of current treatment and/or services such as home health, outpatient therapy services, and rental of durable medical equipment to monitor appropriate utilization and promote quality outcomes for enrollees. All review activities are conducted employing appropriate criteria, documentation standards, and in accordance with applicable timeframes. This team ~~may be comprised~~is comprised of reviewers who receive requests via telephone, portal, mail and/or fax.

Inpatient Clinical Review (Telephonic/Remote/Onsite)

~~The clinical review team may be comprised of reviewers who work and review requests remotely, and onsite reviewers who have facility access and review live charts.~~

The ~~practitioner~~ provider or facility notifies the Plan that an enrollee has been admitted to an inpatient or observation setting. All admissions must be reviewed in a timely manner consistent with applicable processes and timeframes. ~~-~~

The clinical review team is comprised of reviewers who work and review requests remotely, and onsite reviewers who have facility access and review live charts.

~~All admissions must be reviewed in a timely manner consistent with applicable processes and timeframes.~~

Concurrent review time frames must be applied if the enrollee is still currently inpatient or in an observation setting.~~,~~

- ~~(e.g., i~~If a discharge date/time cannot be verified at the time of the initial request/notification of the admission, even if the Plan is notified of discharge once the concurrent review process is underway~~)~~.
- 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.

See LA.UM.05 Timeliness of UM Decisions and Notifications for timeframes.

~~Onsite Facility clinical review staff represents the Plan in a professional, respectful manner and follow any facility specific health and wellness requirements and/or operational rules of the facility.~~

- ~~The onsite clinical review reviews the enrollee's chart following facility protocol.~~
- ~~Clinical review staff conducting onsite facility reviews must always wear their Plan identification badge while conducting reviews. The identification badge includes a picture ID, the full name of the reviewer and the name of the Plan.~~

- Clinical review staff schedules onsite reviews at least one business day in advance with the indicated facility staff, unless otherwise agreed upon. Onsite reviews at large volume hospitals may be setup in advance, as part of a preset routine schedule (e.g., weekly on Monday, Wednesday, and Friday).
- Clinical review staff receives an initial facility orientation to review facility rules. Orientation should include review of applicable contract language and facility rules/procedures with which UM staff is expected to comply.
- Clinical review Staff requests clinical information applicable to the case and document it in the clinical documentation system. The clinical criteria rationale used to make the decision is also documented.
- If a determination cannot be made due to lack of necessary information, the UM designee must document attempts to obtain the additional information.
- Whenever possible, documentation in the clinical documentation system should be entered while on-site at the facility, utilizing the provided laptop, as this allows the best utilization of time.

Facilities with a New Onsite Review Agreement

The Company identifies a need for an onsite reviewer at a facility:.

- A Clinical Manager contacts the Utilization Management / Case Management (UM / CM) Department at the facility and explains the purpose of having an onsite reviewer.
- The benefits of having an onsite reviewer in a facility are:
  - Face to face interaction with the enrollee.
  - Ensuring appropriate services are rendered, which decreases readmission.
  - Assist facility with discharge planning.
- A Company MManager of, CClinical CCare and Onsite Inpatient Care Manager assigned to a facility visits the facility and meets with a representative of the Utilization Management / Case Management Department. The facility requirements are discussed and any requirements including, but not limited to, documents and agreements are reviewed and signed, if appropriate.

New Reviewer at a Facility Where Onsite Review Is in Place

- The Plan's MManager of, CClinical CCare makes arrangements to visit the facility with the newly assigned Onsite Inpatient Care Manager (Onsite Reviewer).
- The Plan MManager of, CClinical CCare and the Onsite Inpatient Clinical Reviewer visits the facility and meet with a representative of the facility's UM / CM Department.
- Facility requirements are explained and any required documents re reviewed and signed, and other requirements initiated by the newly assigned Onsite Inpatient Clinical Reviewer.
- The Company's MManager of , CClinical CCare follows up with the facility representative within the first month of the new Company reviewer's start date at the facility for input on the reviewer's work.

Ongoing Onsite Review Activity

The Plan Manager of, CClinical CCare schedules an onsite meeting with the Onsite Inpatient clinical reviewer at their assigned facility(s) a minimum of once a quarter or more often if needed, to evaluate the reviewer's work activity at assigned facilities. This provides each reviewer with individual discussion with the Manager including, but not limited to, their onsite effectiveness, identification of strengths and areas requiring work, and status of goal achievement. Any facility requirements for continuation of onsite reviewing is completed timely by the Onsite Inpatient clinical reviewer as required by the facility.

Coordination of Benefits

All stays requiring authorization are reviewed for current eligibility and coordination of benefits (COB). Any other coverage (e.g., primary insurance, worker's compensation) must be documented in a "COB" note type in the clinical documentation system.

Medical Necessity Review Process

The clinical reviewer applies medical necessity criteria (NCD/LCD, clinical policy, InterQual, and the American Society of Addiction Medicine (ASAM)) using the clinical information received. Both clinical inpatient criteria and level of care criteria are assessed during the review. Additional information on the review criteria is listed in LA.CP.CPC.05 Medical Necessity Review Criteria.

- If the hospital stay meets medical necessity criteria, the facility is notified of the approved days the approval notification is documented in the clinical documentation system.
- If the hospital stay does not meet medical necessity criteria, as necessary the clinical reviewer requests additional information from the appropriate facility contact and/or the attending physician to obtain additional clinical information, if available, and enters this information in the clinical documentation system.
- If the admission is approved as requested, the Medical Director documents the decision and rationale in the clinical documentation system.
    - The Plan provides electronic or written (i.e., email, fax, mail, or EMR) notification of the approval to the requesting ~~practitioner~~provider, not to exceed the original time frame. The facility or other treating provider is also notified, as applicable. The facility and attending/servicing ~~practitioner~~ provider must be notified of approved days and levels of care, (as applicable per the Plan) and date of next anticipated review (remote/onsite) with updated clinical information to support a continued length of stay, as necessary.
- If the request is denied, the Medical Director documents the decision and rationale in the clinical documentation system, and the facility/practitioner is notified in a manner consistent with applicable processes and timeframes (see LA.UM.07 – Adverse Determination (Denial) Notices).
- If the Medical Director recommends an alternative level of care, the Medical Director documents this determination in the clinical documentation system. The facility UM ~~staff~~ employees ~~is~~are notified of the level of care at which the enrollee is approved.

Continued Stay Review

Frequency of case reviews are based on multiple factors including current level of care, severity, or complexity of the illness, expected length of stay, ~~-~~how close to discharge the enrollee is, discharge planning, etc. All hospitalized enrollees are reviewed based on guidelines and recommendations from the Medical Director or leadership of Population Health and Clinical Operations.

- UM works closely with contracting to develop and adopt an average length of stay (LOS) tool by diagnosis (for example the Center for Medicare and Medicaid Services (CMS) length of stay by diagnosis) for use when conducting concurrent reviews, indicating the inpatient reimbursement methodology, i.e., per diem, case rate, etc.
- All admissions are checked for a previous, recent admission and processed in accordance with state, contract and/or NCQA re-admission regulations.
- The reviewer applies medical necessity criteria using the policy LA.UM.02 Clinical Decision Criteria and Application with the clinical information received. Both clinical inpatient criteria and level of care criteria are assessed during the review. Additional information on the review criteria is listed in LA.CP.CPC.05 Medical Necessity Review Criteria.
    - If the inpatient stay meets medical necessity criteria:
        - A total LOS is assigned and documented based on the diagnosis code provided by the facility (using the adopted tool for average LOS). The facility is notified of the approved days and the approval notification is documented in the clinical documentation system.
        - The LOS should continue to be monitored throughout the stay and any adjustments or information related to the LOS be documented within the authorization in the clinical documentation system.
        - The average/anticipated LOS, impending outlier date, and targeted discharge date should be considered in establishing the next review date.
    - If the inpatient stay does not meet medical necessity criteria, the review employee requests additional clinical information from the appropriate facility contact and/or the attending physician, if available, and enters this information in the clinical documentation system.
    - If the additional information is still insufficient for a level I approval, then the review process is followed according to LA.UM.02 Clinical Decision Criteria and Application.
    - ~~o~~ During a level II review if the Medical Director recommends an alternative level of care, the Medical Director documents this determination in the clinical documentation system. The facility UM is notified of the level of care at which the enrollee is approved.
- The enrollee is followed for discharge planning according to the policy ~~**Discharge Planning –** Refer to~~ LA.UM.16.03 – Continued Stay and Discharge Planning.

REFERENCES:
Louisiana Medicaid MCO Model Contract
~~TruCare Training Manual~~
NCQA ~~HP~~ Health Plan Standards and Guidelines UM 1: Program Structure; UM 4: Appropriate Professionals
LA.UM.01 ~~—~~Utilization Management~~UM~~ Program Description
LA.UM.02~~-~~ Clinical Decision Criteria and Application
LA.UM.05~~—~~ Timeliness of ~~UM~~ Utilization Management Decision and Notifications
LA.UM.07~~—~~ Adverse Determination (Denial) Notices
LA.UM.16.03~~—~~ Continued Stay and Discharge Planning
LA.CP.CPC.05~~—~~ Medical Necessity Review Criteria

ATTACHMENTS: N/A

ROLES & RESPONSIBILITIES: N/A

REGULATORY REPORTING REQUIREMENTS: LARS §46:460.54 applies to material changes for this policy.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Ad Hoc Review	LA Procurement 2015 Policy Update Revised to utilize LA specific policies	11/2014
Annual Review	Removed 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	06/24/15
Annual Review	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 Calendar days changed to business days for LA requirements; “The Plan” changed to LHCC; grammar corrections	03/24/16
Ad Hoc Review	Added- Start Smart for Your Baby Neonate Admissions and Leveling of Care dated 8/6/2014 the prospective approval guidelines for NICU cases.	08/24/16
Ad Hoc Review	Updated prospective day guidelines Updated CM referrals Grammar corrections	02/24/17
Annual Review	Update Punctuation within the policy Added statement of where to locate clinical notes	01/24/18
Annual Review	Removed language no longer relevant to current process.	01/25/19
Annual Review	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	01/24/20
Annual Review	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	10/26/20

	Added definition of Medical Advisor Updated CM referral process Formatting changes	
Annual Review	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	07/28/22
Ad Hoc Review	Added observation level of care Updated Adult/Peds review cadence Updated NICU review cadence	10/28/22
Ad Hoc Review	Changed Member to Enrollee Reformatted to latest Policy Template	01/12/22
Annual Review	Fully rewritten to align with corporate policy while retaining LA specificity. Renumbered to LA.UM.36 from LA.UM.01.07	09/2023
Annual Review	Grammatical and formatting edits. Updated references. Added "concurrent review, behavioral health review" in purpose section. Added "post service review (retrospective review)" and updated "review criteria" in the definitions section. Under policy added language regarding medical necessity and LOC assessment. Under policy added contract language from Model contract 2.12.8.2. Added portal as a method of receiving request under "outpatient concurrent review" section. Under "inpatient clinical review" section added clarifying language about timeliness. Removed onsite facility review detail. Added bulleted section to "continued stay review" section.	06/05/2024

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.