POLICY AND PROCEDURE

POLICY NAME: Concurrent Review	**POLICY ID:** ~~LA.UM.01.07~~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	
REGULATOR MOST RECENT APPROVAL DATE(S): n/a	

POLICY STATEMENT:

All areas and departments 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 Plan prior authorization (PA) and clinical review staff work collaboratively to ensure appropriate extension of current course of outpatient treatment or addressing the needs of our enrollees during an inpatient event throughout hospitalization.

SCOPE:

This policy applies to employees of the Utilization Management department. 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 hospital 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.

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: 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 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:

In performing reviews, the PA and clinical review staff:

- 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 Care Management (CM) and Disease Management (DM), when applicable.
- These 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.

PROCEDURE:

I. Outpatient Concurrent Review

The Plan may conduct medical necessity review 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 of reviewers who receive requests via telephone, mail and/or fax.

II. Inpatient Clinical Review (Telephonic/Remote/Onsite)

A. 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.

B. The practitioner or facility notifies the Plan that an enrollee has been admitted to an inpatient or observation setting.

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

1. Concurrent review time frames must be applied if the enrollee is still currently inpatient or in an observation setting, (e.g., 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).
2. 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.
3. See LA.UM.05 Timeliness of UM Decisions and Notifications for timeframes.

D. 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.

1. The onsite clinical review reviews the enrollee's chart following facility protocol.
2. 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.
3. 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).
4. 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.
5. 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.
6. If a determination cannot be made due to lack of necessary information, the UM designee must document attempts to obtain the additional information.
7. 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.

E. Facilities with a New Onsite Review Agreement

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

1. A Clinical Manager contacts the Utilization Management / Case Management (UM / CM) Department at the facility and explains the purpose of having an onsite reviewer.

2. 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.

3. A Company Manager, Clinical Care 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.

F. New Reviewer at a Facility Where Onsite Review Is in Place

1. The Plan's Manager, Clinical Care makes arrangements to visit the facility with the newly assigned Onsite Inpatient Care Manager (Onsite Reviewer).
2. The Manager, Clinical Care and the Onsite Inpatient Clinical Reviewer visits the facility and meet with a representative of the facility's UM / CM Department.
3. Facility requirements are explained and any required documents re reviewed and signed, and other requirements initiated by the newly assigned Onsite Inpatient Clinical Reviewer.
4. The Company's Manager, Clinical Care 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.

G. Ongoing Onsite Review Activity

The Manager, Clinical Care 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.

III. 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.

IV. Medical Necessity Review Process

A. 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.

1. 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.
2. 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.

   a. 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, 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, (as applicable per Plan) and date of next anticipated review (remote/onsite) with updated clinical information to support a continued length of stay, as necessary.

   b. 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).

c. 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 is notified of the level of care at which the enrollee is approved.

V. 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.

VI. Discharge Planning – Refer to LA.UM.16.03 – Continued Stay and Discharge Planning

REFERENCES:
TruCare Training Manual
NCQA HP Standards and Guidelines
LA.UM.01 – UM Program Description
LA.UM.05 – Timeliness of UM 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: HB434, Act 319 applies to material changes for this policy.

~~**POLICY STATEMENT:**~~

~~This work process outlines procedures for concurrent reviews.~~

~~**PURPOSE:**~~

~~1) To ensure a timely and accurate concurrent review process with appropriate documentation.~~

~~2) To ensure enrollees 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 enrollee, 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 enrollee and family/caregiver's needs.~~

~~**SCOPE:**~~

~~Louisiana Healthcare Connections (LHCC) Population Health and Clinical Operations~~**~~DEFINITIONS:~~**

~~**Medical Advisor:** MD or PhD member of the Medical Affairs team~~

~~**PROCEDURE:**~~

~~**Concurrent Review**~~

- ~~The practitioner or facility notifies LHCC that a enrollee has been admitted to an inpatient or observation setting.~~
- ~~The UM Clinical Reviewer assigned to that hospital/residential facility contacts the facility to obtain clinical information on the enrollee, 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).~~
- ~~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.)~~

- After reviewing the Inpatient Daily Census report, discharge list, and inpatient task list, the UM Clinical Reviewer will identify enrollees 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., 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.
- All admissions are reviewed for current eligibility and Coordination of Benefits (COB). Any other coverage (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.
- All admissions must be reviewed and determined within the timeliness guidelines outlined in LA.UM.05 - Timeliness of UM Decisions and Notifications.
- 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, then the concurrent review time frames must be applied.

- 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.
- 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 enrollee 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 enrollee condition and treatment
- All hospitalized enrollees must be reviewed based upon clinical information obtained from the facility.
- Prospective Day Guidelines
  - Adult/Pediatric: Three (3) to five (5) 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
    - LTAC, Rehab, SNF: A min of six (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.

- 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 request, 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 (i.e.. met and approved), the utilized version of InterQual® (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.
- 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.
- For reviews of neonatal admissions, the UM CR should complete an SSFB NICU admission admit note within seven calendar days of admission.
- 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.
- 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 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 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 enrollee will be approved. The nurse documents the date, time, and person who informed the change.

- 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.
- 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.
- During the course of the hospitalization, the UM Clinical Reviewer will identify enrollees 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 enrollees 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
- 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:

ROLES & RESPONSIBILITIES:

REGULATORY REPORTING REQUIREMENTS:
Which regulator(s) require reporting, what should be reported, when to report, and how to report/who to contact.

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	03/24/16

	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	
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 Added definition of Medical Advisor Updated CM referral process Formatting changes	10/26/20
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	01/12/232
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

POLICY AND PROCEDURE APPROVAL

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