

Inpatient Acute Care Admissions - Precertification Review

Objective:

Determine the medical necessity and quality of services to be provided in an acute inpatient Medical/Surgical hospital setting, the appropriateness of the setting as well as the number of days reasonably required to treat the patient's condition.

Performed By:

Inpatient Review Supervisor, Utilization Review Coordinators (URC), Physician Advisors (PA)

Policy:

All non-emergency, planned or otherwise elective Medical/Surgical admissions must be precertified by HSM. For urgent admissions, providers are required to request certification review at the earliest opportunity. When conditions permit, certification review should be initiated prior to admission. Otherwise, certification should be requested no later than HSM's next business day.–Refer to the *Inpatient Acute Care Admissions – Emergency Admission (Post Admission) Policy and Procedure* for additional information when certification was not obtained prior to an urgent admission. Requests for review and relevant information must be submitted to HSM, via the web, telephone, fax, or mail, by the facility or attending physician prior to admission.

NOTE: Emergency admissions do not require precertification prior to admission. Please refer to the *Inpatient Acute Care Admissions – Emergency Admission (Post Admission) Policy and Procedure* section for additional information.

HSM must notify the facility, if requested, and the physician of the review determination, via telephone, within twenty-four (24) hours [one (1) business day if the request is received on a Friday or the day before a holiday] of receipt of the request and all necessary information. HSM must also send a written notice of the determination to the facility and attending physician within this timeframe. If a case is denied written notice is also issued to the beneficiary.

The beneficiary or representative, the facility and the physician have a right to a reconsideration of any denial decision. The request for reconsideration may be submitted to HSM by telephone, fax, or mail within thirty (30) calendar days of the date on the denial notice for non-expedited reconsiderations and within three (3) business days of the date on the denial notice for expedited reconsiderations. Refer to the *Reconsideration Process Policy and Procedure* section of this manual for additional information.

Procedure: Precertification Review of Non-emergency Admissions

1. Facilities/Physicians submit a request for precertification to HSM prior to the beneficiary's admission. This request may be submitted via the web, telephone, fax, or mail. If the fax or mail submission method is chosen by the facility/physician, a completed HealthSystems of Mississippi Medicaid Admission Review Form must be used to submit the request. The request form is included in the *Review Request Forms* section of this manual.

NOTE: To expedite the certification process, HSM encourages facilities to utilize the web option. For telephonic review, having a completed request form available at the time of the call will significantly reduce the amount of time necessary to complete the precertification process.

2. If the fax or mail method is chosen for submitting a review request, the non-clinical review staff (clerical staff) review the form(s) to ensure that the non-clinical information on the form is complete, is legible, all pages are received, and the form is completed in all applicable areas (i.e., beneficiary's Medicaid number, physician's name and phone number, requestor's name and phone number, all applicable spaces on form are filled in, all pages of the review form were received, etc.) If it is incomplete or not legible, the non-clinical staff notifies the requestor verbally by telephone. The non-clinical review staff attempts telephone contact two (2) times and documents the attempts in the electronic tracking notes screen.

Depending on the time of day a faxed review request is received and tracked into HSM's data system, the non-clinical staff allows either three (3) hours from the time of verbal notification or until 12:00 p.m. (CST) the next business day, whichever is longer, for receipt of the necessary information to reinstate review.

If the information is not received within the applicable timeframe, the non-clinical staff issues written notification (Lack of Information – Unable to Initiate Review) to the requestor that the review process cannot be initiated and that all information will have to be resubmitted to reinstate the review process.

3. Once the necessary information is received, the review request is forwarded to the Utilization Review Coordinator (URC).
4. Upon receipt of the request, the beneficiary's eligibility is verified. Facility and attending physician identification is also verified, including telephone and fax numbers. If the beneficiary is not eligible, the review process is ended. The facility/physician is notified via telephone with written follow-up (Notice of Receipt of Certification Request - Non-Medicaid Beneficiary).
5. The beneficiary's benefits remaining for the current fiscal year are verified. If there are no remaining benefits, the facility/physician is notified via telephone with written follow-up (Notice of Receipt of Certification Request – Benefits Exhausted).
6. Once eligibility and remaining benefits are verified, the URC assesses the case to determine if there is sufficient clinical information to make a determination. If additional information is required, it is requested via telephone and in writing (Request for Additional Information) or via the web (if initial request was submitted via the web) within twenty-four (24) hours [one (1) business day if the request is received on a Friday or the day before a holiday] of receipt of the request and the review is pended. The facility/attending physician is afforded three (3) business days to submit the requested information.
7. If the requested information is not received within three (3) business days, the URC will close the case. A Notice of Incomplete Information - Certification Review Suspended will be sent to the facility/attending physician informing each party that the case has been closed.
8. Once all available information has been received, the URC performs review of the case to:
 - evaluate the proposed admission for medical necessity and appropriateness of the setting by screening the information contained in the request against the following criteria:
 - ⇒ InterQual's ISD-AC Severity of Illness (SI), and Intensity of Service (IS) criteria for Medical/Surgical Admissions

⇒ InterQual's ISP - Indications for Surgery and Procedures criteria for appropriateness of surgery and procedures

- evaluate the quality of care through application of appropriate quality screens as described in the *Quality Assurance and Utilization Review: Quality Screening Policy and Procedure* included in this manual
9. If the case meets criteria, the URC certifies an initial length of stay, utilizing the fiftieth (50th) percentile of Solucient's Length of Stay (LOS) norms as a guide. The URC may adjust the LOS downwards based upon the clinical information submitted.
 10. The URC assigns a Treatment Authorization Number (TAN) and next review date (on or prior to the last day certified).
 11. The facility and the physician are notified via telephone or fax, depending on the provider's requested preference, of the approval determination within twenty-four (24) hours [one (1) business day if the request is received on a Friday or the day before a holiday] of receiving the request and all necessary information. Written notification (Notice of Certification Approval - Precertification Review) is also sent to the facility and attending physician within the same timeframe.
 12. If the case does not meet criteria and/or a quality screen is failed, the case is referred for review by an HSM Physician Advisor (PA) licensed in the appropriate clinical specialty. The URC may refer the case to PA for a potential quality issue when criteria are met and the URC certifies the admission.
 13. The PA reviews the case and all available information, and if necessary contacts the attending physician to obtain additional information. If additional information is required, twenty-four (24) hours are allowed for submission of the information. The PA and/or the URC requests the information from the physician and, when appropriate, from the facility via telephone with written follow-up (Request for Additional Information) or via the web (if initial request was submitted via the web).

If the requested information is not received within twenty-four (24) hours, the URC will close the case. A Notice of Incomplete Information - Certification Review Suspended will be sent to the facility/attending physician informing each party that the case has been closed.

14. When the needed information is received, PA review continues.

The PA makes a determination based on practice standards, and his/her clinical experience and judgment. Review of the case is completed within twenty-four (24) hours of receiving the request and obtaining any necessary additional information.

15. If the PA's initial determination is to deny, verbal notification to the agency and/or the physician is made. PAs call the attending physician two (2) times prior to issuance of written denial determination. If no contact occurs because the physician is not available, HSM proceeds with issuance of the denial notification letter to maintain review timeframe completion requirements. During attempted telephone contacts the PA provides verbal instructions and contact information for the attending physician, affording the attending physician an opportunity to discuss the case (peer-to-peer conversation). HSM makes every attempt to arrange a peer-to-peer conversation within one (1) business day of a request with the same PA making the initial determination or as soon as possible.

NOTE: A peer-to-peer conversation that occurs following issuance of the denial determination notification in no way may change the PA's initial denial determination. If the attending physician continues to disagree with the PA's determination following the peer-to-peer conversation, the attending physician may submit a request for reconsideration to HSM. Please refer to the Reconsideration Policy and Procedure for detailed information on this process.

16. If the admission is approved and no quality concern(s) is/are identified, steps ten (10) and eleven (11) as described above are completed.
17. If the admission is denied or quality concern(s) is/are identified, verbal notification of the facility and/or the physician (based on whether the PA informed the physician) is made within twenty-four (24) hours of receiving all necessary information. Written notification of the denial determination is sent to the beneficiary/representative, the facility, and the attending physician, within twenty-four (24) hours of the determination.
18. Determination notifications will include the following information:

Notices of certification approval will include:

- date of notice
- date(s) of service being approved
- the number of days certified for hospital admission
- the Treatment Authorization Number (TAN)
- the Last Day Certified (LDC)

Notices of certification denial will include:

- date of notice
- date(s) of service being denied
- the principal and clinical rationale for denial
- the process for submitting a reconsideration, and
- reconsideration timeframes

NOTE: The beneficiary's denial notice will not contain the principal and clinical rationale for the determination.

19. The beneficiary or representative, the facility, and the physician have a right to reconsideration of any denial decision. Refer to the *Reconsideration Process Policy and Procedure* section of this manual for additional information.
20. If a quality issue is confirmed by the PA, the facility and/or physician have a right to request a quality re-review. Refer to the *Quality Re-review Policy and Procedure* section of this manual for additional information.