

Inpatient Obstetrical and Newborn Admissions

Objective:

Establish a consistent process for reviewing designated obstetrical and newborn inpatient stays that ensures access to medically necessary care for Mississippi Medicaid beneficiaries, while meeting appropriateness and quality of care standards.

Performed By:

Inpatient Review Supervisor, Inpatient Coordinator, Utilization Review Coordinators (URC), Physician Advisor Referral Data Entry staff, Physician Advisors (PA)

Policy:

Hospitals and/or physicians are required to request certification from HSM for all obstetrical and/or newborn cases meeting the criteria for certification requirement according to the following timeframes:

Certification Timeframes

Type of Delivery and Length of Stay	When Certification Required	When to Seek Certification
Vaginal Delivery Length of stay exceeds 2 days	Certification required beginning hospital day 3	Hospital day 4 or HSM's next business day
Cesarean Section Length of stay exceeds 4 days	Certification required beginning hospital day 5	Hospital day 6 or HSM's next business day

Providers may submit certification review requests to HSM via the web, telephone, FAX or mail.

MATERNITY CASES EXEMPT FROM REVIEW:

The cases listed below are exempt from certification review:

1. Cases in which the physician's orders specifically state that the patient be placed in twenty-three (23) hour observation status and the patient stayed twenty-three (23) hours or less.
2. Acute care cases in which the patient has Medicare Part A and Part B coverage unless inpatient Medicare benefits are exhausted. Note: Patients with Medicare Part A and Part B do not require certification if the patient also has private insurance.
3. Patients with Medicaid only or patients with Medicaid and third party insurance are also exempt from review in the following circumstances:
 - a. admits for vaginal deliveries who stay two (2) days or less. (See reporting of maternity admissions)
 - b. admits for Cesarean section who stay four (4) days or less. (See reporting of maternity admissions)

REPORTING OF MATERNITY ADMISSIONS FOR DELIVERY - Effective 07/01/05

Vaginal deliveries with stays of two (2) days or less or Cesarean Section deliveries with stays of four (4) days or less must be reported to HSM. Please refer to the *Maternity Admission for Delivery Reporting* policy and procedure in this manual for additional information.

NEWBORN ADMISSIONS

A separate certification is not required for newborns admitted to the “well baby” nursery who are discharged home at the time of mother’s discharge.

Four (4) situations do require separate review certification. If the newborn

- is admitted to any setting other than a “well baby nursery” (*i.e., NICU/PICU, Intermediate, etc.*) regardless of the mother’s length of stay,
- stays longer than the mother. (*The mother’s date of discharge should be used as the certification admit date.*),
- is transferred from a well baby setting to a more acute setting. (*The infant’s transfer date should be used as the certification admit date.*), or
- is admitted to any setting other than a “well baby nursery” and is born to a mother who has Medicare A and B coverage.

It is also important to note that:

- infants **must be** admitted or transferred to a NICU/PICU, Intermediate, etc., setting in order to require separate certification from HSM. (*Changing the infant’s status or level of care without physically transferring the infant to a more acute setting does not require HSM certification.*)
- it is necessary to provide HSM with the name of the infant. “Baby Boy” or “Baby Girl” is **not acceptable**.

HSM will document, track and profile instances for which certification review was required but not obtained. Information regarding these instances of non-compliance with Medicaid program requirements will be forwarded to the Mississippi Division of Medicaid for consideration of interventions.

HSM will notify the requestor of determinations within twenty-four (24) hours of receipt of the request and all necessary information, or one (1) business day if the request is received on a Friday or the day before a holiday

If services are denied, HSM will notify the requestor via telephone of the determination within twenty-four (24) hours, or one (1) business day if the request is received on a Friday or the day before a holiday. Written notification will be issued to all involved parties within the same timeframe

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 by telephone, FAX, or mail to HSM within thirty (30) calendar days of the date on the denial notice for non-expedited reconsiderations. Expedited reconsiderations must be submitted within three (3) business days of the denial notice. Refer to the *Reconsideration Process Policy and Procedure* section of this manual for additional information.

Procedure: Obstetrical and Newborn Cases

1. Request for certification of cases must be submitted to HSM by the facility or attending physician according to the established timeframes (see table on page 1 of this policy).

2. This request may be submitted by web, telephone, FAX, or mail. To expedite the certification process, HSM encourages facilities/physicians to utilize the web/telephone option. For telephonic review, having a completed HealthSystems of Mississippi Medicaid Admission Review Form available at the time of the call will significantly reduce the amount of time necessary to complete the certification process. If the FAX submission method is chosen by the facility/physician, a completed HealthSystems of Mississippi Medicaid Admission Review Form must be used to submit the request.
3. 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 of the specific information needed to be submitted within one (1) business day of notification. The non-clinical review staff attempts telephone contact two (2) times and documents the attempts in the electronic tracking notes screen.

If the information is not received within the designated 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 re-initiate the review process.

If the necessary information is received within the designated timeframe, the review request is forwarded to the Utilization Review Coordinator (URC).

4. Upon receipt of the request, the Utilization Review Coordinator (URC) verifies the mother's eligibility. Facility and attending physician identification is also verified, including telephone and FAX numbers.

If the beneficiary is not eligible or has no remaining inpatient hospital benefits, the facility and physician are notified via telephone with written follow-up (Notice of Receipt of Certification Request - Non-Medicaid Beneficiary or Benefits Exhausted). This ends the review process.
5. The URC assesses the case to determine if there is sufficient clinical information to make a determination. If not, the URC requests additional information via telephone and in writing (Request for Additional Information) or via the web (if initial request was submitted via the web) within one (1) business day [if the request is received on a Friday or the day before a holiday] of receipt of the request. The review is considered pended until the information is received. The facility/attending physician has one (1) business day to submit the requested information.
6. If the requested information is not received by HSM within one (1) business day, the case will be closed. HSM will issue written notification (Notice of Incomplete Information - Certification Suspended) to the facility/attending physician informing each party that the case has been closed.

If the information is received while the beneficiary remains in the hospital, the case will be reopened. Review of days not certified (if any) and review required for continued stay will be performed. If the information is received after the beneficiary is discharged, the facility must submit a post-discharge concurrent review request. Refer to the *Post Discharge Concurrent*

Review policy and procedure in this manual for additional information.

7. Once all available information has been received, the URC performs review of the case to:
 - evaluate the 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.
8. 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. If a URC is able to certify the admission, he/she may still refer the case to PA for a potential quality issue.
9. The URC assigns a Treatment Authorization Number (TAN) and next review date (on or prior to the last day certified).
10. HSM will notify the requestor of determinations twenty-four (24) hours of receipt of the request and all necessary information, or one (1) business day if the request is received on a Friday or the day before a holiday.

If services are denied, HSM will notify the requestor via telephone of the determination within twenty-four (24) hours, or one (1) business day if the request is received on a Friday or the day before a holiday. Written notification will be issued to all involved parties within the same timeframe.

11. If the case does not meet criteria, and/or the Solucient's ninety-ninth (99th) percentile has been met or exceeded and/or a quality screen is failed, the case is referred for physician review.
12. The PA reviews all available information, and, if necessary, contacts the attending physician to obtain additional information. If additional information is required, the case is pended and one (1) business day is allowed for submission of the information. The PA and/or the URC request 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 by HSM within one (1) business day the case will be closed. A Notice of Incomplete Information -Certification Suspended will be sent to the facility/attending physician informing each party that the case has been closed. When the needed information is received, PA review continues.
13. 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 hours of receiving/initiating the request and obtaining any necessary additional information.

If the PA's initial determination is to deny, verbal notification to the facility and/or the physician is made. PA's attempt to call the attending physician and/or facility two (2) times prior to issuance of written denial determinations. 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 call 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. Refer to the Reconsideration Policy and Procedure for detailed information on this process.

14. If the admission is approved and no quality concern(s) is/are identified, the case is forwarded to the Physician Advisor Referral Data Entry (PARDE) who enters the PA's assigned length of stay, and completes steps nine (9) and ten (10) described above.
15. If the admission is denied, the review is forwarded to the Denial/Reconsideration Coordinator who verbally notifies the requestor by telephone. Verbal notification is made regardless of whether no callbacks have been requested from HSM and regardless of whether the review was submitted via the web. The DRC will only verbally notify the requestor if the PA had not already done so in step thirteen (13).

HSM issues written notification to all involved parties within twenty-four (24) hours [one (1) business day if the request is received on a Friday or the day before a holiday]. All denial notifications are issued via mail. No denial notifications are issued by autofax.

Notices of certification approval will include the following information:

- 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 the following information:

- 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 denial notification letter will not include the medical basis for the denial.

16. The beneficiary/representative, the facility and the physician have a right to a reconsideration of any denial decision. Refer to the *Reconsideration Process Policy and Procedure* section of this manual for additional information.
17. If a quality issue is confirmed by the PA, refer to the *Quality Screening* policy and procedure in this manual for additional information on this process.
18. If concurrent review (continued stay) is required, please refer to the *Concurrent Review Policy and Procedure* in this manual for additional information on this process.