

Inpatient Acute Care Admissions- Concurrent Review

Objective:

Establish a consistent process for reviewing all Medical/Surgical 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, Utilization Review Coordinators (URC), Physician Advisors (PA)

Policy:

It is the facility's responsibility to obtain concurrent certification on or prior to the last day certified (LDC). If the last day certified is a Saturday or Sunday or a holiday, the facility must request concurrent review on HSM's next business day.

If continued stay certification (concurrent review) is not obtained as required, the facility must submit a request for review using HSM's Concurrent Review Form for the appropriate setting (i.e., inpatient, swing-bed, etc.). The request may be submitted to HSM by web, telephone, or FAX.. The web request option is not available for swing-bed services. Refer to Swing-Bed Admissions – Concurrent Review Policy and Procedures in this manual for additional information. This requirement applies to those cases where HSM has certified the admission and/or prior continued stay. The HSM Concurrent Review Form is to be used regardless of whether the beneficiary remains in the hospital or has been discharged.

NOTE: Psychiatric residential treatment facilities must request concurrent review at least seven (7) business days prior to the last day certified.

If the admission was not precertified and the beneficiary remains in the hospital, the facility should request an admission review as soon as the occurrence is identified. HSM will perform all required review activity on the case to date and determine whether continued hospitalization is necessary. This review can be requested via the web, telephone, or FAX.

HSM provides all facilities with a daily list of beneficiaries whose certification expires within forty-eight (48) hours. HSM may also provide the attending physician with this list if requested by the attending physician. It is the responsibility of the UR staff at each facility to request concurrent review on or prior to the Last Day Certified (LDC).

To avoid unnecessary telephone calls and to streamline the certification process, HSM requires all facilities to FAX to HSM an admission and discharge list, indicating Medicaid beneficiaries, on the day following admission/discharge. Weekend admissions/discharge list should be submitted to HSM on Monday. This admission and discharge list is also available electronically on HSM's website.

Note: It is the responsibility of the facility to ensure that concurrent review takes place and that all inpatient stays are certified.

The beneficiary or representative, the facility and the physician have a right to 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: Concurrent Certification Review

1. **Admission was Precertified - Beneficiary Remains in Hospital:** The facility must submit a request for review using HSM's Concurrent Review Form for the appropriate setting (i.e., inpatient, swing-bed, etc.) or submit a request via the web, telephone or FAX on or prior to the LDC. *[Process continues with step three (4).]*

Admission was Precertified – Beneficiary Discharged: The facility must submit a review request as outlined in the *Post Discharge Concurrent Review Policy and Procedure* in this manual.

2. **Admission was Not Precertified - Beneficiary Remains in Hospital:** If the admission was not precertified and the beneficiary remains in the hospital, the facility should request a concurrent review by submitting a completed HealthSystems of Mississippi Medicaid Concurrent Review Form to HSM as soon as the occurrence is identified. This request may be submitted via the web, telephone, FAX or mail. To expedite the certification process, HSM encourages facilities to utilize the web option. The web request option is not available for swing-bed services. For telephonic review, a completed request form available at the time of the call will significantly reduce the amount of time necessary to complete the precertification process.

Admission was not Precertified – Beneficiary Discharged: The facility must request a retrospective review as outlined in the *Retrospective Review Policy and Procedure* in this manual. A web or telephonic review request may be submitted for stays of eight (8) days or less (no web option for swing-beds).

The facility is required to indicate the circumstances for the delayed certification. HSM will track and generate profiles of instances where inpatient precertification was not obtained. These profiles will be supplied to the Mississippi Division of Medicaid for consideration of interventions.

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. 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 initiate 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.

Once the necessary information is received, the review request is forwarded to the Utilization Review Coordinator (URC).

4. The URC verifies eligibility and remaining beneficiary inpatient hospital benefits. 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. Written follow-up (Notice of Receipt of Certification Request - Non-Medicaid Beneficiary or Benefits Exhausted) is sent to both the facility and attending physician. This ends the review process.

5. Once eligibility and remaining beneficiary hospital 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 has one (1) business day to submit the requested information. Information submitted should include:

- current medical/mental health status
- treatment results to date
- proposed treatment plan for continued stay
- expected outcome
- short- and long-term discharge needs
- care delivered to determine if it has been, and will continue to be, consistent with standards of care
- care delivered to determine if the level of care continues to be the most appropriate level of care, for meeting the medical/psychiatric needs of the beneficiary
- care delivered to screen for quality concerns

6. If the requested information is not received by HSM within twenty-four (24) hours, 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. 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 has been discharged from the hospital, refer to the *Post Discharge Concurrent Policy and Procedure* for additional information.

7. Once all available information has been received, the URC:
 - screens the request against the following criteria:
 - ⇒ InterQual's ISD-AC Intensity of Service (IS) criteria for Medical/Surgical Admissions
 - ⇒ InterQual's ISP - Indications for Surgery and Procedures criteria for appropriateness of surgery and procedures (if applicable)
 - evaluates the quality of care through application of appropriate quality screens according to the *Quality Assurance and Utilization Review: Quality Screening Policy and Procedure*;

8. If the case meets criteria, the URC certifies additional days utilizing the ninety-ninth (99th) 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. The URC may certify the concurrent review request but still refer to PA for a potential quality issue(s).
9. The URC updates the total number of days certified and assigns the next review date (on or prior to the LDC).
10. The facility and/or the attending 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 - Concurrent Review, is sent to the facility and the attending physician within the same timeframe.
11. If the case does not meet criteria, and/or a quality screen is failed, the case is referred for review by a Physician Advisor (PA) licensed in the appropriate specialty.
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 twenty-four (24) hours are 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 twenty-four (24) hours, 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.

13. When the needed information is, the PA review continues.

The PA makes a determination based on practice standards, and his/her clinical experience and judgment.

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 to have 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.

Review of the case is completed within twenty-four (24) hours of receiving/initiating the request and obtaining any necessary additional information.

14. If additional days are approved, step eight (8) is performed for the first concurrent review extension. If the URC has assigned the seventy-fifth (75th) percentile on a prior review, he/she will assign the next percentile [ninetieth (90th)] or other percentile/days.
15. If the continued stay is denied, verbal notification of the facility and the physician (based on whether the PA informed the physician) is made within twenty-four (24) hours of receiving all necessary information.
16. 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.

Notices of certification approvals 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 denials will include the following information:

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

NOTE: The beneficiary's notice will not contain the medical basis for the denial.

17. 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.
18. If a quality issue is confirmed, 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.