

## ***Inpatient Acute Care Admissions- Post Discharge Concurrent Review***

### ***Objective:***

Establish a consistent process for reviewing, on a retrospective basis, 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 via the web, telephone, FAX, or mail. The web request option is not available for swing-bed services. 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: It is the responsibility of the facility to ensure that concurrent review takes place and that all inpatient stays are certified.***

If the patient has been discharged, and continued stay certification (concurrent review) was not obtained as required, HSM will accept a request for review for the remaining length of stay not yet reviewed by HSM. HSM will perform all required review activity on the case to date and determine whether continued hospitalization was necessary. This review can be requested via the web, telephone, FAX, or mail. The web request option is not available for swing-bed services.

Review determination and notification are completed within twenty (20) business days (from the day HSM receives all necessary information) allowing ten (10) business days for the URC to complete the review, and ten (10) additional business days if the case is referred for physician review.

HSM will document and profile instances of non-compliance with Post Discharge Concurrent review timeframes. Post Discharge Concurrent certification requests will be considered non-compliant if the circumstances for the delayed certification is for any reason other than that the beneficiary's Medicaid eligibility was not established at the time the services were rendered. Please refer to the HSM's Provider Certification Non-compliance Policy for additional information.

### ***Procedure: Post Discharge Concurrent Certification Review***

1. The facility must submit a request for review by telephone or by using HSM's Concurrent Review Form by web, FAX, or mail. The web request option is not available for swing-bed services.
2. If the FAX or mail method is chosen for submitting a review request, the non-clinical review staff (clerical staff) reviews 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 FAX 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).

3. 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 requestor is 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.

- 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 and the review is pending). The facility/attending physician has ten (10) calendar days to submit the requested information.
4. If the requested information is not received by HSM within the allotted timeframe, 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. HSM will track each occurrence and generate profiles for identification of patterns of non-compliance with Medicaid program requirements.
  5. 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*;
6. If the case meets criteria, the URC updates the total number of days certified utilizing the ninety-ninth (99<sup>th</sup>) percentile of Solucient's Length of Stay (LOS) norms as a guide. The URC may certify the Post Discharge Concurrent review request. However the case may be referred to PA if a quality screen is failed.
  7. Written notification, Notice of Certification Approval-Post Discharge Concurrent Review, is sent to the facility and the attending physician.
  8. 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.
  9. The PA reviews all available information, and if necessary contacts the attending physician to obtain additional information. If additional information is required, a period of ten (10) days is allowed for submission of the information. The PA and/or the URC request the information, 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 the allotted timeframe, 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, the PA review continues.

10. 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, affording the attending physician the 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 (20) business days of receiving/initiating the request and obtaining any necessary additional information.

11. If additional days are approved and no quality concern(s) is/are identified, the URC completes step six (6).
12. If the continued stay is denied, verbal notification of the requestor (based on whether the PA informed the physician) is made within twenty-four (24) hours of receiving all necessary information.
13. 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 denial notice will contain the principal or clinical rationale for the denial determination.**

14. 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. Refer to the *Reconsideration Process Policy and Procedure* section of this manual for additional information.
15. 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.