

Swing-Bed Admissions - Concurrent Review

Objective:

Establish a consistent process for reviewing all Swing-Bed 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:

All Medicaid swing-bed stays must be concurrently reviewed by HSM to determine if additional length of stay can be certified and to assess the appropriateness and quality of care to be rendered. Concurrent review is conducted on or prior to the last day certified (LDC). If the last day certified falls on a Saturday, Sunday or HSM holiday, the concurrent review is conducted on HSM's next working day.

If the admission was not precertified and the beneficiary remains in the swing-bed setting, 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 swing-bed stay is necessary. This review can be requested via mail, 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. The facility should then request concurrent review on or prior to the last day certified.

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.

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

Procedure: Concurrent Certification Review - Swing-Bed

1. ***Admission was Precertified – Beneficiary Remains in Swing-Bed:*** The facility must submit a request for review using HSM's Concurrent Review Swing-Bed Form. The request may be submitted to HSM by telephone or FAX prior to or on the last day certified (LDC). *[Process continues with step three (3)].*

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 Swing-Bed:** If the admission was not precertified and the beneficiary remains in the swing-bed, the facility should request an admission review by submitting a completed HealthSystems of Mississippi Medicaid Swing Bed Admission Review Form to HSM as soon as the occurrence is identified. The request may be submitted by mail, telephone or FAX. The facility is required to indicate the circumstances for the delayed certification. HSM will track and generate profiles of instances where swing-bed precertification was not obtained. These profiles will be supplied to the Division of Medicaid for consideration of interventions.

Admission was Not Precertified - Beneficiary Discharged – The facility must request a retrospective review as outlined in the *Swing-Bed Retrospective Review Policy and Procedure* in this manual. A telephonic review request may be submitted for stays of eight (8) days or less.

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 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.

4. Once the necessary information is received, the review request is forwarded to the Utilization Review Coordinator (URC).
5. The URC verifies the beneficiary's Medicaid eligibility. Facility and attending physician identification information is also verified by the URC, including telephone and FAX numbers.

If the beneficiary is not eligible, the URC notifies the facility/physician via telephone with written follow-up (Notice of Receipt of Certification Request - Non-Medicaid Beneficiary) and ends the review process.

6. The facility representative submits updated clinical information and additional clinical information from the attending physician, if needed. Information to be submitted includes:
 - 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 acceptable treatment patterns
 - 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 problems
7. If eligibility is confirmed, 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) 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 pends the review. The facility has twenty-four (24) hours to submit the requested information.
 8. If the requested information is not received by HSM within the allotted twenty-four (24) hours, the case will be closed. A Notice of Incomplete Information - Certification Suspended will be sent to the facility and attending physician informing each party that the case has been closed. If the information is received while the patient remains in the swing-bed setting, 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 patient is discharged, refer to the *Post Discharge Concurrent* policy and procedure in this manual for additional information.
 9. Once all available information has been received, the URC performs review of the case to:
 - evaluate the proposed admission/treatment to date, if any, for medical necessity and appropriateness of the setting by screening the information contained in the request against the following criteria:
 - Division of Medicaid's Swing-Bed Criteria (Refer to *Criteria* section of this manual.)
 - evaluate the quality of care through application of appropriate quality screens described in the *Quality Assurance/Utilization Review: Quality Screening Policy* and Procedure to ensure that care proposed to be provided meets professionally recognized standards of care.
 10. If the patient's condition deteriorates to a point where acute care criteria (SI) and/or (IS) are met, the URC must refer the case for physician review. The physician may deny further swing-bed care and recommend a change to acute care status.
 11. If the case meets criteria and no quality screens are failed, the URC certifies up to thirty (30) additional days based on the clinical condition of the beneficiary. The URC may certify the review, but can still refer the case to PA if there is a potential quality issue.
 12. The URC updates the total number of days certified and assigns the next review date (on or prior to the last day certified).

The URC notifies the facility, the physician 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. A Notice of Certification Approval - Concurrent Review letter is sent to the facility and the attending physician within twenty-four (24) hours of the

determination.

If private duty nursing (PDN) services are required (only applies to beneficiaries age twenty-one (21) and under through the EPSDT Program), the facility representative is encouraged to seek early precertification from HSM. Please refer to the PDN Provider Training Policy Manual for additional information on certification requirements.

13. Notification of approval includes the number of certified days, the TAN, which is necessary for billing purposes and the last day certified.
14. If the case does not meet criteria and/or a quality screen is failed, the case is referred for physician review. The case will be reviewed by a Physician Advisor (PA) licensed in the appropriate specialty.
15. 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 a period of twenty-four (24) hours is allowed for submission of the information. The PA 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).

If the requested information is not received by HSM within the allotted 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. When the needed information is, the PA review continues.

16. 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 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.

17. If additional days are approved, the URC enters the PA's determination and completes step twelve (12).
18. If the swing-bed continued stay is denied, verbal notification of the facility and the physician (based on whether the PA informed the physician) is also made.
19. Written notification of the review denial determination is sent to the beneficiary/representative, the facility and the attending physician within twenty-four (24) hours of the determination.

Notice of certification approval will include the following information:

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

Notice of certification denial 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 an reconsideration, and
- reconsideration timeframes

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

20. The URC repeats this process at each review date, until the beneficiary is discharged, or continued stay is denied.
21. The beneficiary/representative, the facility or 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.
22. 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.