

Swing-Bed Admissions - Retrospective Certification Reviews

Objective:

Evaluate, on a retrospective basis, the medical necessity, quality of services provided in a Swing-Bed setting, the appropriateness of services, and the number of days reasonably required to treat the beneficiary's condition.

Performed By:

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

Policy:

Retrospective certification review is initiated when a health care facility notifies HSM that one of the following has occurred:

- The beneficiary received a service and the past admission and hospital stay through discharge was not submitted to HSM for precertification and/or certification of days
- The beneficiary was not Medicaid eligible at the time of admission but has since received a retroactive eligibility status.

There are three (3) options available to facilities/providers for submission of requests for certification:

1. The facility completes the HSM Retrospective Certification Request Form and attaches a copy of the entire medical record, or
2. The facility completes the HSM Retrospective Certification Request Form and attaches copies of the following parts of the medical record: Face Sheet, History and Physical, Discharge Summary, Operative/Procedure Notes, Pathology Report (where applicable), Physician's Orders and Progress Notes, Lab and X-ray Reports, or
3. For admissions of eight (8) days or less, the facility may submit requests for review and relevant information via telephone.

If the beneficiary was discharged during the same weekend as admission, HSM will accept the admission review by telephone, fax (use the Admission Review Form), , if it is submitted by the following Friday. Otherwise, the facility must request a retrospective review which must be submitted by mail or fax.

The facility must explain such circumstances to HSM. HSM will monitor and track such occurrences.

Review and notification will be completed within twenty (20) business days (from the day HSM receives all necessary information. Telephonic retrospective reviews meeting established criteria will be assigned a Treatment Authorization Number (TAN) by the URC at the completion of the review. Cases which are referred to a Physician Advisor (PA) will be completed within two (2) business days.

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 of the denial notice. Please refer to the *Reconsideration Process Policy and Procedure* section of this manual for additional information.

HSM will document and profile instances of non-compliance with precertification/concurrent review timeframes. All retrospective reviews resulting from failure to obtain precertification and/or concurrent review in accordance with requirements will be considered “non-compliant” with the exception of retrospective reviews where the beneficiary’s Medicaid eligibility was not established at the time the services were rendered. Refer to HSM’s Provider Certification Non-Compliance Policy for additional information.

HSM will conduct retrospective review of cases with dates of service older than one (1) year ONLY in the following situations:

- The patient was Medicaid eligible at the time of admission and the facility submits proof that the claim was filed with the fiscal agent in a timely manner by submitting the Transaction Code Number (TCN) assigned to the claim
- The patient’s Medicaid eligibility was retroactively established and the request for certification was received within one (1) year of the eligibility determination date.

NOTE: Cases not meeting the above criteria are not eligible for certification and should not be submitted to HSM for review.

Procedure: Retrospective Review - Patient Has Been Discharged

1. The facility submits a request for retrospective review to HSM by selecting one of the three (3) available options below:
 - a. The facility completes the HSM Retrospective Certification Request Form and attaches a copy of the entire medical record via mail or fax, or
 - b. The facility completes the HSM Retrospective Certification Request Form and attaches copies of the following parts of the medical record: Face Sheet, History and Physical, Discharge Summary, Operative/Procedure Notes, Pathology Report (where applicable), Physician’s Orders and Progress Notes, and Lab and X-ray Reports via mail or fax, or
 - c. For admissions of eight (8) days or less, the facility may submit requests for review and relevant information via telephone.

The facility is required to indicate the circumstances for the delayed certification on the Retrospective Certification Request Form. HSM will record, track and generate profiles of instances where inpatient precertification/concurrent review was not obtained. Refer to HSM’s Provider Certification Non-Compliance Policy for additional information.

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 initial 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. The URC will review the request, verify Medicaid eligibility, and determine whether HSM will proceed with the review.
 - A. If the beneficiary was not eligible, HSM notifies the facility and physician in writing (Notice of Receipt of Certification Request- Non-Medicaid Beneficiary). This ends the review process.
 - B. If the date of service is less than one (1) year old, the URC will initiate certification review if the beneficiary is Medicaid eligible during the dates of service.
 - C. If the date of service is more than one (1) year old, based on the discharge date, and the beneficiary was retroactively eligible for Medicaid, the URC will initiate certification review after the retroactive eligibility status has been verified when the request for review is received within one (1) year of the retroactive Medicaid eligibility determination.
 - D. If the date of service is more than one (1) year old, based on the discharge date, and the beneficiary was not retroactively eligible for Medicaid, the URC will determine if the claim was submitted timely (using the TCN) and, if the claim was timely, will initiate certification review. If the claim was not filed timely or if a TCN was not submitted along with the review request, the URC will log in the request and notify the facility that the request is not acceptable.
5. If the URC determines that the request for retrospective review is acceptable, the URC then checks to see if a prior review has already been completed. If the URC identifies the request as a duplicate, HSM will inform the facility of the duplicate request along with the results/status of the original review.
6. If the URC finds that the request is not a duplicate of a prior review, the URC verifies the facility and attending physician information, including telephone and fax numbers.

The following situations require swing-bed certification:

- The patient has only Medicaid coverage.
 - A patient having both Medicare and Medicaid coverage is admitted to a swing-bed for intermediate care (Medicare only covers skilled care).
 - Patients having Part A Medicare are the responsibility of the Medicare program when in a swing-bed for skilled care. Medicaid will pay the Medicare co-insurance after the twentieth (20th) consecutive day in a swing-bed for Medicare/Medicaid beneficiaries through day one hundred (100) or the last day covered by Medicare, whichever comes first. When Medicaid becomes the primary payor, the stay must be certified.
7. If all required information was not submitted with the request, missing information is requested from the facility, and the case is pended. This Request for Additional Information is issued to the

facility informing them the review is pended and that the information must be submitted within ten (10) calendar days for review to proceed.

8. If the additional information is not received within the allotted timeframe, 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.
9. Once all available information has been received, the URC performs review of the case. The URC must:
 - evaluate the medical necessity and appropriateness of the setting by screening the clinical information submitted along with the request for review against the following criteria:
 - ⇒ Division of Medicaid Swing-Bed Criteria
 - evaluate the quality of care through application of appropriate quality screens according to HSM's *Quality Assurance and Utilization Review: Quality Screening Policy and Procedure*, to ensure that care provided meets professionally recognized standards of care
10. If the case meets criteria and no quality screens are failed, the URC reviews the entire length of stay.
11. If approved, a Treatment Authorization Number (TAN) is assigned and written notification (Notice of Certification Approval - Retrospective Review) is sent (via mail or fax) to the facility and attending physician within twenty (20) business days of the receipt of all necessary information. Notification of approval includes the number of certified days and the TAN, which is necessary for billing purposes.
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 specialty.
13. 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, 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.

14. If the case is approved and no quality concern(s) is/are identified, the URC enters the Pa's documentation and certifies the entire length of stay and completes the notification process outlined in step eleven (11).
15. If the admission **OR** days of the stay is/are denied, written notification of the review determination is sent to the beneficiary/representative, the facility, and the attending physician within twenty (20) business days of receipt of all necessary information.

Notices of certification approval will include the following information:

- date of notice
- date(s) of service being approved
- the number of days certified for the hospitalization
- the Treatment Authorization Number (TAN)

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
- denial start date
- may include approved number of days (partial approval)
- the process for submitting an reconsideration, and
- reconsideration timeframes

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

16. The beneficiary or representative, the facility and the physician have a right to a reconsideration of any denial or partial approval decision. Refer to the *Reconsideration Process Policy and Procedure* section of this manual for additional information.
17. 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.