<table>
<tr><td colspan="3" rowspan="2">Policy Title: Concurrent Hospital Review</td><td colspan="2">POLICY #: 70.2.3</td></tr>
<tr><td colspan="2">Line of business: ALL</td></tr>
<tr><td>Department Name:
Utilization Management</td><td>Original Date
11/97</td><td colspan="2">Effective Date
5/19</td><td>Revision Date
12/18</td></tr>
<tr><td colspan="4">Department Head:</td><td>Date: 3/21</td></tr>
<tr><td colspan="4">Medical Services/P&T Committee: (If Applicable)</td><td>Date: 4/21</td></tr>
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PURPOSE

To establish and define mechanisms for the Blue Shield of California Promise Health Plan (Blue Shield Promise) Utilization Management (UM) Department to concurrently review, approve, modify, or deny, inpatient care services. To identify provider preventable conditions as a condition of payment and comply with the State and Federal regulations, in accordance with Section 2702 of the Affordable Care Act.

POLICY

Blue Shield Promise provides for continual reassessment of all acute inpatient care through concurrent review. Other levels of care such as partial day hospitalization or skilled nursing care may also require concurrent review. Authorization of inpatient services is generally on a per diem basis. The authorization is given for the admission day and from then on, on a day to day basis contingent on the inpatient care day satisfying approved criteria/guidelines for the level of care for that day. This would include the professional services delivered to the inpatient on that day. Procedures, diagnostic studies, or professional services provided on an otherwise medically necessary inpatient day which do not appear to satisfy approved criteria/guidelines are noted in Auth Accel and evaluated by the Blue Shield Promise Chief Medical Officer or physician reviewer for determination.

Blue Shield Promise shall establish a process of coordinating with Claims and QI Departments when provider preventable conditions are identified.

BLUE SHIELD OF CALIFORNIA PROMISE NOTIFICATION: Blue Shield of California Health Plan shall be notified prior to any elective admission, and as soon as possible for any non-elective admissions.

FIRST CONCURRENT REVIEW: Blue Shield Promise shall conduct initial concurrent review within 24 hours of notification of patient's admission to acute care facility.

ELECTIVE ADMISSIONS:
Elective admissions are reviewed prospectively. The date of the first concurrent review will generally occur on the second hospital day. The benefit of this process is to identify further

discharge planning needs the member may have due to unforeseen complications and or circumstances.

- Clinical information may be obtained from the admitting physician, the hospital chart, or the hospital Utilization Review (UR) nurse.
- The case manager will compare the clinical presentation to approved criteria/guidelines.
- If approved criteria/guidelines are satisfied, an appropriate number of days will be authorized for that stay. If the patient is still in house, further concurrent review will be performed daily.
- The number of hospital days and level of care authorized for elective admissions are variable.
- They are based on the medical necessity for each day of the patient's stay and the application of approved criteria/guidelines and practitioner recommendations.
- When considering approval of admission and continued stay, individual and local healthcare delivery system factors will be considered. (See UM P & P 70.2.42 UM Standards for Medical Decision Making)
- If the clinical information obtained does not satisfy approved criteria/guidelines, the Case Manager will contact the admitting/attending physician directly for additional information.
- If the approved criteria/guidelines are satisfied, authorization will be issued. If approved criteria/guidelines are not satisfied, authorization will be pended, and the case forwarded to the Blue Shield Promise Chief Medical Officer or physician reviewer for review.
- The Chief Medical Officer or physician reviewer will contact the admitting/attending physician to review the case.
- The Chief Medical Officer or physician reviewer may approve, modify, or deny the requested level of care.
- In the event that the case involves the expertise of a specialist, the Chief Medical Officer or physician reviewer may consult with a specialist selected from the Blue Shield Promise list of Board Certified Specialists.
- A summary of the consultation will be documented on the Physician Consultation Form.
- The practitioner will be notified within the timeframes specified in UM P & P 70.2.50.

<u>URGENT/EMERGENT ADMISSIONS</u>:

- As specified in the UM P & P # 70.2.2 Admission Review, an inpatient stay may be authorized after hours by the on call licensed LVN or RN at the time of admission notification.

- If initial clinical information is not sufficient for the licensed LVN or RN to authorize he/she will issue a tracking number and request a concurrent review with clinical details to occur within one business day or as soon as possible after initial Blue Shield Promise notification.

- Determination of satisfaction/non-satisfaction of criteria, and authorization issuance occurs as specified above.

SUBSEQUENT CONCURRENT REVIEW:

- Subsequent concurrent reviews are obtained no later than the end of the currently authorized period. Information may be obtained from any of the sources as specified above.

- Determination of satisfaction/non-satisfaction of criteria, and authorization issuance occurs as specified above.

- Additional days authorized are documented in Auth Accel reflecting all pertinent medical information.

- If there is no information available to make a determination, authorization will be deferred and the case pended for retrospective review (See P & P 70.2.10 Retrospective Review). The practitioner will be notified within the timeframes specified in UM P & P #10.2.11-MediCal or 50.2.11-Medicare.

CONCURRENT REVIEW NOT MEETING CRITERIA:

- In the case of inpatient, intensive outpatient, or ongoing ambulatory services, care shall not be discontinued until the enrollee's treating practitioner has been notified of the Blue Shield Promise's decision, and a care plan has been agreed upon by the treating practitioner that is appropriate for the medical needs of that patient.

- For concurrent review decisions that result in a denial or modification, the practitioner will be notified within the timeframes specified in P & P 70.2.50.

DISCHARGE PLANNING:

- Discharge planning is an integral part of inpatient concurrent review. Planning for discharge needs begins at the time of notification of admission and continues throughout the hospital stay.

- Discharge planning shall include ensuring that necessary care, services, and supports are in place in the community for the dual-eligible member once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver.

PAYMENT ADJUSTMENTS FOR PROVIDER-PREVENTABLE CONDITIONS:

Provider preventable condition (PPC) means a condition that meets the definitions of:

A. Health Care-Acquired Condition (HCAC) – Health care-acquired condition is a medical condition for which an individual was diagnosed that could be identified by a secondary diagnostic code described in the Social Security Act as follows:

1. The cases described by such code have high cost or volume, or both;

2. The code results in the assignment of a case to a diagnosis-related group

3. that has a higher payment when the code is present as a secondary diagnosis;

4. The code describes such conditions that could reasonably have been prevented through the application of evidence-based guidelines.

Health Care Acquired Conditions

- Apply to Medicaid inpatient hospital settings;

- Are defined as the full list of Medicare's HAC, with the exception of deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement in pediatric and obstetric patients.

B) Other Provider-Preventable Condition – a condition occurring in any health care setting (inpatient and outpatient) that is identified by the State (Medicaid); has a negative consequence to the beneficiary; is auditable; and includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

List of Medicare Hospital-Acquired Conditions (HAC) (as of 2011):

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma
    - Fractures
    - Dislocations
    - Intracranial injuries
    - Crushing injuries
    - Burns
    - Electric shock
- Manifestations of poor glycemic control
    - Diabetic ketoacidosis
    - Nonketotic hyperosmolar coma
    - Hypoglycemic come
    - Secondary diabetes with ketoacidosis
    - Secondary diabetes with hyperosmolarity
- Catheter-associated urinary tract infection
- Vascular catheter-associated infection
- Surgical site infection following:
    - Coronary artery bypass graft
    - Bariatric surgery
        - Laparoscopic gastric bypass
        - Gastroenterostomy
        - Laparoscopic gastric restrictive surgery
    - Orthopedic procedures:
        - Spine
        - Neck
        - Shoulder
        - Elbow
- Deep Vein Thrombosis / Pulmonary Embolism

- Total knee replacement
- Hip replacement

PROCEDURE

1. The Inpatient Case Manager shall identify provider preventable conditions (PPCs) through concurrent reviews of inpatient and ambulatory cases, re-admissions in the hospitals, skilled nursing and rehab facilities, and any other opportunities that trigger identification of patient adverse events.

2. The Inpatient Case Manager shall enter the code as a variance in Care Web QI. Care Web QI has a drop-down list of all the health-acquired codes where the Case Manager can select.

3. The identified cases shall be reported to the appropriate committee using the DHCS standard tool.

4. The report shall be given to QI Department for identification of quality care issues.

5. The report shall be forwarded to Peer Review Committee for appropriate action, as required.

6. The identified cases shall be forwarded to Claims Department for appropriate action, as required by the federal law.

Reporting:

On a quarterly basis, a quality report is run for all HAC codes identified in Care Web QI and match them with the claims payment of all hospital authorization information to determine if those health-acquired conditions are reported.

REFERENCES

NCQA UM 5, Timeliness of UM Decisions
Federal Register, Vol 76, No. 108
42 CFR § 447.26
Institute for Healthcare Improvement