<table>
<tr><td colspan="3">Policy Title:
Concurrent Hospital Review</td><td colspan="2">POLICY #: 10.2.30
Line of business: Medi-Cal</td></tr>
<tr><td>Department Name:
Utilization Management</td><td>Original Date
11/97</td><td colspan="2">Effective Date
11/22</td><td>Revision Date
12/18, 6/22, 11/22, 2/23</td></tr>
<tr><td colspan="4">VP Approval:
Tracy Alvarez, VP, Medical Care Solutions</td><td>Date of Approval:
2/17/2023</td></tr>
<tr><td colspan="4">Medical Services/P&T Committee: (If Applicable) PHP CMO</td><td>Date of Committee Review:
2/9/2023</td></tr>
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A. PURPOSE

To define the policy and procedure and provide guidance on how Blue Shield Promise Health Plan's (BSCPHP) Utilization Management (UM) Department will concurrently review 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.

B. DEFINITIONS

1. "Concurrent Review" is the utilization review for members currently in an acute or post-acute setting. The three components of this member centric review: 1) medical necessity review; 2) discharge and transitional care planning; and 3) coordination of care. Utilization Management's focus during acute hospital stay is for a smooth transition across the continuum of the member's stay.

Commented [CA1]: Need to better define. It's the "utilization review"

2. "Discharge Planning" begins at time of admission to ensure that necessary services and supports are in place in the community before the individual leaves the hospital or institution in order to reduce re-admission risks, improve member and family participation, enhance member satisfaction, assure post-discharge follow-up, increase medication safety, and to support a safe transition.

3. "Medical Necessity" is the term that includes all covered services that are reasonable and necessary to protect the life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22 CCR §51303(a) and 42 CFR §438.210(a)(5).

   a. When determining the medical necessity of covered services for Medi-cal beneficiary under the age of 21, medical necessity is expanded to include the standards set forth in 42 USC §1396d(r) and W&I Code §14132.

   b. For individuals under age 21, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is considered medically necessary when it is necessary

Commented [CA2]: Need to define acronym

to correct defects and physical and mental illnesses and conditions that are discovered by screening services.

C. POLICY

I. BSCPHP 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. The authorization is given for the admission day and from then on, is reviewed concurrently based on the member's condition using approved criteria/guidelines.

II. BSCPHP Identifies and reports Health Care Acquired Conditions (HCAC) and Provider Preventable Conditions Care (PPC) according to Section 2702 of the Patient Protection and Affordable Care Act of 2010.

D. PROCEDURE

I. **BSCPHP NOTIFICATION:** BSCPHP will be notified by the provider or facility prior to any elective admission, and as soon as possible for any non-elective admissions.

II. CONCURRENT REVIEW NOT MEETING CRITERIA:

a. 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 BSCPHP's decision, and a care plan has been agreed upon by the treating practitioner that is appropriate for the medical needs of that patient.

b. For concurrent review decisions that result in a denial or modification, the practitioner will be notified within the timeframes specified in P & P 10.2.38 Auth Deferral.

III. DISCHARGE PLANNING:

a. 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.

b. Discharge planning shall include ensuring that necessary care, services, and supports are in place in the community for the 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.

IV. ELECTIVE ADMISSIONS:

a. Elective admissions are reviewed prospectively. The date of first concurrent review will 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.

b. Clinical information may be obtained from the admitting physician, the facilities Electronic Medical Records (EMR), or the hospital Utilization Review/Case Management (UR) nurse.

Commented [CA3]: Is this truly happening??

Commented [BK4R3]: If they are on the prior auth list it is

Commented [CA5R3]: @Bartley, Karin - However, the following sentence states "concurrent review." There is a discrepancy here. While elective admissions can get the first couple of days authorized in Prior auth (and this is only if the facility actually asks for the inpt days with the service request). Not all elective admissions are reviewed prospectively as we may not be notified of an elective admission until it has already occurred.

Commented [CC6R3]: As Karin indicated, we review upon request.

Commented [CA7]: Or hospital case manager

c. The UM nurse will compare the clinical presentation to approved criteria/guidelines.

d. 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 to establish ongoing medical necessity.

e. The number of hospital days and level of care authorized for elective admissions are variable based on clinical presentation.

f. 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.

g. When considering approval of admission and continued stay, individual and local healthcare delivery system factors will be considered. (See UM P & P 10.2.22 UM Standards for Medical Decision Making)

h. If the clinical information obtained does not satisfy approved criteria/guidelines, the UM nurse will contact the admitting/attending physician directly for additional information.

i. 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 BSCPHP Chief Medical Officer or physician reviewer for review.

j. BSCPHP Medical Director or physician reviewer may approve, modify, or deny the requested level of care.

k. In the event that the case involves the expertise of a specialist, the BSCPHP Medical Director or physician reviewer may consult with a specialist selected from the BSCPHP list of Board-Certified Specialists.

l. The practitioner will be notified within the timeframes specified in P & P 10.2.38 Auth Deferral

V. **FIRST CONCURRENT REVIEW:** BSCPHP conducts initial concurrent review within 72 hours of notification of patient's admission to acute care facility.

VI. **SUBSEQUENT CONCURRENT REVIEW:**

a. BSCPHP will respond to a concurrent authorization request within three (3) Calendar Days or less, consistent with the urgency of the Member's medical condition and in accordance with H&S Code section 1367.01(h)(1). 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.

Commented [CA8]: Should be BSCPHP UM Nurse

Commented [CA9]: IF variable, what is the variance based on?

Commented [CA10]: I don't think this is correct. Doesn't the BSCPHP Nurse contact the hospital CM for info and if not obtained, then requests for a P2P?

Commented [BK11R10]: This is the PHP process

Commented [CA12]: Is this correct? Does Dr. Cruz get notified of these??

Commented [BK13R12]: It says either so we are covered

Commented [CA14]: What/where is this list? Is this AMR?

Commented [CA15]: Where is 5 working days from? NCQA is 3 calendar days

Commented [BK16R15]: This is DHCS language

Commented [CA17R15]: @Bartley, Karin and @Albertsen, Mirela But isn't PHP also held accountable to NCQA and DMHC standards? NCQA and DMHC both indicate 3 days TAT for Urgent Concurrent Review for Medicaid.

Commented [CA18]: I don't think this is true either

Commented [BK19R18]: This is true

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

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

d. If there is no information available to make a determination, BSCPHP Medical Director will review request and potentially deny for lack of information. The practitioner will be notified within the timeframes specified in P & P 10.2.38 Auth Deferral.

VII. **URGENT/EMERGENT ADMISSIONS:**

a. 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 UM Clinicians at the time of admission notification.

b. If initial clinical information is not sufficient for the licensed UM Clinicians 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 BSCPHP notification.

E. MONITORING:

N/A

F. REPORTING:

N/A

G. REFERENCES & ATTACHMENTS:

1. 42 CFR § 447.26
2. Federal Register, Vol 76, No. 108
3. Institute for Healthcare Improvement
4. NCQA UM 5, Timeliness of UM Decisions
5. P & P 10.2.8 Auth Deferral

H. REVISION HISTORY:

Date	Modification (Reviewed and/or revised)	E-Filing Number
2/2023	Updated Regulatory Requirements DHCS	