

Policy & Procedure			
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Contract Reference(s):	LDH 2015-2015 RFP Section 8.4; 4.3.2, 8.4.5 – 8.4.5.3		

POLICY

The Plan performs Concurrent Review of inpatient hospitalizations to:

- Assess the medical necessity of inpatient confinement based on documentation of Member's care;
- Evaluate member eligibility and appropriate utilization of inpatient services;
- Promote delivery of quality care on a timely basis;
- Facilitate the discharge plan and allow for peer consultation between the attending facility physician and the Plans' Medical Director, Behavioral Health Medical Director or physician designed, as needed; and
- Identify and facilitate transition to alternate levels of care when appropriate.

ACLA does not require authorization or Medical Necessity review for observation services up to 48 hours. All observation service extension requests exceeding 48 hours require an authorization.

ACLA associates review all requests for services to reduce inappropriate and duplicative use of health care services. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligible members under the Medicaid State Plan. ACLA shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member. ACLA may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210.

ACLA shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210.

ACLA shall deny payment to providers for Provider Preventable conditions including but not limited to those conditions:

- Defined by LDH in Section 25.8 of the Louisiana Medicaid Program Hospital Service Provider Manual;
- That have been found by LDH, based upon a review of medical literature by qualified professions, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
- That have a negative consequence for the member;
- That are auditable; and
- That include, 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.

ACLA shall require all providers to report provider-preventable conditions associated with claims for payment or member treatments for which payment otherwise be made. ACLA shall report all identified provider preventable conditions to LDH in a format specified by LDH.

UM Program medical management criteria and practice guidelines shall be posted to the ACLA website. If ACLA uses proprietary software that requires a license and may not be posted publicly according to associated licensure restrictions, the MCO may post the name of the software only on its website. Upon request by an enrollee, their representative, or LDH, the MCO must provide the specific criteria and practice guidelines utilized to make a decision and may not refuse to provide such information on the grounds that it is proprietary. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.

Concurrent Review is performed by licensed qualified clinicians, including nurses and licensed mental health and substance abuse clinicians who are supported by licensed physicians. Only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested. The individual(s) making these determinations shall have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.

Concurrent Review decisions are based on nationally accepted guidelines as outlined in ACLA Policy #UM.008L, *Clinical Criteria*. The Concurrent Review staff can approve inpatient lengths of stay when Utilization Criteria have been met. Any decision to deny, alter or approve coverage for an admission, service, procedure or extension of stay in an amount, duration or scope that is less than requested is made by the ACLA Medical Director, ACLA Behavioral Health Medical Director or physician designee after evaluating the individual health needs of the Member, characteristics of the local delivery system and, as needed, consultation with the treating physician.

Concurrent Review determinations are documented in the appropriate medical management system to facilitate claim payment, and are communicated to the facility, attending physician and Member in accordance with ACLA Policy # UM.010L, *Timeliness of UM Decisions*. AmeriHealth Caritas Louisiana's medical management system electronically stores and reports the date and time all service requests are received, the determination, date and time determination is given to provider and member, and the documentation received supporting the decision. The ACLA medical management system generates and stores an authorization number and the effective dates of the authorization to servicing and requesting Practitioners/Providers, regardless of contracted status. Any decision to deny coverage is communicated in writing to the facility, attending physician, and to the Member in accordance with ACLA Policy #UM.017L, *Notice of Adverse Determination*.

ACLA shall not deny continuation higher level services for failure to meet medical necessity unless ACLA can provide the service through an in-network or out-of-network provider for a lower level of care. ACLA shall identify and develop alternatives to inpatient hospitalization for those members who are receiving inpatient services who could leave the hospital if appropriate alternatives were available. In the event ACLA does not provide appropriate alternatives, ACLA shall remain financially responsible for the continued inpatient care of these individuals.

ACLA shall use comparable (parity) processes, strategies, evidentiary standards, or other actors in determining access to out of network providers for mental health or substance abuse use disorder benefits that are comparable to an applied no more stringently than the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in accordance with 42 CFR §438.910(d) (3). When utilizing out-of-network provider, ACLA shall ensure, at a minimum, the following:

- The provider shall have qualifications equivalent to providers within the network; and
- Upon request ACLA shall submit to LDH proof of the out-of-network provider meeting these requirements.

ACLA shall report the number of out-of-state placements as specified by LDH. LDH may require ACLA to take corrective action in the event LDH determines the rate of out of state placements is excessive.

An ACLA associate may need to Use and/or Disclose a Member's Protected Health Information (PHI) for the purpose of Treatment, Payment and Operations (TPO). Federal HIPAA privacy regulations do not require Health Plans to obtain a Member's written consent or Authorization prior to Using, Disclosing, or requesting PHI for purposes of TPO therefore, PLAN is not required to seek a member's authorization to release their PHI for any one of the aforementioned purposes (see ACFC Policy #168.227, *Use and Disclosure of Protected Health Information Without Member Consent/Authorization*).

ACLA associates may not Use, request or Disclose any PHI that is more than the minimum necessary to accomplish the purpose of the use, request, or disclosure (with certain exceptions as outlined in ACFC Policy #168.217, *Minimum Necessary Rule*). ACLA Associates are required to comply with specific policies and procedures established to limit uses of, requests for, or disclosures of PHI to the minimum amount necessary.

ACLA will maintain adequate administrative, technical, and physical safeguards to protect the privacy of PHI from unauthorized use or disclosure, whether intentional or unintentional, and from theft and unauthorized alteration. Safeguards will also be utilized to effectively reduce the likelihood of use or disclosure of PHI that is unintended and incidental. (see ACLA Policy #161.112, *Safeguards to Protect the Privacy of Protected Health Information*). ACLA will reasonably safeguard PHI to limit incidental uses and disclosures. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and occurs as a by-product of an otherwise permitted use or disclosure. (See ACLA Policy #161.112, *Safeguards to Protect the Privacy of Protected Health Information*)

All documentation created or maintained in this policy will be recorded in the appropriate information system. ACLA shall retain documents relating to PHI for 7 years in accordance with company policy, unless otherwise required to retain such documentation for a longer period of time under applicable law or regulation (see ACLA Policy #161.001, *Documentation Retention Period: Documents Relating to the Privacy of Protected Health Information*).

Associates must follow Facsimile guidelines in handling PHI that is transmitted or received in accordance with the company policy (see ACLA Policy #161.110, *Facsimile Machine and Transmission of Protected Health Information*).

ACLA shall ensure that inpatient psychiatric hospital and concurrent utilization reviews are completed by an LMHP for each enrollee referred for psychiatric admissions to general hospitals. The MCO shall comply with the requirements set forth in the Inpatient Psychiatric Services Rule [Louisiana Register, Vol. 21, No. 6, Page 575].

Concurrent utilization reviews are administrative in nature and should not be reported to LDH in encounter data. These reviews are not considered prior authorizations because inpatient reimbursement is not edited against the utilization review prior to payment. Also, there are instances where individuals personally presenting at the inpatient psychiatric hospital may be admitted by hospital staff. However, LDH does reserve the right to recoup reimbursement when concurrent utilization reviews fail to document medical necessity for the inpatient psychiatric treatment.

PURPOSE

To outline the process for Concurrent Review of inpatient hospital confinements.

DEFINITIONS

See: ACLA Policy #UM.001L Glossary of Terms

See: ACFC Policy # 168.235 HIPAA Privacy Definitions

PROCEDURE

A. Concurrent Review

1. Concurrent Review is initiated when;
 - A facility notifies the ACLA UM Department of an inpatient admission,
 - An inpatient stay extends beyond the last approved or last reviewed day; or
 - A member submits, orally or in writing, a request for continued inpatient care.
2. Clinical information to facilitate Concurrent Review is requested from the facility. Clinical information should include, but is not limited to, the following:
 - Medical history
 - Mental health and substance abuse history
 - History of present illness
 - Presenting symptoms
 - Current clinical status
 - Plan of care
 - ER treatment
 - Current treatment
 - Disposition
 - Discharge plan
 - Information regarding condition and instructions at prior discharge if readmission is at the same facility
3. Record review, to collect the above information, is conducted on-site at facilities where onsite review is mutually agreed upon between ACLA and the facility.
4. UM performs concurrent reviews telephonically and/or by fax per the provider's preference. UM clinicians will access Electronic Medical Records if access is granted by the provider for ongoing/continued stay inpatient medical necessity reviews. Initial notification of admission and requests for medical necessity review are required to be called or faxed in to ACLA by the provider.
5. The UM clinician may make a determination that coverage for the admission or continued stay is Medically Necessary based on ACLA's accepted utilization management criteria (See ACLA Policy #UM.008L, *Clinical Criteria*). The facility, attending physician and/or Member are notified of this determination as outlined in ACLA Policy #UM.010L, *Timeliness of UM Decisions*.
6. If the UM clinician is not able to approve the admission for additional day(s) he/she will refer the case to the Medical Director, Behavioral Health Medical Director or physician

designee for review. Cases referred to the Medical Director, Behavioral Health Medical Director or physician designee include, but are not limited to, the following:

- Cases that do not meet currently accepted utilization management criteria for appropriateness of service or setting.
 - Cases where the number of approved days has been reached and we received no additional information.
 - Cases not progressing appropriately.
7. As part of the Physician review process, the Physician reviews the clinical information submitted in support of the request. In the instance where the Medical Director or Behavioral Health Medical Director gives verbal approval after discussion with the UM clinician, the UM clinician will document the approval, along with the reason for approval, within the specific case notes in the medical management information system.
 8. Under no circumstances may the UM clinician deny or downgrade coverage for services or downgrade the covered level of care; any such denial or downgrade must be made by either the Medical Director, Behavioral Health Medical Director or physician designee.
 9. The UM clinician is responsible for communicating the Medical Director, Behavioral Health Medical Director or physician designee's determination to the facility, treating physician and/or Member as outlined in ACLA Policy # UM.010L, *Timeliness of UM Decisions* and, as applicable, ACLA Policy #UM.017L, *Notice of Adverse Determination*.
 10. ACLA communicates the opportunity to discuss the determination with the Plan Medical Director, Behavioral Health Medical Director or physician designee to the facility and the attending practitioner as outlined in ACLA Policy #UM.105L, *Peer-to-Peer Discussion*. Appeal Rights are also communicated as outlined in Policy #131.309.03 *Member Appeals Process – Standard Pre and Post Service and Expedited Pre-Service*. Utilization Management criteria and practice guidelines shall be disseminated to all affected providers, members and potential members upon request. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.
 11. Upon admission and with each new review, ACLA will request discharge assessment and planning information. When the Member is nearing discharge level of care, ACLA communicates with the facility discharge planner to facilitate the discharge plan, finalize the discharge disposition, and arrange appropriate follow-up care.
 12. The frequency of reviews performed is determined by the acuity of the Member's illness and ACLA's contract with the facility.

REFERENCES (Cited Policies and Procedures and Source Documents)

ACLA Policy #161.110 - Facsimile Machine and Transmission of Protected Health Information

ACFC Policy #168.227 - General Policy Use and Disclosure of Protected Health Information without Member Consent/ Authorization

ACLA Policy #168.112 - Safeguards to Protect the Privacy of Protected Health Information

ACFC Policy #168.217 - Minimum Necessary Rule

ACFC Policy #168.235 - HIPAA Privacy Definitions

ACLA Policy #161.001 - Document Retention Period: Documents Relating to the Privacy of Protected Health Information

ACLA Policy #131.309.03 Member Appeals Process – Standard Pre and Post Service and Expedited Pre-Service.

ACLA Policy #UM.001L - Glossary of Terms

ACLA Policy #UM.008L - Clinical Criteria

ACLA Policy # UM.010L- Timeliness of UM Decisions

ACLA Policy #UM.017L - Notice of Adverse Determination

ACLA Policy #UM.105L - Peer-to-Peer Discussion

LA CCN-P Request for Proposals, Section 6.1.5 – 6.1.9

ATTACHMENTS

N/A

[-End of Policy-]