Government Business Division
Policies and Procedures

Section (Primary Department) **Health Care Management**		**SUBJECT (Document Title)** **Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process - Core Process**	
Effective Date 06/26/1996	**Date of Last Review** 02/28/2019	**Date of Last Revision** 12/18/2019	**Dept. Approval Date** 12/18/2019
Department Approval/Signature :			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid**	☐ Arkansas	☐ Indiana	☐ Minnesota	☐ Tennessee
☒ **Medicare**	☐ California	☐ Iowa	☐ Nevada	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☐ Kansas	☐ New Jersey	☐ Virginia
	☐ District of Columbia	☒ Kentucky	☐ New York – Empire	☐ Washington
	☐ Florida	☐ Louisiana	☐ New York (WNY)	☐ Wisconsin
	☐ Georgia	☐ Maryland	☐ South Carolina	☐ West Virginia

POLICY:

This P&P is also applicable to Medicare-please see exceptions section for Medicare specific exceptions to this P&P.

This policy is also applicable to Georgia Families 360

The purpose of this procedure is to:

- Identify the on-site and telephonic review protocol process
- Assess members' progress and needs during the inpatient stay
- Coordinate members' needs prior to discharge
- Facilitate members' transitions from inpatient through discharge
- Avoid delays in discharge due to unanticipated care needs

Document all elements required for adjudication of claims consistent with medical necessity determinations.

Behavioral Health does not do on-site reviews.

DEFINITIONS:

Appropriate Practitioner: A representative who makes utilization management denial decisions. Depending on the type of case, the reviewer may be a health plan Medical Director, or a physician, pharmacist, chiropractor, clinical psychologist, dentist or other licensed practitioner type as appropriate. Licensed health care professionals may include appropriately qualified practitioners in accordance with state laws.

Concurrent Review: Process of obtaining clinical information to establish medical necessity for an inpatient stay throughout the member's hospitalization, to include review for extending a previously approved ongoing course of treatment over a period of time or number of treatments; concurrent review may be done telephonically or on-site; the choice of

methodologies is contingent upon available health plan resources and complexity and size of the inpatient network.

Criteria and Guidelines: The health plan primarily utilizes current editions of Medical Policies and Clinical Utilization Management (UM) Guidelines (**Associate must verify if their state or region has adopted the Clinical UM Guidelines prior to using them)**, InterQual® Level of Care, MCG® Care Guidelines, State-specific Guidelines, AIM and/or Medicare Guidelines (NCD/LCD) to review the medical necessity and appropriateness of both physical and behavioral health services. These guidelines provide a rules-based system for screening proposed medical/behavioral care based on member-specific, best medical/behavioral care processes and consistently match medical services to patient needs based upon clinical appropriateness. InterQual comprehensive Level-Of-Care (LOC) alternatives/MCG® LOC are sensitive to the differing needs of adults, adolescents and children. These guidelines are evidenced-based and supported by appropriate references in the peer-reviewed literature. The health plan utilizes the current edition of American Society of Addiction Medicine (ASAM) Patient Placement Criteria for substance abuse decisions in the Florida, Iowa, Kentucky, New Jersey, and Texas health plans in establishing the medical necessity of requests for substance abuse treatment precertifications, and in the Florida health plan as part of the discharge planning.

Diagnosis-Related Group (DRG): A system to classify hospital cases into one of the approximately 500 groups, also referred to as DRGs, expected to have similar hospital resource use. DRGs were developed by Centers for Medicare and Medicaid Services (CMS) as part of the prospective payment system. DRGs are assigned by a "grouper" program based on ICD diagnoses, procedures, age, gender, discharge status and the presence of complications or co-morbidities.

Discharge Planning: Utilizing the Concurrent Review (CCR) process to coordinate a member's care needs for psychosocial, economic and other variables related to discharge planning:

1) Discharge planning is expected to be ongoing throughout the treatment process and includes member participation and whenever possible, with the member's permission, input from the member's family and other identified supports, including outpatient providers.
2) Progress in discharge planning is addressed in CCRs documentation and includes issues related to discharge readiness, barriers to discharge, specific individualized plans to support the member after discharge and basic plans for aftercare.
3) There is a plan in place for the member to have access to follow-up care after discharge from inpatient hospitalization as appropriate. (Note: A member has the right to decline to seek or receive treatment

Medical Necessity: Refers to activities that may be justified as reasonable, necessary or appropriate based on evidenced-based clinical standards of care; the following criteria are the basis for the determination that a service, procedure or supply is medically necessary:

1) The service or supply must be recommended by a physician or other licensed health care provider who is treating the member and practicing within the scope of his or her license.
2) The service, procedure or supply:
   a) Must be provided for the diagnosis, treatment, cure or relief of a health condition, illness, injury or disease and not for experimental, investigational or cosmetic purposes
   b) Must be consistent with the member's symptoms, diagnosis, condition or injury
   c) Is recognized as the prevailing standard and is consistent with generally accepted, scientifically supported evidence and usual customary practice patterns within the community
   d) Must not be solely for the convenience of the member, the member's family or provider
   e) Must be the most cost-efficient service that can be provided without sacrificing effectiveness or access to care

Medicare Advantage Dual-eligible Special Needs Plan (D-SNP): D-SNP is a health plan designed especially for those who have Medicare Parts A, B and D and Medicaid coverage. D-SNP combines Medicare and Medicaid health and drug benefits to be covered by one network of doctors, specialists, hospitals and dentists.

On-site Review: Process of CCR associates reviewing charts at the facility where the member has been admitted; these reviews are preferred because the CCR associate can review charts for specific clinical information as it relates to the admission; this hands-on approach allows for an improved quality of clinical review, which is useful information for discharge planning, rounding activities and assessing members for case-management services. Behavioral Health does not perform on-site review.

Transition of care: Movement of a member from one care setting to another as the member's health status changes; for example, moving from home to hospital as the result of an exacerbation of a chronic condition or moving from the hospital to a rehabilitation facility after surgery.

PROCEDURE:

1) **On-site Review**:
   On-site reviews may not apply to all situations and is only applicable to physical health.
   a) The Health Care Management (HCM) clinical leadership meets with the facility's Director of UM at facilities that have been selected for on-site utilization review.

b) Working with the facility UM Director, the HCM clinical leadership reviews applicable hospital policies related to on-site review to plan the CCR orientation to the associated facility.
c) Once the orientations have been agreed upon, the HCM clinical leadership and the Director of UM at the facility schedule the dates for training prior to starting on-site reviews.
d) All CCR associates scheduled for on-site review must complete all plan-level/in-house orientation prior to being allowed to perform on-site reviews at a facility.
e) All CCR associates scheduled for on-site reviews comply with the facility's requirements regarding physical examinations and immunizations; this is included as part of the orientation process prior to the start of on-site review.
f) Once all requirements for orientation and health services are completed, the CCR associate begins the on-site review process.
g) Clinical reviews are coordinated and scheduled with the assigned facility according to facility and/or health plan policy and procedure; on-site reviews are scheduled in advance unless otherwise agreed upon (e.g., health plan obtains a documented agreement with the facility stating advanced scheduling of an on-site review is not necessary).
h) Identification and Appearance
    i) Identification badges with the health plan logo must be worn and displayed at all times while performing on-site review.
    ii) Associates performing on-site review dress in accordance with the dress code Policy and Procedures of the assigned facility and/or the dress code policy; casual-dress attire should not be worn to on-site facilities at any time.
    iii) Facilities may require CCR associates to display a facility-issued ID badge.
i) Facility UM Directors are provided with a listing of contact information for the CCR on-site associate and HCM clinical leadership for discussion and/or resolution of issues or concerns related to the utilization review process.
j) On-site associates notify their HCM clinical leader immediately of any real or potential facility issues regarding the on-site review process.
k) On a quarterly basis, or as necessary, the HCM clinical leadership meets face-to-face or telephonically for review of the on-site utilization review process and to ensure all assigned on-site CCR associates are adhering to facility rules and regulations while on-site as outlined during the orientation process; CCR associates not adhering to the health plan and/or assigned facility policy and procedures may be subject to additional orientation training or may be removed from on-site review, and another CCR associate may be assigned to the identified facility; in addition, based upon the exact policy and procedure violation, corrective action for the CCR associate may be administered as applicable.

2) **Acute Inpatient Admission (Telephonic and On-Site Reviews):**
   a) Admission approvals and continuing Length-Of-Stay (LOS) approvals are determined by utilizing the nationally recognized InterQual® LOC Criteria/MCG® LOC Criteria as determined by the health plan. See #4 below for NICU admission exceptions.
   b) Urgent Concurrent Requests - An initial decision is required within twenty-four (24) hours (or one (1) calendar day) of receipt of the request. The time frame may be extended for the following reasons:
      i) The request to approve additional days for urgent concurrent care is related to care not previously approved, due to lack of necessary clinical information. The clinical associate documents that at least one (1) attempt was made and was unable to obtain the needed clinical information within the initial twenty-four (24) hours after the request for coverage of additional days. In this situation, a decision is made within seventy-two (72) hours of the date of the request for coverage.
      ii) The request to extend urgent concurrent care was not made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. In this situation, the case is processed as urgent pre-service request and a decision must be made within 72 hours.

   Note: where State or Federal time standards differ from the National Committee Quality Assurance (NCQA) time standards noted above, the more stringent time standard applies.
   c) Qualified, licensed professionals supervise all medical necessity decisions which are made in accordance with currently accepted medical or health care practices, taking into account special circumstances requiring deviation from the norm.
   d) Efforts are made to obtain all necessary information, including pertinent clinical information and consult with the treating physician as necessary.
   e) The reasons for decisions and the criterion utilized are clearly documented in the claims payment system per documentation standards; criterion utilized is available upon request.
   f) The appropriate CCR associate is notified of the member's admission; notification may be via:
      i) E-mail, phone call to the National Customer Care (NCC), WebPortal or fax to the NCC for telephonic and on-site
      ii) Cellular Devices (may be used for on-site)
      iii) Health plan census reports and/or facility-specific census of members
   g) Upon notification of the acute inpatient admission, the CCR associate performs the following activities:
      i) Contacts the facility's attending physician or facility's UM staff via phone, fax, secure e-mail or during an on-site visit to request clinical information or accesses electronic records (if access has been granted) to determine if the acute inpatient admission meets criteria.

(1) If the clinical information provided meets the guidelines for medical necessity and LOC placement, the CCR associate approves the request at the time of the review; the decision can be communicated verbally, via fax and/or via secure e-mail.
   (a) **Per Diem** - The CCR can approve up to the responder days (IQ) or Goal Length of Stay (GLOS in MCG)
   (b) **DRG** - The CCR can approve up to the days covered as allowed by the DRG, notifies the UM reviewer of the next review date for d/c planning and last covered day.

(2) If the request does **not meet inpatient LOC but meets observation LOC**, the CCR associate contacts the facility and discusses the LOC. See the SLOS QRG.
   (a) If the **facility agrees to convert** to an observation LOC then the "DD12" process is followed. See the Observation Diversion Desktop Process.
   (b) If the **facility does not agree to the conversion** to observation LOC, then the CCR completes the CCR DoT Template. Under "Does not meet criteria" the CCR documents the following:
      (i) The reason the case is being referred to the MD
      (ii) Why it is not meeting criteria (what is missing)
      (iii) A short clinical summary
      (iv) Routes the request to the appropriate health plan Medical Director for review.

(3) If the attending physician or facility's UM staff cannot supply the needed clinical information, the information obtained **does not meet the guidelines for medical necessity or LOC placement** then the CCR associate refers the case to the health plan Medical Director or (appropriate practitioner) for review and determination of approval or denial based on available clinical information.
   (a) Notifies the attending physician or facility's UM staff of the decision as policy requires and the availability of the health plan Medical Director or (appropriate practitioner) to discuss denial cases in a peer-to-peer review.

(4) Where market specific regulations or contracts allow, when a facility fails to notify the health plan timely or fails to supply requested clinical information, the health plan may deny requested days as per contract and/or regulation.

3) **Acute Inpatient Concurrent (Telephonic and On-Site Reviews):**
Per Diem Reviews

a) The CCR provides continued LOS certification at each CCR interval if the acute inpatient stay continues to meet medical necessity (See #4 below for Neonatal Intensive Care Unit (NICU) continued LOS process).
b) If the information obtained from the attending physician and/or facility's UM staff does **not** meet the guidelines for continued LOS medical necessity or LOC placement, the CCR associate:

i) Offers an alternative level of care:
   (1) Member can agree; or
   (2) Complete a Medical Director Review to keep same level of care
ii) Completes the CCR DoT Template. Under "Does not meet criteria," the CCR documents the following:
   (1) The reason the case is being referred to the MD
   (2) Why it is not meeting criteria (what is missing)
   (3) A short clinical summary
iii) Routes the case to the health plan Medical Director or (appropriate practitioner) for review and determination of approval or denial.
iv) Notifies the attending physician or facility's UM staff of the decision as policy requires and the availability of the health plan Medical Director or (appropriate practitioner) to discuss denial cases in a peer-to-peer review.

c) The CCR continues the discharge planning process, which includes coordination of care needs for psychosocial, economic and other variables related to discharge planning (Refer to Procedure #4 – Discharge Planning).

DRG reviews

1) The CCR follows-up as clinically needed or weekly with the facility to ensure discharge planning is appropriate.

2) The CCR documents the d/c plan with each follow up in the medical management system using the appropriate DoT template.

Once the outlier days are reached the CCR begins per diem reviews. During per diem reviews the health plan can determine the amount of days approved per review based on severity of the case.

4) **NICU Admissions (Continued LOS):**
   a) If less than thirty-two (32) weeks gestation, the CCR associate performs a minimum of weekly reviews and discharge planning focusing on:
      i) Mom and support system for mom and baby
      ii) Identify significant social issues
      iii) Referrals of infants less than 1200gms for SSI and transition to market-specific applicable programs (e.g., Medicaid Fee- For-Service (FFS))
      iv) Home Health Care Assessments
   b) At thirty-two (32) weeks adjusted gestational age forward, the CCR associate may perform CCRs from once a week to daily depending upon the clinical readiness of the infant for discharge.
      i) Infants who have morbidities (e.g., apnea, chronic lung disease with oxygen dependency) or intervening clinical conditions that would necessitate additional prolonged hospitalization (i.e., sepsis, neonatal necrotizing enterocolitis, major

surgery) the CCR associate performs a weekly review. The timing of reviews should be discussed at NICU rounds.

ii) Infants approaching discharge criteria (e.g., clinical stability, maintaining body weight in an open crib, nippling all feeds and having a pattern of weight gain) the CCR associate reviews should increase in frequency in order to detect and mitigate avoidable delays in the infant's clinical progression towards discharge.

(1) If the information obtained from the attending physician and/or the facility's UM staff does not meet the medical necessity criteria, the CCR associate sends the case to the health plan Medical Director (or appropriate practitioner) for review and determination of approval or denial.

(a) The health plan NICU Progression of Care References may be utilized as secondary to assess progression of care and to identify the need for pro-active intervention in preparation for a timely and clinically appropriate discharge.

(2) Notifies the attending physician or facility's UM staff of the decision as policy requires and the availability of the health plan Medical Director (or appropriate practitioner) to discuss denial cases in a peer-to-peer review.

c) The CCR associate refers cases to the NICU/Pediatric Case Manager as indicated by the NICU /Pediatric CM referral-trigger list or any other Medical Director or (appropriate practitioner).

i) NICU Infants are referred to CM when Discharge Plan/Date is in place- 2-4 weeks prior to discharge.

ii) NICU CM Referral Trigger List includes but not limited to:

(1) ≤ 34 weeks gestation with multiple needs
(2) Complex genetic conditions requiring multispecialty follow post discharge
(3) Complex medical conditions requiring multispecialty follow up and/or surgery
(4) Complex home health needs
(5) DME needs (such as monitors, vents, oxygen, tube feeding)
(6) Failure to thrive (admission and discharge weights required)
(7) Neonatal abstinence syndrome (NAS) on medication post discharge
(8) Preemie > 1200 grams with complex needs
(9) Unresolved state agency issues requiring intervention post discharge
(10) Private duty nursing
(11) Teen mothers under 18 years
(12) Other per Medical Director

d) The CCR associate continually monitors for member eligibility and provides information on market-specific waiver programs where applicable.

e) NICU review patterns may vary based upon health plan review methodology, contract, birth weight and/or DRG review process; consult your specific health plan contract for specific review process.

5) **Discharge Planning**:
   a) During the course of treatment, the CCR associate reviews and documents (using DoT template) the status of the discharge plan at **each** review. The discharge plan is reviewed for appropriateness, based on the individual's needs. The CCR associate makes every effort to ensure the following is addressed:
      i) The plan is realistic, comprehensive, timely and concrete
      ii) For readmissions, the plan evaluates factors that may have contributed to the readmissions and includes strategies to address those factors
      iii) Transition from one LOC to another is coordinated
      iv) The plan incorporates actions to assure continuity of existing therapeutic relationships, as desired by the member
      v) The member, parent or guardian understands the discharge plan and receives a signed copy
      vi) Transportation issues are addressed as appropriate
      vii) A copy of the discharge plan is sent to the outpatient provider(s), as appropriate
      viii) Psychopharmacological needs are addressed, including any potential formulary issues
      ix) Collaboration with medical and behavioral health practitioners has occurred, as necessary
      x) The member has timely access to the recommended aftercare services including date and time of first provider appointment, with whom and location
      xi) For behavioral health, the CCR confirms that an aftercare appointment with a behavioral health provider has been scheduled to occur within seven (7) calendar days after discharge, including documentation of provider contact information in the discharge notes.
      xii) Support systems are outlined and incorporated into the plan, as appropriate
      xiii) Community services and/or self-help groups are recommended, as appropriate
   b) Upon discharge of the member, the CCR associate ensures the documentation is completed in the claims payment system to include the following as per health plan documentation guidelines:
      i) Discharge date entered and episode of care is closed (discharge plan is also documented)
      ii) All objective medical facts pertinent to the case
      iii) All relevant information obtained via telephone conversations
      iv) All conversations with any individuals who supply relevant facts concerning the case
      v) All documentation must be dated
      vi) Identification of reviewer must be included and the names of all individuals consulted in the case must be documented
      vii) Documentation entry is expected at the time of the initial review and ongoing throughout the process

viii) Completes appropriate fields in the claims payment system

(1) If the admission or continued LOS is not authorized, a denial letter that includes reasons for the denial decision, appeal rights and expedited appeal information is issued to the hospital facility, the attending physician and the member based on specific NCQA, AAAHC, Balanced Budget Act, State or Federal requirements.

c) The copy of the denial letter is maintained in a secure location per health plan processes for future reference and/or appeal information.

d) The CCR associate refers members for case-management services per health plan guidelines and documents any referrals in the claims payment system for continued follow-up post discharge.

e) If at any time a potential quality issue is identified through the review process, an appropriate referral is made to the health plan Quality Management department.

REFERENCES:

42 CFR 438.6(h)
AAAHC Accreditation Standards and Guidelines: Clinical Records and Health Information
Contract for BadgerCare Plus and/or Medicaid SSI HMO Services - Wisconsin
Iowa eRFP# MED-16-009 11
Kentucky Medicaid Managed Care Contract, §1.0, 21.1, 21.2, 21.3, 34.13, 34.8
Kentucky Revised Statute 304.17A-607, KRS 304.17A.600, 304.17A-603, 304.17A-005
NCQA Accreditation Standards and Guidelines: Appropriate Professionals, Clinical Information, and Timeliness of UM Decisions
NV RFP 3260 § 3.10.19.3
Virginia FAMIS Contract 7.1.P
Virginia Medallion 3.0 Contract Section 7.1.D.I; 7.1.P
Virginia Medallion 4.0 Contract Section 8.2.N; 8.1.D
Virginia CCC Plus Contract Section 4.4; 6.2.6; 6.2.10.1
Washington Apple Health Managed Care Contract K1335 §11.11.6.1.5; Integrated Managed Care contract K2477 §11.5.1.7

Related Policies or Procedures

Clinical Criteria for Utilization Management Decision - Core Process
Clinical Information for Utilization Management Reviews - Core Process
Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process - Core Process - LA
CS-STD-004 Security Access Controls
HCM03 Advantage Part C Healthcare Organization Determinations
HCM05 Notification of Hospital Discharge and Appeal Rights policy
Health Care Management Denial - Core Process
Health Care Management Denial - Core Process - KY

Section (Primary Department)	SUBJECT (Document Title)
Health Care Management	**Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process - Core Process**

Health Care Management Denial - Core Process - LA
Medicare Coordination of Service Delivery for Dual Eligible Members (SNP)
Medicare Managing Transitions in Care
Medicare Notification of Medicare Non Coverage
Medicare Rendering Decisions on Medicare Advantage Requests
Plan Denial Processes

Prior Procedure Reference(s)
On-site Review Protocol - SBS
Concurrent Review Process

Desktop Processes
Denial - Late Notification
Denials
Inpatient Discharge Planning
Medicaid Inpatient Review
Observation Diversion
Peer to Peer and Reconsideration

Quick Reference Guides
Approval - Concurrent Review
Approval - Initial Inpatient Review
Denial - Continued Stay
Denial - Entire Admission
Documentation - CCR DoT
Documentation - Inpatient Discharge Planning DoT Tool
Documentation - Inpatient Post-MDR DoT
Handling Inpatient Late Notification
Observation Diversion
Pend to MD - Concurrent Review
Pend to MD - Initial Inpatient Review
Referring a Member to CM
Site of Service – Non Par Provider Facilities - Medicare ONLY
SLOS QRG_IQ
SLOS QRG_MCG

RESPONSIBLE DEPARTMENTS:

Primary Department: Health Care Management - Utilization Management

Secondary Department(s): Behavioral Health

Section (Primary Department) Health Care Management	SUBJECT (Document Title) Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process - Core Process

EXCEPTIONS:

Kentucky
The health plan uses the definition of Medical Necessity pursuant to the Kentucky Medicaid Managed Care Contract, Section 1: "Medically Necessary or Medical Necessity means Covered Services which are medically necessary as defined under 907 KAR 3:130, meet national standards, if applicable, and provided in accordance with 42 CFR § 440.230, including children's services pursuant to 42 U.S.C. 1396d(r)."

Health Care Service: means health care procedures, treatments, or services rendered by a provider within the scope of practice for which the provider is licensed.

Medically Necessary Health Care Services: means health care services that a provider would render to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:
(a) In accordance with generally accepted standards of medical practice; and
(b) Clinically appropriate in terms of type, frequency, extent, and duration.

All Necessary Information is limited to the items listed in statute KRS 304.17A-607(1)(i):
- Results of any face-to-face clinical evaluation;
- Any second opinion that may be required; and
- Any other information determined by the department to be necessary to making a utilization review determination (current guidance 806 KAR 17:370 for attachments to a claim)

Any medical necessity decision (Medical or Behavioral Health), to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, must be made by a licensed physician who is of the same specialty and subspecialty, when possible, as the ordering provider, has appropriate clinical expertise in treating the Member's condition or disease and is consistent with state and federal regulations and state contracts.

The health plan primarily utilizes current editions of InterQual® Criteria for Medical Necessity for both physical health and behavioral health services, except that the health plan utilizes ASAM for substance use. If InterQual® Criteria does not cover a behavioral health service, the health plan utilizes the following standardized tools for medical necessity determinations -- for adults: Level of Care Utilization System (LOCUS); for children: Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children; Early Childhood Service Intensity Instrument (ECSII). If it is determined that one of the medical necessity criteria named in this section is not available or not specifically addressed for a service or for a particular population, the health plan shall submit its proposed medical necessity criteria to the Department for Medicaid Services (DMS) for approval. The health plan may also, at their discretion, require use of other criteria they

create or identify for services or populations not otherwise covered by the aforementioned criteria/guidelines. The health plan will be given ninety (90) days to implement criteria the health plan may otherwise require.

The criteria's comprehensive range of level-of-care alternatives is sensitive to the differing needs of adults, adolescents, and children. When using the criteria to match a level of care to the member's current condition, all reviewers consider the severity of illness and co-morbidities, as well as episode-specific variables. Their goal is to view members in a holistic manner to ensure they receive necessary support services within a safe environment optimal for recovery.

These criteria and guidelines are objective and provide a rules-based system for screening proposed medical and behavioral health care based on patient-specific, best medical care processes and consistently match medical services to patient needs, based upon clinical appropriateness of services across the continuum of care: prospectively, concurrently and retrospectively.

The health plan has in place mechanisms to check the consistency of application of review criteria. The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate. The Medical Director and Behavioral Health Director supervise the UM program and are accessible and available for consultation as needed.

For behavioral health discharges, the Telephonic Concurrent Review Clinician also makes certain the member has a follow-up appointment within seven (7) days of discharge and documents the location, time, and practitioner in the discharge notes. The health plan requires, through Provider contract provision, that all Members receiving inpatient behavioral health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge. The health plan ensures that Behavioral Health Service Providers contact Members who have missed appointment within twenty-four (24) hours to reschedule appointments.

Urgent Concurrent Review: The health plan will provide a utilization review decision and notification within twenty-four (24) hours after obtaining all necessary information to make the utilization review decision. A failure to make a determination and provide written notice on a requested service within the required timeframes shall be deemed authorized.

Urgent health care services include all participating requests for hospitalization and outpatient surgery.

Precertification is not required for births or the inception of NICU services and shall not be required as a condition of payment. Continued hospital NICU stays require authorization.

The health plan shall identify and develop community alternatives to inpatient hospitalization for those Enrollees who are currently receiving inpatient psychiatric facility services and could be discharged from the facility if an appropriate treatment alternative were made available in the community. In the event that the health plan does not provide and cover an appropriate community alternative, the health plan shall remain financially responsible for the continued inpatient care of these individuals until the health plan ensures availability and access to an appropriate community provider.

REVISION HISTORY:

Review Date	Changes
12/18/2019	• Off-Cycle Review • Revised KY exception language
07/22/2019	• Off-cycle Review • Revised NY/WNY Exception
02/28/2019	• Annual review • Removed KS as an applicable market • Removed KS from Criteria and Guidelines section • Revised References • Removed KS & MN exception language; Revised KY, NJ & VA exception language
01/25/2019	• Off-cycle edit to add AR as an applicable market. No content edits.
01/04/2019	• Off-cycle edit to revise TX exception language.
12/13/2018	• Off-cycle edit to add DC as an applicable market. Revised MN go-live date to 1/1/19.
08/10/2018	• Off-cycle edit to add MN as an applicable market. Exception added to notate market go-live of 12/1/18.
07/26/2018	• Off-cycle edits for Mental Health Parity • Revised KY, NJ and WA exception language
04/29/2018	• Off-cycle edit to References for NV
02/02/2018	• Annual review • Added IN as an applicable market • Revised Criteria and Guidelines definition • Minor wordsmithing to Procedures section • Revised References section

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	• Revised MMP exception language; removed TN exception language
08/30/2017	• Off-cycle edits for VA CCC+
05/23/2017	• Off-cycle edits to remove Medicaid-Medicare as an applicable product and add Medicaid-Medicare exception
03/16/2017	• Off- cycle for WA Amendment #8.
03/15/2017	• Off-cycle edit to KY exception to remove Milliman
01/23/2017	• Off-cycle edits to add IA contract reference and revise IA exception language
12/22/2016	• Annual review by PPOC and MOC. Removed MMP applicability, wordsmithing and process changes in procedure section; updates to references section; added NYW exception language and revised WI exception language; added NICU CM triggers.
12/01/2016	• Off-cycle edits to add New York – Western as an applicable market and add NY – Western exception language.
06/21/2016	• Off-cycle edit to Texas exception language
04/13/2016	• Off-cycle edit to add “telephonic” to purpose statement of Policy section – “Identify the on-site review protocol process”
03/24/2016	• Off-cycle edit to WA exception language
03/10/2016	• Administrative task. Transferred to Shared Services template. No content revisions made.
12/03/2015	• Off-cycle edit to add Iowa as an applicable market. Approved by Iowa DHS 12/03/2015 for use effective 04/01/2016. • Added Iowa to Criteria and Guidelines definition • Added Iowa exception language
10/22/2015	• Annual review by PPOC and MOC • Minor wordsmithing throughout • Added KY reference • Updates to KY, NJ, VA & WA exception language
07/01/2015	• Additional edits for WA Apple Health Contract
05/20/2015	• Removed LA as applicable market. Added related P&P - Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process – Core Process - LA
04/21/2015	• Off-cycle edits to New York exception
03/04/2015	• Off-cycle edits for WA Apple Health Contract
01/20/2015	• Language added to VA exception to meet MED 3.0 & FAMIS contract amendment • Edits made for LA readiness Review
11/25/2014	• Updated VA exception
08/22/2014	• NJ made edits per the MLTSS Project

Section (Primary Department) **Health Care Management**	**SUBJECT (Document Title)** **Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process - Core Process**

06/24/2014	• Annual Review
06/17/2014	• Added Desktop Process to References Section
11/01/2013	• Off-cycle review to add Virginia as an applicable market. Add VA exception and move to MBU template.