AmeriHealth Caritas Family of Companies
Medicaid Policy and Procedure

Supersedes:	State-specific ACFC Health Plan versions of this policy	**Policy Number:**	UM.002
Subject:	**Concurrent Review**		
Department(s):	Utilization Management	**Current Effective Date:**	08/2024
		Last Review Date:	06/2024
		Original Effective Date:	09/15/2022
		Next Review Date:	08/2025

Applicable Lines of Business:

☒**100**: Keystone First
☒ **500/530/540/550**: AmeriHealth Caritas Pennsylvania
☒ **2100**: AmeriHealth Caritas Louisiana
☒ **2400**: Select Health of South Carolina
☒ **2600**: Blue Cross Complete
☒ **5400/5410**: AmeriHealth Caritas District Of Columbia
☒ **6400:** AmeriHealth Caritas Florida
☒ **7100**: AmeriHealth Caritas Delaware
☒ **7200:** Community HealthChoices (KFCHC, ACPCHC)
☒ **900**: AmeriHealth Caritas New Hampshire
☒ **1200:** AmeriHealth Caritas North Carolina
☒ **7700:** AmeriHealth Caritas Ohio

Scope
This policy applies to the following AmeriHealth Caritas Family of Companies (ACFC) business operations.

Member is defined as enrollee, participant,recipient or beneficiary.

As necessary to comply with local state regulations, the contents of this policy may be copied into a stand-alone document for a specific business operation.

Purpose
To outline the process for Concurrent Review of inpatient hospital stay.

Policy
ACFC performs Concurrent Review of inpatient hospitalizations to:

- Assess the medical necessity of inpatient admission based on documentation of Member's care
- Evaluate appropriate utilization of inpatient services
- Promote delivery of quality care on a timely basis, and
- Identify members for referral to case management or transitions of care programs.

In addition, Concurrent Review provides information to facilitate the discharge plan and allows for peer consultation between the attending facility physician and the ACFC Medical Director, Behavioral Health

Medical Director, or physician designee, as needed (See also Policy UM.105, *Peer-to-Peer Discussion*). Concurrent Review also identifies and facilitates transition to alternate levels of care when appropriate.

Concurrent Review is performed by Utilization Management (UM) Reviewers including Clinical Care Reviewers (CCR) comprised of (registered nurses) and Behavioral Health UM Reviewers (licensed behavioral health clinicians (BH) and/or substance use disorder (SUD) clinicians) who are supported by licensed physicians. Concurrent Review decisions are based on nationally accepted guidelines as outlined in Policy UM.008, *Utilization Management 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 ACFC 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 information system to facilitate claim payment, and are communicated to the facility, attending physician and Member in accordance with Policy UM.010, *Decision Response Time.* The ACFC UM medical management information 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 Policy UM.017, *Notification of Adverse Benefit Determination*.

All information with PHI is handled in accordance with Policy 168.213 *Safeguards to Avoid Unauthorized Use or Disclosure of Protected Health Information, Personally Identifiable Information, and/or Certain Sensitive Demographic Data* and related policies listed in the Related Procedures section, unless otherwise required by Law or regulation.

Definitions
N/A
See Policy UM.001 Glossary of Terms

Procedure

1. Concurrent Review is initiated (1) when a facility notifies the ACFC UM Department of an inpatient admission; and/or (2) when an inpatient stay extends beyond the last approved or last reviewed day; or (3) ADT notification, where available. Clinical information to facilitate Concurrent Review is requested from the facility. Clinical information should include, but is not limited to, the following:
    a. Medical history
    b. History of present illness
    c. Mental Health and Substance Abuse History
    d. Presenting symptoms
    e. Current clinical status
    f. Plan of care
    g. ER treatment
    h. Current treatment
    i. Disposition
    j. Discharge Plan

k. Information regarding condition and instructions at prior discharge if readmission
l. Psychosocial situation including home environment

2. UM performs concurrent review electronically (i.e., provider portal submission, electronic medical record(EMR)), telephonically and/or by fax per the provider's preference, including ADT admission and discharge data, where available. At facilities for which ACFC has an agreement with a facility for an on-site reviewer, medical record review to collect the above information is conducted. UM may also gather information for initial and ongoing/continued stay inpatient medical necessity reviews through EMR access when it is agreed upon and access is granted by the provider.

3. For the scope of review information, staff will:
    a. Accept information for continued stay reviews from any reasonably reliable source at the facility/practitioner
    b. Collect only the information necessary to certify the requested treatment stay and assist in treatment planning
    c. Not require hospitals, physicians, or other providers to numerically code diagnoses or procedures to be considered for certification, but may request such codes, if available
    d. Not routinely request copies of all medical records on all members reviewed
    e. When medical records are requested, only request that section(s) of the record necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency, or duration of treatment
    f. Administer a process to share all clinical and demographic information on individual members among its various clinical and administrative departments that have a need to know, to avoid duplicate requests for information from members or providers

4. The UM Reviewer may make a determination that coverage for the admission or continued stay is medically necessary based on the ACFC's accepted utilization management criteria (See Policy UM.008, *Utilization Management Criteria)*. The facility, attending physician, and/or Member are notified of this determination as outlined in Policy UM.010, *Decision Response Time*.

5. Authorization for coverage of inpatient services is based on the information available at the time the authorization is issued (including information regarding the member's eligibility for coverage). Staff performing Concurrent Review base determinations solely on the medical information obtained at the time of the review determination.

6. If the UM Reviewer is not able to approve the admission or additional day/days 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 or physician designee include, but are not limited to, the following:
    a. Cases that do not meet currently accepted utilization management criteria for appropriateness of service or setting.
    b. Cases where the number of approved days has been reached.
    c. Cases where member's care is not progressing or progressing slowly leading to potential delays in treatment and/or discharge.
    d. Cases that require secondary review by a Medical Director.

7. Under no circumstances may the UM Reviewer deny, alter, or approve a lower or different level of care or scope of services than requested; any such denial or downgrade must be made by the Medical Director, BH Medical Director, or physician designee.

8. The Medical Director/BH Medical Director or physician designee reviews the clinical information submitted in support of the request and documents the determination in the medical management information system. He/she may also consult a specialty Provider for input into the determination (Policy UM.315 *Independent Consultant Review)*.

9. If the needed and approved level of care for SUD treatment is not available, ACFC will authorize the next highest level of care for SUD treatment.

10. The UM Reviewer is responsible for communicating the Medical Director or physician designee's determination electronically, by fax, phone call, and/or written notification to the facility, treating physician and/or Member as outlined in Policy UM.010, *Decision Response Time* and, as applicable, Policy UM.017, *Notice of Action for Adverse Benefit Determination.*

11. For adverse benefit determinations, the UM Reviewer communicates to the facility and the attending practitioner the opportunity to discuss the adverse benefit determination with the ACFC Medical Director, BH Medical Director, or physician designee as outlined in Policy UM.105, *Peer-to-Peer Discussion.*

12. Throughout the inpatient stay, ACFC communicates with the facility discharge planner to facilitate the discharge plan, finalize the discharge disposition, and help to coordinate appropriate follow-up care.

Related Policies
Policy UM.001 *Glossary of Terms*
Policy UM.008 *Utilization Management Clinical Criteria*
Policy UM.010 *Decision Response Time*
Policy UM.017 *Notice of Action for Adverse Benefit Determination*
Policy UM.105 *Peer to Peer Discussion*
Policy UM.315 *Independent Consultant Review*
See also - Policy *168.235 HIPAA Privacy Definitions*
See also - Policy 168.200 *Authorization to Use or Disclose PHI*
See also - Policy 168.212 *Facsimile Machines and Transmission of Protected Health Information*
See also - Policy 168.213 *Safeguards to Avoid Unauthorized Use or Disclosure of Protected Health Information, Personally Identifiable Information, and/or Certain Sensitive Demographic Data*
See also - Policy 168.227 *Use and Disclosure of Protected Health Information without Member Consent or Authorization*
See also - Policy 591.001 *Records Retention Policy & Schedule*

Source Documents & References
MCO Standards for Accreditation - National Committee for Quality Assurance (NCQA), Utilization Management Standards

Attachments

A: State/Plan specific addenda

Approved by

Vanessa Johnson
Vice President, Utilization Management Operations
Date: July 2, 2024

Lenaye Lawyer, MD
Vice President, Medical Affairs
Date: July 2, 2024

Revision Date	Revision
8/2023	Annual review. No changes to the policies scope or intent.
06/2024	Annual Review. No changes to the policy's scope or intent, minor formatting and grammar edits.

AmeriHealth Caritas Family of Companies

Medicaid Policy Addendum

Territory: Louisiana

Addendum Number: UM-A.002.LA

Subject: Concurrent Review

Department(s): Utilization Management

Current Effective Date:

Last Review Date:

Original Effective Date:

Next Review Date:

POLICY

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 Enrollee. 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 Enrollee in accordance with 42 CFR §438.3(i) and 42 CFR §422.208.

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.

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 an Enrollee'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 Standard).* 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.

All documentation created or maintained in this policy will be recorded in the appropriate information system. ACLA shall retain documents relating to PHI for 10 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 ACFC Policy #591.001, *Records Retention Policy & Schedule).*

Associates must follow Facsimile guidelines in handling PHI that is transmitted or received in accordance with the company policy (see ACFC Policy #168.212, *Facsimile Machine and Transmission of Protected Health Information*).

Service/Program	ACDE State Distinction	Reference/Source
Concurrent Review Initiation Process	• Concurrent Review is initiated when: o A facility notifies the ACLA UM Department of an inpatient admission via telephone, fax, provider portal or written request to the Utilization Management (UM) department, o An inpatient stay extends beyond the last approved or last reviewed day; or o A member submits, orally or in writing, a request for continued inpatient care. • 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.	
Provider Preventable Conditions (PPCs)	• ACLA shall deny payment to providers for Provider Preventable conditions including but not limited to those conditions : o Identified in the State Plan; o 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; o That have a negative consequence for the Beneficiary o That are auditable; and o 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 Enrollee treatments for which payment otherwise be made. PPCc should be identified on the Encounter file via the Present on Admission (POA) indicators.	*2.11.10- Provider Preventable Conditions (PPCs)*
Higher Level of Service Continued Stay Requests	• ACLA shall not deny continuation higher level services for failure to meet medical necessity unless ACLA can provide the service through an in-	*2.12.8.2- Other Service Authorization Requirements*

Service/Program	ACDE State Distinction	Reference/Source
	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.	
Coordinated System of Care	• If a CSoC enrolled youth no longer meets medical necessity criteria for a higher level of service (e.g. inpatient hospital) that was authorized by the CSoC Contractor, and the MCO has authorized PRTF, TGH, or SUD Residential treatment services (ASAM Levels 3.1, 3.2-wm, 3.5 and 3.7), but is unable to secure placement, the MCO shall be responsible for assuming the continued authorization of, and payment for, the higher level service until placement is made, regardless of the youth's CSoC enrollment status unless the Child and Family Team (CFT) agrees that the youth's behavioral health and/or medical condition is stable enough for the youth to be safely discharged home, and the CFT has made a plan to support the youth and family with outpatient care until placement in residential treatment is secured .	*2.11.16.5- Federal Responsibility for Payment for SBHS Provided to Enrollees Participating in Coordinated System of Care*
Behavioral Health Out-of-Network Providers	• 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: o The provider shall have qualifications equivalent to providers within the network; and o Upon request ACLA shall submit to LDH proof of the out-of-network provider meeting these requirements. o o ACLA shall report the number of out-of-	*2.9.2.4- Availability and Furnishing of MCO Covered Services*

Service/Program	ACDE State Distinction	Reference/Source
	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.	
Specialized Behavioral Health Providers	• ACLA shall ensure that all placements are at the most appropriate, least restrictive, and medically necessary level to treat the specialty needs of the Enrollee. ACLA shall defer to the responsible state agencies regarding the appropriateness of residential placement options for Long Term Supports and Services. Institutional placements should not be viewed as substitutes for needed behavioral health treatment .	*2.9.25.22- 2.9.25.25- Specialized Behavioral Health Providers*
Inpatient Psychiatric Hospital and Concurrent Utilization Reviewer Requirement	• 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].	*2.12.8.5- Other Service Authorization Requirements*
Public Health/Isolation Medical Necessity	• A public health quarantine or isolation order or recommendation also establishes the medical necessity of healthcare services	*2.4.1.5.1- MCO Covered Services*

Reference:
Louisiana Department of Health. Louisiana Medicaid Managed Care Organization Contract, 2.12.3.2-2.12.3.3; 2.12.5.1; 2.12.6.3.3

Approved By:

Rodney Wise, MD.
Rodney Wise, M.D
Market Chief Medical Officer (CMO) Signature
Date

Loretta Sonnier, MD
Lorretta Sonnier, MD
BH Medical Director
Date

Date	Description of Revision
09/26/2023	• Transitioned policy from 153.002 plan policy to corporate base policy UM.002 Concurrent Review with state specific addendum to meet plan requirements. • Removed authorization requirement for observation services; placed in Standard, Expedited Prior Authorization of Services policy (UM.003.LA) • Removed information referencing encounter data and reimbursement recoupment.