POLICY AND PROCEDURE	
Policy # and TITLE: Inpatient Admissions and Concurrent Review	
Primary Policy owner: Utilization Management	**POLICY #:** UM02
Impacted/Secondary policy owner: Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined	
1) ☐All Departments 2) ☐Behavioral Health & Social Services (BH/SS) 3) ☐ Benefits Administration (BA) 4) ☐ Care Management (CM) 5) ☐ Claims (CLMS) 6) ☐ Community Marketplace & Member Engagement (MAR) 7) ☐ Compliance (CMP/HPA) 8) ☐ Configuration (CFG) 9) ☐ Provider Contracting (CONT) 10) ☐ Cultural & Linguistics (CL) 11) ☐ Customer Service (CS)	12) ☐ Facilities (FAC) 13) ☐ Finance (FIN) 14) ☐ Human Resources (HR) 15) ☐ Information Technology / Core Systems (IT) 16) ☒ Pharmacy (PH) 17) ☒ Provider Networks (PRO) 18) ☐ QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) ☒ Utilization Management (UM) 20) ☐ Procurement (PRM) 21) ☐ Administration (SAF/BC/EM) 22) ☐ Medical Management (MM)
PRODUCT TYPE: ☒Medi-Cal	**Supersedes Policy Number:** *N/A*

I. PURPOSE

To describe the process for a Provider to obtain authorization for covered inpatient services for a Health Plan of San Joaquin and Mountain Valley Health Plan ("Health Plan") member.

II. POLICY

A. A Provider shall request authorization for elective inpatient services and post-stabilization services after an emergency admission prior to providing services to a member.

B. Emergency services are not subject to Prior Authorization, and Health Plan shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

1. Health Plan covers Emergency and Post Stabilization Services regardless of whether or not the Provider that furnishes the services is a Network Provider, Subcontractor, Downstream Subcontractor, or Out-of-Network Provider.
2. Emergency Services are available and accessible twentyfour (24) hours a day, seven (7) days a week.
3. Emergency Services shall include ambulance services for the area served by Health Plan to transport the member to the nearest Emergency Room facility with twenty-four (24) hour physician coverage.
4. Agreements for these providers reflect the one-half hour requirement for post-stabilization requests.
5. Health Plan shall follow the standard definition of a Prudent Layperson, acting reasonably, to determine that the presenting complaint might be an emergency.
6. The attending emergency physician, or the Provider treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge.

C. A hospital shall notify Health Plan:

1. Within twenty-four (24) hours for an elective admission, or
2. Once members in the Emergency Department are stabilized to request a post-stabilization authorization if Medically Necessary.

D. If a member is seen in the emergency room and held for observation (not admitted for up to twenty-four (24) hours), no prior authorization is needed.

E. If a member is seen in the emergency room for an emergency condition and is stabilized, but admission is recommended for additional medically necessary care, the hospital must notify Health

Plan and provide clinical documentation to support the medical necessity of continued inpatient care.

F. If a member requires additional inpatient services beyond the approved length of stay, the hospital must provide updated clinical documentation to support the medical necessity of continued inpatient care.

III. PROCEDURE

Inpatient Admission Process:

A. A hospital is required to notify Health Plan within 24 hours of inpatient admission.

B. Upon receipt of the admission notice, Health Plan's intake processor enters information into the medical management system and routes it to the appropriate Concurrent Review Nurse (CCRN) for review.

C. The authorization decision is completed within 72 hours of receipt of the admission notification and all clinical documentation required to make a medical necessity determination.

D. The CCRN reviews the admission information for medical necessity and appropriateness of care using nationally recognized evidence-based guidelines approved by Health Plan's QIHEC Committee, in accordance with Health Plan Policy UM06 Medical Review Criteria.

E. If the criteria are met, the CCRN approves the admission, the authorization is processed in the medical management system, a level of care (LOC) and bed type are assigned.

F. If the admission *does not* meet the criteria due to lack of documentation/information, further information from the facility staff/physician may be requested by the CCRN.

   1. If after all provided information has been reviewed and the admission does not meet established criteria, the CCRN requests a review by Health Plan Medical Director or Physician Peer Reviewer.
   2. If Health Plan Medical Director or Physician Peer Reviewer approves the admission, the CCRN assigns the bed type, length of stay and next review date.

3. Health Plan Medical Director or Peer Physician Reviewer may attempt to contact and consult with the treating practitioner prior to making a denial for medical necessity.
4. If Health Plan Medical Director or Peer Physician Reviewer denies admission, the CCRN notifies the admitting physician and the facility UR nurse within 24 hours of the decision to deny, orally or by a faxed letter.
5. A copy of the denial letter is mailed to the member and the provider and includes appeal rights.
6. The denial with the denial rationale is entered into the medical management system by the CCRN and is available immediately in the provider portal for providers to access and review.
7. The admitting physician may request an expedited peer-to-peer review/discussion:
    a. If after the peer-to-peer process, Health Plan Medical Director or Peer Physician Reviewer approves the inpatient stay, the CCRN assigns the bed type and length of stay.
    b. If after the peer-to-peer process, Health Plan Medical Director or Peer Physician Reviewer determines the admission is not to be approved:
        i. Health Plan Medical Director or Peer Physician Reviewer documents in the notes of the case being discussed the discussion that ensued, and that the admitting physician is aware.
        ii. If a NOA has not been issued for the denial, the admitting physician, facility, and member are notified in writing within 24 hours
8. The NOA includes the specific evidence-based criteria used in making the determination and specific information regarding why the service was denied.

G. **Post-Stabilization Admission Review Process**

1. Emergency services do not require prior authorization, for both in-network and out-of-network emergency services.
2. Health Plan maintains 24-hour, 7 days a week post-stabilization telephone line for members and providers, including

noncontracting hospitals, to obtain timely authorization medically necessary post-stabilization care, for circumstances where the member has received emergency services and care is stabilized, but the treating provider believes the member may not be discharged safely. This post-stabilization telephone line is available to all Emergency Departments (ED) of a Network, Subcontracted, Downstream Subcontracted or Out-of-Network hospitals.

3. A representative of the hospital shall not be required to make more than one telephone call to Health Plan, provided in all cases, Health Plan shall be able to reach a representative of the hospital upon returning the call during the call back, the representative of the hospital that makes the telephone call may be, but is not required to be, a physician or surgeon.
4. The CCRN or delegated Nurse Consultant, within 30 minutes of the time the hospital makes the initial telephone call requesting information, either authorize post-stabilization instructing the facility to admit the member or inform the hospital that Health Plan to arrange for prompt transfer of the member to a contracted hospital.
    a. For members requiring transfer to a Network or contracted hospital:
        i. The consultant nurse/CCRN works with the transferring facility to find an accepting facility and arrange transportation.
        ii. Health Plan shall pay for all medically necessary services provided to the member to maintain the stabilized condition up to the time Health Plan has set up the transfer.
5. If Health Plan fails to transfer the member within a reasonable time after notifying the facility it would assume management of the member's care, post-stabilization care shall be deemed approved, and Health Plan shall pay charges. The Chief Medical Officer (CMO) is available 24 hours a day, 7 days per week to authorize medical necessary post-stabilization services.

6. If there is disagreement between Health Plan 's CMO or Medical Directors and the treating provider regarding the need for necessary medical care, following stabilization of the member, Health Plan shall assume responsibility for the care of the member either by having medical personnel contracted with Health Plan or at a contracted facility personally take over the care of the member or accept the transfer of the member within a reasonable amount of time after the disagreement.
7. Health Plan is financially responsible for post-stabilization care services obtained from Out-of-Network and Network Providers that are not pre-authorized, but administered to maintain, improve, or resolve the Member's stabilized condition if:
    a. Health Plan does not respond to a request for pre-approval within the time allotted (30 minutes),
    b. Health Plan approves post-stabilization care without any transfer,
    c. Health Plan cannot be contacted, or
    d. Health Plan and the treating Provider cannot reach an agreement concerning the Member's care and a Health Plan physician is not available for consultation.
8. Health Plan must give the treating Provider the opportunity to consult with a Health Plan physician and the treating Provider may continue with care of the Member until a Health Plan physician is reached or one of the following criteria is met:
    a. A Health Plan physician with privileges at the treating Provider's hospital assumes responsibility for the members care,
    b. A Health Plan physician assumes responsibility for the Member's care through transfer,
    c. Health Plan and the treating Provider reach an agreement concerning the Member's care, or
    d. The member is discharged.
9. All requests for authorization and all responses to such requests for authorization of Medically Necessary post-stabilization care services must be fully documented in the member record within

the Medical Management System including the following at minimum:

a. The date and time of the request,
b. Name of the healthcare Provider making the request,
c. Name of Health Plan representative responding to the request.

10. An authorization for the member admission to the receiving (contracted) facility is deemed approved at the time transfer directive is given.
11. For members admitted to non-contracted facilities without approval, admission is reviewed for medical necessity in accordance with Section III. c of this Policy.

H. **Continued Stay Review/Concurrent Review Process**

1. The CCRN conducts concurrent review telephonically with the facility's utilization review staff, through the hospital's electronic medical record system, or review of faxed clinical on all patients in acute or post-acute facilities, including continued stay of prior authorized elective admissions, for appropriateness of care and use of healthcare services to assure medical necessary/quality and cost-effective delivery of care.
2. The objective of the concurrent review is to:
   a. Evaluate continued medical necessity.
   b. Monitor and ensure the efficient use of healthcare services.
   c. Determine if the hospital level of care is consistent with care being rendered.
   d. Evaluate the course of treatment and length of stay.
   e. Assess the quality of care in relation to professional standards.
   f. Reduce length of stay by preventing unnecessary or avoidable inpatient days.
   g. Provide timely discharge planning with the facility discharge planners.
   h. Provide case management assistance when indicated.
   i. Identify cases requiring medical director review and/or intervention, which include but are not limited to cases:
      i. Which failed to meet medical necessity criteria.

ii. For which medical information provided is insufficient to make a medical necessity decision.
iii. For which a level of care determination may be required.
iv. For which physician to physician consultation is deemed necessary, *e.g.*, procedures that may not be considered standard medical practice, questionable procedures/treatment.
v. Delay in care or delay in discharge or for inpatient care that could have been rendered on an outpatient basis as example.

j. Identify Potential Quality Issues (PQIs) and Provider Preventable Conditions (PPCs) and refer to quality improvement department.
k. If a member requires additional inpatient services beyond an approved length of stay, the hospital must provide updated clinical documentation to support the medical necessity of continued inpatient care.

I. **Notification to Non-Contracting Hospitals and Department of Managed Health Care (DMHC)**

1. Health Plan provides non-contracting hospitals in California with Health Plan 's contact information for submitting authorizations for post-stabilization care. Health Plan updates the contact information provided to the hospitals as necessary, but not less than once a year.
2. Health Plan provides the DMHC with Health Plan's contact information for submitting authorizations for post-stabilization care. Health Plan updates the contact information provided to the DMHC as necessary, but not less than once a year.

J. **Appeal Process**

1. The rendering physician or member, if in disagreement with the medical director or peer physician reviewer's decision, may request an appeal.

K. **Retrospective Review Process**

1. Retrospective review is the process that applies the inpatient review process and criteria for past-service care in which an authorization and/or claim has not yet been received by Health Plan. The Medical Management Department has 30 days to review and decide on retrospective requests.

IV. ATTACHMENT(S)

A. DHCS Medi – Cal Managed Care Plans Definitions (Exhibit A, Attachment I, 1.0 Definitions)
B. Glossary of Terms Link
C. Medi-Cal Managed Care Contract Acronyms List (Exhibit A, Attachment I, 2.0 Acronyms)

V. REFERENCES

A. Department of HealthCare Services 2024 contract section III, 5.2 Network Access to Care
B. Department of Health Care Services All Plan Letter (APL) 23-009: authorization for Post-stabilization Care Services
C. Title 42, Code of Federal Regulations, Section 438.114 Emergency and Post stabilization Services.
D. Health and Safety Code Section 1262.8
E. Health and Safety Code Section 1371.4
F. Title 28 CCR Sections 1300.70(b)(2)(I)(1)(a), and 1300.71.4.

VI. REVISION HISTORY

*Version 001 as of 01/01/2023

Version*	Revision Summary	Date
000	12/19, 3/21, 8/22, 12/22, 3/23, 7/23	N/A
001	Moved policy to new template	2/29/2024
Initial Effective Date: 2/1/1996		

VII. Committee Review and Approval

Committee Name	Version	Date
Compliance Committee	001	8/15/2024

• Privacy & Security Oversight Committee (PSOC)		
• Program Integrity Committee		
• Audits & Oversight Committee		
• Policy Review	001	6/19/2024
Quality Improvement Health Equity Committee (QIHEC)		
• Quality Operations Committee		
• Grievance		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare services (DHCS)	DHCS Contract Manager	001	11/2/2023
Department of Managed Care (DMHC)	DMHC Attorney	001	4/25/2024

IX. *Approval signature**

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

*Signatures are on file, will not be on the published copy