ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	UM-003
Policy Name	Concurrent Review and Discharge Planning Process
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Department Owner	Senior Director, Health Care Services
Lines of Business	All
Effective Date	11/21/2006
Subcommittee Name	~~Health Care Quality Committee~~Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~8/18/2023~~TBD
Compliance Committee Approval Date	~~9/19/2023~~TBD

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POLICY STATEMENT

This policy addresses the provision of inpatient services provided in an acute and long-term care acute inpatient settings: medical/surgical or behavioral. The attending physician is responsible for the care of the inpatient member seven (7) days a week, twenty-four (24) hours a day.

Admission Review: Admissions to the acute hospital / long-term care acute hospital/inpatient behavioral or sub-acute facility (i.e., SNF, Rehabilitation facility, etc.) for Elective or Non-elective diagnostic or therapeutic reasons must meet the guidelines for admission, utilizing approved written criteria, whether or not the admission was prior approved.

Continuous Stay Review: subsequent review for ongoing medical necessity. Continued stay, (timeframe dependent upon the diagnosis and the progress of the patient) review will be performed using written criteria for medical necessity/continuous care and must be met to be approved.

PROCEDURE

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A.Admission Review

1. The contracted Hospitals will fax a copy of the admission face sheet for any new admissions to the health plan within 24 hours of the admission.
   a. Elective admissions will have a tracking number and pre-

certification referral on file.

b. Emergent admissions will require new case creation.

2. All facilities, contracted and non-contracted, must notify the Alliance within 24 hours of a change in the level of care or discharge from facility.

   a. Upon request, facilities must submit clinical information to the Alliance UM Department by the end of the next business day from the time of the request.

   b. Notifications and clinical notes received outside of the above timeframes may result in a denial of the authorization for service and payment.

3. The timeliness of the admission review is based on the member's line of business:

   a. Medi-Cal: reviewed within 24 hours of receipt of the request.

   b. Group Care: reviewed within 24 hours of admission, even during non-business operating days. This ensures compliance with 45 CFR § 146.136 for the Mental Health Parity and Addiction Equity Act (MHPAEA) that requires the same standards applied for medical/surgical and mental health and/or substance abuse disorder benefits. This includes the standards for the UM authorization process and criteria applied for medical necessity review.

4. Eligibility and member's delegate assignment will be verified.

5. Authorization number will be assigned by the data system.

6. The review process may include, but not be limited to, the following:

   a. Chart review;

   b. Data collection;

   c. Application of written criteria to determine the medical necessity of admission.

   d. Review of care plans; and/or

   e. Transition of care services (TCS) and discharge planning

7. Complex and/or catastrophic cases will be discussed with the Medical Director.

8. The Medical Director will consult with the admitting practitioner on questions of medical necessity.

   a. If the Medical Director/designee, following that consultation, determines the hospitalization is inappropriate, an alternative plan will be discussed with the admitting practitioner and a patient discharge will be requested.

b. Inpatient care will be continued until the treating practitioner is notified and agrees on an appropriate care plan.

   c. Notifications will be made according to established regulatory requirements if the admission does not meet medical necessity criteria. (See most recent versions of DHCS NoticSe of Action Templates or Commercial – IHSS UM Determination Templates)

d. Only a physician/doctoral Behavioral Health Practitioner may make a decision to deny services when medical necessity criteria are not met.

B. Behavioral Health Concurrent Review Process

1. Concurrent review is conducted for mental health and substance use disorder inpatient, residential, partial hospitalization and intensive outpatient programs. For behavioral health care, concurrent reviews occur no more than two (2) days per week. Applied behavioral analysis is reviewed on a concurrent basis every six (6) months.

2. Ongoing medical necessity determinations for Group Care members are based on non-profit professional organizations guidelines (Early Childhood Intensity Service Instrument (ECSII), Child and Adolescent Level of Care (CALOCUS), Level of Care Utilization System (LOCUS), American Society of Addiction Medicine (ASAM), and World Professional Association for Transgender Health (WPATH).

3. For inpatient hospital stays and residential treatment, the review frequency is at minimum every 2 weeks or when the member's condition changes, until the Member is safely transitioned to the next level of care. For behavioral health concurrent reviews for partial hospitalization, intensive outpatient and applied behavioral analysis may occur over longer periods based on the nature of the services. For example, up to six (6) months for applied behavioral analysis (ABA). Standard Concurrent Review processes will be utilized, including physician review as needed. Notice of Action letters are sent to members and requesting providers for each concurrent review resulting in a denial of services.

   a. The Providers Initial Treatment~~s~~ plan is reviewed for:
   b. Identification of and verification that consent has been documented, contact has been made and care coordination has occurred with:
   c. Primary Care Physician (PCP)
   d. All current Behavioral Health (BH) providers,
   e. State agency affiliation(s)
   f. Identification of any non-clinical supports and the role they serve for the member.
   g. Ongoing review to monitor identified barriers to care and services and strategies to address them.

5. For inpatient hospital stays, the treatment, the review frequency is at minimum every 2 weeks or when the member's condition changes, until the Member is safely transitioned to the next level of care. For behavioral health concurrent reviews for residential treatment, partial hospitalization, intensive outpatient and applied behavioral analysis may occur over longer periods based on the nature of the services. For example, up to six (6) months for applied behavioral analysis (ABA). Standard Concurrent Review processes will be utilized, including physician review as needed. Notice of Action letters are sent to members and requesting providers for each concurrent review resulting in a denial of services.

6. Concurrent review processes for behavioral health follow the same information gathering, documentation, medical review and notice of action (NOA) processes as described in this policy for medical services.

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~~B.~~C. Concurrent Review

1. Concurrent review is performed applying written criteria to determine medical necessity on a daily basis or on the cadence indicated in the criteria guidelines or by the member's clinical condition:

   a. Two (2) to five (5) days a week, as appropriate medical care

   ~~a.~~b. Not more than two (2) days per week for mental health and substance use admissions.

   ~~b.~~c. The patient is followed through the continuum/ levels of care, until returned to the optimum level of functioning.

   ~~c.~~d. Inpatient stay days for recipients who no longer require acute hospital care and are awaiting placement in a nursing home or other subacute or post-acute care, Utilization Management staff will continue to perform continued stay reviews. The minimum review frequency is every 2 weeks or when the member's condition changes, until the Member is safely transitioned to the next level of care. Standard Concurrent Review processes will be utilized, including physician review as needed. Notice of Action letters are sent to members and requesting providers for each concurrent review resulting in a denial of services.

2. Concurrent review information is obtained either via telephonic review, by facsimile, or onsite review by a UM Clinical Reviewer.

   a. Select Medical Groups/ IPAs are delegated to perform concurrent review of assigned members applying written criteria, at the appropriate clinical cadence while hospitalized.

   b. The health plan and Medical Group/IPA UM Department coordinate with each other, as appropriate.

3. Documentation is entered in the plan's database:

   a. Member progress is documented in a clinical note in the plan's database.

   b. The review cycle is continued at the appropriate clinical cadence until discharge.

   c. Documentation includes the date, time, and condition upon patients' discharge.

4. Following review, if the Medical Director determines the patient does not meet the medical necessity criteria for the current level of care and could be safely discharged or transferred to a lower level of care:

   a. Only a physician/doctoral Behavioral Health Practitioner may make a decision to deny services.

   b. Qualified physicians review all denials of continued acute and long-term acute care (LTAC), Subacute, ICF-DD, Skilled Nursing Facility services throughout the members' hospital stays.

~~C.~~D. Notice of Action Letters

1. For admissions that do not meet ongoing medical necessity for initial admission or continued stay, Medi-Cal members and providers are sent a Notice of Action (NOA) letter, for the initial denial and at every subsequent review. See UM-054 Notice of Action and UM-057 Authorization Request, for details on decision notification content and appeal rights.

a. All other lines of business – send standard denial letter if coverage is being discontinued.

2. The UM Staff responsible for letters will follow the Standard Review procedures which includes the requirement that members and providers are given a NOA letter with accurate information about the denied date(s) and the requesting providers.

3. UM Staff will generate NOAs in the UM Information System, TruCare, which is configured to display the correct dates and providers in the automated portion of the NOA letters.

4. Prior to final issuing of NOAs, UM staff will verify the dates on the NOA match the dates of the final determination.

   a. NOAs found with discrepancies are immediately brought to the attention of UM Management team for immediate intervention.

~~D.~~E. Discharge Planning for All Lines of Business

1. Discharge planning and transitions of care services (TCS) begins at the time of admission for unscheduled patient stays and prior to admission for elective inpatient stays and continues throughout the patient's stay. The patient's progress is evaluated in order to plan for a timely discharge to the appropriate level of care with any scheduled home care or equipment as applicable.

   a. The discharge plan will be coordinated with the attending physician, the member and/or family, the hospital staff, the identified TCS care manager and any appropriate home health agencies/vendors (i.e., home health, DME vendors, etc.)

   b. The need for patient education will be assessed as part of the Discharge Planning process.

   c. Evaluation of the discharge plan is included in the concurrent review sessions between the UM Clinical Reviewer, the Medical Director and facility's discharge planning staff.

      1). The member will be evaluated for potential alternative care needs.

      2). The attending physician will be responsible for keeping the member and family informed of progress toward discharge or transition to an alternative level of care.

      3). Notification of transition to an alternative level of care:

         i). Medi-Cal members and providers are sent a Notice of Action (NOA) letter.

         ii). All other lines of business – send standard denial letter if coverage is being changed/discontinued.

   d. Based on the discharge plan, the UM Clinical Reviewer will verify benefits for services and provide contracted vendor information and issue an authorization number to the Hospital Case Manager, as appropriate.

   ~~e.~~ Non-clinical staff may administratively enter limited visit authorizations for Home Health follow up when a Home Health order is in place and an accepting provider has been identified.

   e.

   ~~f.~~ The UM Clinical Reviewer will coordinate the notification of the appropriate

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vendor regarding the discharge plan, date of discharge, and provide the authorization number.

f.

g. The UM Clinical Reviewer will apprise the appropriate Primary Care Physician (PCP) and/or mental health provider, identified TCS Care Manager, when appropriate, of the discharge instructions for the purpose of scheduling follow-up care, as needed.

h. For discharge to a lower level of care facility:

1). The discharge plan will be coordinated with the attending physician, the member and/or family and the hospital interdisciplinary staff. Evaluation of the discharge plan is included in the concurrent review process with the AAH UM Nurse/Reviewer, the facility discharge planning staff, the identified TCS Care Manager and the AAH Medical Director as indicated.

2). The Alliance UM Nurse/Reviewer will verify benefits and provide the authorization decision to the hospital for appropriate placement.

i). When significant barriers to placement exist, the Alliance UM Nurse/Reviewer will assist the facility in locating accepting facilities capable of managing the members' care needs.

- The AAH UM staff will assist in contacting potential accepting facilities.
- The AAH UM staff will initiate the Letter of Agreement (LOA) process for Out of Network facilities that would accept the member for care. The OON facility and AAH will mutually agree to the policies and procedures for discharge planning and transitional care services for the member. The procedure for discharge to the out of network facility will be coordinated with the OON facility and agreed upon before the discharge to ensure that the Member's needs are met during and after the transition. The option to create an ongoing contract with the OON facility will be offered.
- The case will be discussed at Extended Length of Stay Rounds to identify placement options.
- If LOS is prolonged, the AAH UM staff will escalate the case to AAH clinical and/or operational leadership to develop strategies to locate appropriate placement. See UM-052
  - Strategies to locate placement may include working administratively with facilities to develop capacity to manage the member's needs, contacting DHCS to assist in problem resolution, and/or identify contractual opportunities regarding placement.

~~E.~~F. Discharge Planning and Care Coordination, including for SPD Members

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1. Discharge planning covers the period from admission to a hospital or institution and continues into the post-discharge period and ensures:
   a. Necessary care, services and supports are in place in the community after discharge.
   b. Outpatient appointments and/or follow-up visits with the member and/or caregiver are scheduled.
   c. Placement in lower level of care facilities is a coordinated transition of care.
   d. All discharge planning applies to in-network providers or out of network providers if needed to meet the needs of the members.
   e. The OON facility and AAH will mutually agree to the policies and procedures for discharge planning and transitional care services for the member.
2. Discharge planning is:
   a. Conducted through collaboration between the hospital/institution discharge planning staff and the Alliance UM Clinical Reviewer and the identified TCS Care Manager.
   b. Based on a standardized Discharge Risk Assessment that is completed by either the discharging facility staff or AAH/Delegate staff prior to discharge to assess, at minimum, a member's risk of:
      1). Re-institutionalization,
      2). Re-hospitalization,
      3). Destabilization of a mental health condition,
      4). And/or SUD relapse.
   c. Documented in both the hospital's patient medical record and/or the Alliance's member database and includes the following elements:
      1). Pre-admission status, including living arrangements, physical and mental function, social support, DME, and other services received.
      2). Pre-discharge factors including an understanding of the medical condition by the member/representative as applicable, physical and mental function, financial resources, and social supports.
      3). Services needed after discharge to include:
         i). Type of placement preferred and agreed to by the member/representative.
         ii). Specific agency/home recommended by the hospital and agreed to by the member/representative.
         iii). Eligibility for ongoing care management services such as ECM, CCM, or other community case management services.
         iv). Recommended pre-discharge counseling.
      4). Summary of the nature and outcome of:
         i). Member/representative involvement in the discharge planning process

ii). Anticipated problems in implementing post-dischargeplans

iii). Further action contemplated by thehospital/institution.

~~F.~~G. Inpatient Behavioral Health Discharge Planning Coordination

a. The discharge plan is reviewed for appropriateness, based on the individual's needs, and may include the following:
b. The discharge plan is realistic, comprehensive, timely and concrete;
c. The plan takes into consideration the AAH BH Clinician's recommendations and member's preferences, as recorded in previous treatment review notes;
d. Transition from one level of care or program to another is coordinated, and involves coordination with ACBHCS for Medi-Cal members with SMI/SUD;
e. AAH incorporates actions to assure continuity of existing therapeutic relationships, as appropriate;
f. The provider assists the member, parent, or guardian to understand the status of the discharge plan and has a signed copy;
g. Transportation and other needs are addressed as applicable;
h. The discharge plan is communicated to the aftercare provider(s) as applicable and with the member's permission;
i. Psychopharmacological needs are addressed;
j. Medical condition(s) follow-up needs are addressed.
k. Collaboration with medical practitioner has occurred, as necessary;
l. The member has timely access to the recommended aftercare services including date of first appointment, with whom, where, and other treatment and community resources to be utilized;
m. Barriers to aftercare planning are addressed and need for outreach or treatment reminders are indicated;
n. Support systems are outlined;
o. Community services and/or self-help groups are recommended;
p. Linkages to EAP services are established as appropriate;
q. Family/Work/Community preparation has occurred which supports reintegration as appropriate.
r. Review of all ongoing and new in-network continuing care services (both covered and non-covered) to assist the provider/facility in identifying appropriate resources for discharge planning.

~~G.~~H. Transitional Care Services

1. The UM Clinical Reviewer will make referrals to Case/Disease Management and/or the Behavioral Health staff as appropriate, to provide Transitional Care Services at the beginning of the stay to ensure that a safe and appropriate transition plan is enacted for the member.

   a. Transitional Care Services (TCS) includes:

      - Identification of a Care Manager for TCS and communication of the Care Manager assignment to the member and facility to facilitate the participation of the Care Manager with the discharge planning and follow up.
      - Discharge Risk Assessment
        - A standardized Discharge Risk Assessment is completed by either the discharging facility staff or AAH/Delegate staff prior

to discharge to assess, at minimum, a member's risk of:

- re-institutionalization,
- re-hospitalization,
- destabilization of a mental health condition,
- and/or SUD relapse.

- Discharge Planning document.
- A full description of the Alliance TCS program is found in CM-034 Transition of Care policy.

2. The member's needs are identified based on the following:
   a. Social environment
   b. Support structure through family and friends
   c. Availability and accessibility of needed services
   d. General Safety
   e. Complete care of the member on a continuum, including mental health and substance abuse services.

~~H.~~I. Post- Acute care Admission to Hospice:

a. Hospice services will be provided to any member who receives a physician's certification that the member has a terminal illness and who elects hospice services.
b. Covered hospice services will be made available in a timely manner, preferably within 24 hours of the request.
c. Only general inpatient hospice services are subject to prior authorization (PA). PA is not a Medi-Cal requirement for routine home care, continuous home care, or respite care.
d. The following settings are considered appropriate for post-acute care admission into Hospice:
   i. The member's home;
   ii. A distinct part of a hospital psychiatric or rehabilitation unit;
   iii. A home-based community setting; or
   iv. A transition into the home.

~~I.~~J. Admission to Out of Network or Out of Area Facilities

1. Emergency admission to an Out of Network or Out of Area Facility will be followed by the UM or Behavioral Health (BH) Department. The UM/BH Clinical Reviewer will follow the member, utilizing the above guidelines, until the member is able to be safely transferred back into the appropriate network. The LOA process will be enacted for the Out of Network facility as needed or invited to contract with AAH.
2. The UM/BH Department will collaborate on a plan of care for a member who is being prior-authorized for out-of-area/network care. This includes referral to the TCS program to ensure that the safe and appropriate discharge plan and follow up care is enacted. The OON facility and AAH will mutually agree to the policies and procedures for discharge planning and transitional care services for the member.

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~~4.~~3. The Member Services department will be notified if it appears that the member has moved permanently out of the area.

~~J.~~K. Coordination with Behavioral Health

1. Admissions related to behavioral health conditions are managed by the behavioral health staff and in compliance with the regulatory requirements and most recent DHCS All Plan Letter related to Medi-Cal Managed Care Health Plan Responsibilities for Mental Health Services.
2. Behavioral health admissions are co-managed when necessary to ensure the collaboration of medical and behavioral health services. AAH will facilitate access to necessary medical information and services for transition or discharge planning.
3. Members identified with need for medical case management services will be referred as defined in CM policy.

L. Delegation Oversight

1. The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS AND ACRONYMS

Concurrent request – A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.

Discharge Planning – The activities that facilitate a patient's movement from one health care setting to another, or to home. It is a multidisciplinary process involving physicians, nurses, social workers, and potentially other health professionals; its goal is to enhance continuity of care. It begins on admission.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

UM-001Utilization Management Program
UM-051 Timeliness of UM Decision Making
UM-052 Discharge Planning to Lower Level of Care, Including Granting Administrative Days Pending Placement for Facilities contracted for Administrative Days
-UM-054 Notice of Action
UM-057 Authorization Request
UM-060 Delegation Oversight
BH-002 Behavioral Health Services
CM-001 Complex Case Management Identification, Screening Assessment and Triage
CMP-019 Delegation Oversight

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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

NONE

REVISION HISTORY

11/21/2006, 1/1/2008, 1/16/2009, 4/13/2011, 9/7/2012, 7/13/2013, 3/14/2014, 12/9/2016, 12/15/2016, 4/12/2018, 04/15/2019, 09/19/2019, 1/21/2021, 5/20/2021, 6/28/2022, 02/21/2023, 6/20/2023, 9/19~~6~~/2023, TBD

REFERENCES

1. DHCS Contract, Exhibit A, Attachment 5, Provisions 2 and 3
2. Title 42, CFR, Sections 422.118 and 422.620
3. 45 CFR §146.136 Mental Health Parity and Addiction Equity Act

MONITORING

The Compliance, Utilization Management and Behavioral Health Departments will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the ~~Healthcare Quality Committee annually.~~Quality Improvement Health Equity Committee and Administrative Oversight Committee.