

**MEDICAL ASSOCIATES HEALTH PLANS
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL
POLICY NUMBER: PP 11**

POLICY TITLE: CONCURRENT HOSPITAL REVIEW

PURPOSE: To provide immediate feedback (same day as case reviewed) to the practitioners on the appropriateness of their use of hospital services. This feedback is provided concurrently in order to improve the practitioners understanding of the hospital benefits as they pertain to the actual clinical situation.

PROCEDURE:

- I. Criteria Utilized: Nationally developed criteria are utilized for purposes of establishing an estimated length of stay, pre-authorization, determining the appropriateness of continued hospital stay, and identifying discharge indicators. These criteria have been developed by Milliman Care Guidelines, LLC. The Milliman Care Guidelines criteria are reviewed and approved on an annual basis by Utilization Management Committee. The criteria are made available to practitioner upon request and practitioners will have input into recommending changes to the Utilization Management Committee.
- II. For cases where the clinical judgment needed for UM decision making is sufficiently specialized, the MAHP Chief Medical Officer may call upon available board certified specialty physicians from the members of QIC, UMC, and P&T to assist in making UM determinations. It may be necessary to contact “experts” at the tertiary level as deemed appropriate by the Chief Medical Officer.
- III. When applying the criteria to a given individual, the following factors are considered:
 - a. age
 - b. co-morbidities
 - c. complications
 - d. progress of treatment
 - e. psychosocial situation
 - f. home environment, when applicable.

If member does not meet the Milliman Care Guidelines criteria, the case is discussed with the Chief Medical Officer regarding the appropriateness of ongoing inpatient care.

MAHP also considers characteristics of the local delivery system available for specific patients such as:

- a. availability of skilled nursing facilities, home care etc. in the MAHP service area to support the patient after hospital discharge
- b. coverage of benefits for skilled nursing facilities, home care etc. where needed.
- c. local hospitals’ ability to provide all recommended services within the estimated length of stay.

IV. Local Area Admissions - Dubuque

1. Daily printout of admissions is received from Mercy Medical Center and the information is crosschecked with admissions that were previously pre-authorized and entered into the computer system. Any new HMO Commercial and Medicare Admissions are entered

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electronically into the computer system and completed by the Health Care Services Case Managers and Intake Specialist.

2. Finley Hospital admissions are faxed to the Health Care Services Case Managers. These admissions may also be phoned to HCS by Admissions office. These are then entered into the computer system.
3. Inpatient admissions (Commercial) are assigned an estimated Length of Stay if able; this length of stay will be used interdepartmentally as a management tool.
4. Daily inpatient report is run by M.I.S. staff for concurrent review purposes.
5. As needed rounds are made at Mercy Medical Center and Finley Hospital. Mercy reviews are obtained through Cerner (Mercy Medical Centers electronic medical record) and if necessary phone calls to appropriate Mercy staff. Finley reviews are obtained per phone reviews with Finley staff. As indicated the UR Case Managers will make rounds and/or attend care conferences. The UR Case Managers wear MAHP approved identification badges identifying them as MAHP employees while performing utilization review. MAHP staff will provide a courtesy call to Mercy Medical Center and Finley Hospital to give advance notice of an on site review. The facility rules are shared with the UR Case Manager during the orientation process and updates provided as indicated thereafter.
6. Charts are reviewed within 1 working day (with the exception of weekends and holidays) of the admission to determine current clinical status and verify with standard criteria to indicate the appropriateness of the admission.
7. After the initial chart review, cases not previously discussed by the Case Managers with the attending practitioner/practitioner's staff in reference to anticipated length of stay, if criteria not met, will be initiated. Approval for continued stay is assumed unless practitioner is notified otherwise. Concurrent review of services for inpatient [intensive outpatient (partial hospitalization structural programs) and residential behavior] care decisions are made within 24 hours of the request (with exception of weekends and holidays'). Urgent concurrent review decisions for ongoing (ambulatory care), inpatient care, etc. must be made within 24 hours of the request. (Ambulatory care is defined as; care of symptomatic conditions usually requiring one visit or encounter a week or fewer).

[If the request to extend a course of treatment beyond the period of time or number of treatments previously approved by MAHP does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate to that type of decision (i.e. pre-service or post-service)]

8. Within 1 working day of an admission (with exception of weekends and holidays), cases which have not been previously discussed by the Health Care Services Case Managers and the attending practitioner/practitioner's staff in reference to anticipated home care needs upon discharge will be initiated. The Health Care Services Case Managers will initiate this discussion with the attending practitioner, appropriate hospital staff, as well as the patient and patient's family. See Policy #17: Case Management and Discharge Planning. Documentation of Discharge Planning will be placed in the Amisys System behind the certification screen, separate from the UR notes.
9. Subsequent reviews are conducted based upon the patient's clinical condition, type of surgical procedures conducted and severity and complexity of case.
10. Established criteria are referenced to determine continued stay, concurrent review frequency or to indicate potential discharge.

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11. If clinical information indicates possible discharge, the case is discussed by the U.R. Case Manager and the attending practitioner.
12. If the attending practitioner agrees, the patient is discharged or transferred to a lower level of care and as needed, appropriate home arrangements are coordinated.
13. If the attending practitioner disagrees with the U.R. Case Manager, the case is reviewed by the MAHP Chief Medical Officer. The Chief Medical Officer may ask a Board Certified practitioner of a similar specialty as the attending practitioner to review the case to provide an opinion as to the appropriateness of the treatment plan. It may be necessary for the practitioner reviewer to view the hospital medical record for additional information.
14. Denials are communicated according to Policy #2: Health Care Services Denial Policy. If the coverage of services ends (benefits ends), the member still needs care; the MAHP will offer to educate the member regarding alternatives for continuing care and how to obtain care, as appropriate. Instances where MAHP has assisted member transition of care are documented in the information system and /or written correspondences. This information is kept in the Amisys system.
15. Documentation of hospital course is made and entered as indicated in information systems. This documentation will be made available to the attending practitioner upon request.
16. Hospital utilization data for all lines of business is shared with Utilization Management Committee at least quarterly. This information includes by bed type the admits/days per thousand, and average length of stay and includes breakout summaries of the following: Medical, Surgical, Mental Health/Chemical Dependency, OB, and Pediatrics.

V. Local Area Admissions - Outside Dubuque

1. On occasion, a hospital case may be difficult to review via telephone conversation with a designated facility staff. In those cases, a visit by the Health Care Services U.R. Case Manager to that facility may be required. If it is determined a visit would be in the best interest of the member, the case manager will call ahead to the facility and arrange a time for the visit.
 - Upon arrival at the facility, MAHP case manager will check in at the department.
 - All MAHP representatives making on-site reviews in facilities will follow the MAHP dress code and wear their MAHP name badge to identify them as a representative of MAHP.
 - Prior to visiting a patient for an on-site visit review, the MAHP case manager will stop at the nurses' station where the member's room is located and let the floor staff know they are there.
2. In the event the information can be received via telephone, the Health Care Services U.R. Case Manager will collect the necessary information from appropriate hospital staff. These calls may be generated by the Health Care Services U.R. Case Manager or the hospital staff may return calls to the Health Care Services U.R. Case Manager as requested. The procedure listed in Section IV, items 7-13 will be followed.

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VI. Out-of-Area Admissions

1. The procedure listed above in Section III, item #2 is for purposes of concurrent review via telephone with designated facility staff.

VII. Quality Concerns

1. Hospital cases are also reviewed for quality concerns, as well as utilization issues. See Health Care Services Policy # 61: Communication of Quality Concerns.
2. Cases identified as having co-morbidities, including, but not limited to, medical, surgical, mental health, and substance abuse, by Case Managers will have coordination of care with pertinent medical information relayed to attending PCP for appropriate SCP referral and care.
3. Case Manager will expedite inpatients referrals to SCP (as made by PCP) as needed.

VIII. Consistency in Use of Criteria

1. Consistency in the use of established criteria among Utilization Review staff will be maintained according to Health Care Services Policy #62: Procedure for Verifying Utilization Review Consistency.

IX. Annual Review of Facility Procedures

1. On an annual basis, the Manager of Health Care Services will review the established procedures per facility. The facility protocols will also be incorporated into the orientation process as well and discussed at a staff meeting.

X. Review Procedure – Tertiary Level

1. Admitting staff notify via phone or fax to MAHP Case Managers of admission.
2. Concurrent phone or faxed reviews are obtained per UR Case Managers.
3. HCS UR Case Managers promote discharge planning through open communications with Tertiary nurse reviewers and assigned social workers.

Judy Riniker, R.N.
Manager of Health Care Services/Quality Improvement

Date

Mary Leary, R.N.
Director of Health Care Services/Quality Improvement

Date

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