DCS Comprehensive Health Plan
INTERNAL POLICY

TITLE Concurrent Review, Retrospective Review, Readmissions and Discharge Planning	POLICY NUMBER HS-MM-10
RESPONSIBLE AREA Health Coordination	EFFECTIVE DATE 08/31/2023
Initiated: 01/01/96 **Approved by CHP Policy Committee:** 05/21/02; 02/06/06; 03/09/07; 04/28/09; 10/15/09; 11/19/09; 10/06/10; 08/29/11; 11/25/11; 10/22/12; 02/11/13; 04/15/13; 09/15/13; 11/15/13; 11/17/14; 12/07/15; 06/03/16; 11/16/17; 03/21/19; 06/20/19; 09/14/20; 08/15/21; 08/15/22; 10/28/22; 08/15/23	

STATEMENT/PURPOSE

This policy outlines the Department of Child Safety Comprehensive Health Plan's (DCS CHP) Utilization Management (UM) activities to determine the medical necessity of inpatient admissions and continued stays.

AUTHORITY

A.R.S. § 8-512, Comprehensive medical and dental care; guidelines.

A.A.C. R9-22-201, Scope of services and definitions.

A.A.C. R9-22-204, Inpatient Hospital Services, including Concurrent Review.

42 CFR § 447.26 (A), Prohibition on payment for provider-preventable conditions.

The Intergovernmental Agreement (IGA) between the Arizona Health Care Cost Containment System (AHCCCS) and the Arizona Department of Child Safety (DCS) for CHP outlines the contractual requirements for compliance with continuity and quality of care coordination for all members.

The contract between the Department of Child Safety (DCS) for the Comprehensive Health Plan (CHP) and the Managed Care Organization (MCO) contractor outlines the contractual requirements for compliance with utilization management, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), quality and appropriateness of care/services.

DEFINITIONS

Concurrent Review: A process that is performed on admission and at frequent intervals during acute inpatient hospital stays. Reviewers assess the appropriate usage of ancillary resources, Levels of Care (LOC) and service, according to professionally recognized standards of care. Concurrent review validates the medical necessity for continued stay and evaluates quality of care.

Discharge Planning: A process to increase the management of inpatient admissions, improve the coordination of post-discharge services, reduce unnecessary hospital stays, ensure discharge needs are met, and decrease readmissions within 30 days of discharge.

Health Care-Acquired Condition (HCAC): A Hospital Acquired Condition (HAC) which occurs in any inpatient hospital setting and is not present on admission.

Other Provider-Preventable Condition (OPPC): A condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following:

- Surgery on the wrong member;
- Wrong surgery on a member; and
- Wrong site surgery.

Readmission: the admission to a hospital facility within 30 days of the previous discharge.

POLICY

DCS CHP contracts with a statewide MCO to execute utilization management (UM) functions. UM functions include prospective, concurrent and retrospective clinical reviews to determine medical necessity of member inpatient admissions to hospital or institutions in an effort to:

- Determine that members receive and continue to receive appropriate care in the appropriate health care setting to meet the members health care needs;
- Increase coordination with inpatient admissions;
- Improve coordination of post-discharge services;
- Reduce unnecessary hospital stays; and
- Decrease hospital readmissions within 30 days of discharge.

The contracted MCO is required to apply standardized nationally recognized evidence-based medical review criteria; AHCCCS Medical Policy Manual (AMPM); American Academy of Pediatrics' (AAP) Guidelines to determine the appropriate level of care and appropriate length of hospital admissions and/or discharge readiness.

Inpatient stays are reviewed based on standardized criteria, the member's specific condition and the projected discharge date.

The Contracted MCO is required to collect, validate, analyze, monitor, and report utilization data for the DCS CHP population.

Authorization determinations and hospital utilization patterns are documented and reviewed in Medical Management (MM) and Quality Management/Performance Improvement (QM/PI) Committee Meetings.

PROCEDURES

Concurrent Review

Concurrent utilization reviews are conducted for members who are receiving care in inpatient settings or institutions. Concurrent utilization reviews are initiated on the first business day after hospital admission notification is received and continues throughout the hospital stay following the initial admission review determination. The authorization of a stay is assigned a new review date each time a review occurs. Concurrent reviews utilize standardized nationally recognized criteria, reasonable medical evidence or a consensus of relevant health care professionals to determine coverage and medical necessity of the admission and hospital stay.

All admissions are reviewed by Arizona licensed concurrent review/prior authorization nurses or physicians to determine the medical necessity and appropriateness of hospitalization including:

- Identifying need for member care coordination, disease management and/or CRS condition;
- Monitoring efficient use of health care services;
- Determining if the hospital level of care is consistent with care being rendered;
- Evaluating the course of treatment and length of stay;
- Assessing the quality of care in relation to professional standards, including identifying provider preventable conditions or health care-acquired conditions;
- Reducing length of stay by preventing unnecessary or avoidable inpatient days;
- Providing timely discharge planning with hospital discharge planners;
- Coordinating referrals including:
    - Behavioral health referrals to coordinate care and plan post hospitalization services and stability;
    - DCS CHP System of Care Managers and staff may coordinate when members present with behavioral health symptoms that may require inpatient behavioral health hospitalization or treatment in a therapeutic behavioral health level of care when there are challenges;
    - Arizona Long Term Care System (ALTCS) when members' stay approaches 30 days;
    - AHCCCS notification when a member's stay approaches 45 days;
- Identifying cases requiring escalation for enhanced care coordination or discharge planning;
- Identifying potential Quality of Care concerns (QOC) for referral to Quality Management Performance (QM/PI) Committee; and
- Reviewing the record to verify that:
    - Physician has certified to the necessity of inpatient hospital services; and
    - Services were periodically reviewed and evaluated by a physician.

Any prolonged admissions or admissions that do not meet criteria are reviewed with a medical director. Only a medical director can reduce or deny a request for service based on a medical necessity review. If the inpatient stay is denied as not medically necessary, all applicable parties are notified (i.e. the attending physician, the facility, and the member's custodial agency representative (DCS Specialist). The denial notification provides the reason for denial, mechanisms for appeals and the option of peer to peer consultation to review the denied authorization.

At minimum pertinent clinical information and clinical review findings are documented for each hospital admission and subsequent inpatient stay and include:

- Diagnosis or diagnoses;
- Admitting history and physical;

- Surgical procedures performed;
- Medical records which summarize medications, labs, tests, consults, therapies, treatments, x-rays, etc.;
- Patient's progress and response to treatment and care given;
- Necessity of admission and appropriateness of service setting;
- Reasons cited for admission and actual length of stay;
- Discharge plans; and
- Potential discharge placement issues.

Retrospective Review

Retrospective reviews are conducted for medical necessity when notified of a member's hospitalization after the member is discharged or when a service has been provided without the required prior authorization. Claims that meet review criteria are identified and pended for medical review. Retrospective review determinations for hospitalizations are made within 20 calendar days of receipt of the claim or receipt of medical documentation from the health care provider.

Discharge Planning

Discharge planning is a vital part of the concurrent review process. Proactive planning and coordination of post-discharge services begins prior to admission when possible, or upon notification of a member's hospital admission. Prior to a member's discharge, UM staff identify and assess the post-discharge bio-psychosocial and medical needs in order to arrange necessary services and resources for appropriate and timely discharge from a short-term, long-term or institutional stay, and to coordinate services between settings of care. UM staff coordinate prior authorization determinations for identified appropriate medications and Durable Medical Equipment (DME), nursing services and therapies, and address any hospice, or end of life care services that may be required, and coordinate appropriate referral to community resources and care management as needed.

DCS CHP in collaboration with the contracted MCO's UM staff coordinate with the hospital's case management/utilization review staff, the primary care provider, the hospital discharge planner and the member's custodial agency representative (DCS Specialist) to ensure that the member is discharged to a clinically appropriate environment. If covered services are temporarily unavailable when the member is discharge ready, staff reviews the case with the CMO regarding the need to allow the member to remain in the setting until appropriate services are available and coordinated.

UM staff contact the member's custodial agency representative and the member's caregiver within 3 business days post discharge to verify that discharge needs were met including:

- All parties understand the written discharge plan, instructions and recommendations provided by the facility;
- Discharge medications have been filled; other discharge orders initiated;
- A follow up appointment with the PCP and/or specialist is scheduled within seven business days of discharge; and
- Referrals are made to appropriate community resources and care coordination teams.

DCS CHP facilitates proactive discharge planning even when DCS CHP is not the member's primary payer.

Readmissions

UM staff review hospital readmissions when a member is hospitalized within 30 days prior to the readmission date. Medical records from the hospital readmission and the concurrent review are reviewed to identify:

- Same or similar condition or diagnoses;
- Same, similar or related reason;
- Planned readmission; or
- Complications due to the member's placement and/or follow-up care.

If the hospital readmission review does not meet medical necessity criteria, clinical staff reviews the case with the CMO who renders an authorization determination. If the readmission stay is approved or denied as not medically necessary, all applicable parties (i.e., the attending physician, the facility, the member's custodial agency representative and caregiver) are notified.

Claims that meet readmission criteria are identified and pended for medical review. UM/QM clinical staff conduct retrospective review of both hospital admissions to determine if the readmission claim is eligible for payment. Criteria for potential denial of payment includes:

- Members readmitted to the same hospital within 72 hours;
- Base DRG assignment on the readmission claim matches the base DRG assignment on the initial claim; or
- Readmission claim has not been prior authorized.

During concurrent review, readmissions or retrospective review inpatient stays are reviewed for Provider-Preventable Conditions (PPC), Healthcare-Acquired Condition (HCAC) or Other Provider-Preventable Condition (OPPC). DCS CHP prohibits payment for Provider-Preventable Conditions (PPC) that meet the definition of a Healthcare-Acquired Condition (HCAC) or Other Provider-Preventable Condition (OPPC) that may be identified during the review process. If an HCAC or OPPC is identified, a Quality of Care (QOC) investigation is opened and the occurrence and results of the investigation are reported to the AHCCCS Clinical Quality Management Unit.

Reporting

Hospital utilization reports are reviewed by DCS CHP for analysis to plan program-wide action or recommendations to the Quality Management Performance Improvement Committee (QM/PI) through the Medical Management Committee (MM).

A Quarterly Showing Report for Inpatient Hospital Services is submitted quarterly to AHCCCS.

REFERENCES

AHCCCS Medical Policy Manual (AMPM) Policy 1020 – Medical Management Scope and Components.

AHCCCS Contractor Operations Manual (ACOM) Chapter 432 – Behavioral Health Coordination.

FORMS
N/A