blue california
Promise Health Plan

Policy Title: Concurrent Hospital Review		**POLICY #:** 10.2.30 **Line of business:** Medi-Cal	
Department Name: Utilization Management	**Original Date** 11/97	**Effective Date** 11/22	**Revision Date** 6/24
Governing Committee: Medical Services Committee			
Governing Committee Approval: Jennifer Nuovo, MD, Blue Shield Promise Chief Medical Officer			**Date:** 06/11/2024
Vice President (VP) Approval: Tracy Alvarez, VP, Medical Care Solutions			**Date:** 06/11/2024

A. PURPOSE

To define the policy and procedure and provide guidance on how Blue Shield of California Promise Health Plan's (Blue Shield Promise) Utilization Management (UM) Department will concurrently review inpatient care services and to identify provider preventable conditions as a condition of payment and compliance with state and federal regulations, in accordance with Section 2702 of the Affordable Care Act.

B. DEFINITIONS

1. **Concurrent Review** is the utilization review for members currently inpatient in an acute or post-acute setting. The three components of this member centric review are: 1) medical necessity review; 2) discharge and transitional care planning; and 3) coordination of care. Utilization Management's (UM) focus during the inpatient stay is for a smooth transition across the continuum of the member's stay.

2. **Discharge Planning** begins at the time of admission to ensure that necessary services and supports are in place in the community before the individual leaves the hospital or institution in order to reduce readmission risks, encourage member and family participation, enhance member satisfaction, assure post-discharge follow-up, increase medication safety, and to support a safe transition.

3. **Medical Necessity** is the term that includes all covered services that are reasonable and necessary to protect the life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22 of the California Code of Regulations (CCR) §51303(a) and Title 42 of the Code of Federal Regulations (CFR) §438.210(a)(5).
    a. When determining the medical necessity of covered services for Medi-Cal beneficiaries under the age of 21, medical necessity is expanded to include the standards set forth in 42 United States Code (USC) §1396d(r) and Welfare and Institutions (W&I) Code §14132.
        i. For individuals under age 21, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is considered medically necessary when it is necessary to correct defects and physical and mental illnesses and conditions that are discovered by screening services. See Clinical Access Programs policy 70.29.5.1 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program.

4. **Provider preventable conditions** consist of health care-acquired conditions (HCAC) when they occur in acute inpatient hospital settings only and other provider-preventable conditions (OPPC) when they occur in any health care settings. HCACs are the same as hospital-acquired conditions (HAC) for Medicare, except that Medi-Cal does not require providers to report deep vein thrombosis/pulmonary embolism for pregnant women and children under 21 years of age.
    a. OPPCs are also known as "never events" and Serious Reportable Events under Medicare. For Medi-Cal, OPPCs are defined as follows:
        i. Wrong surgery/invasive procedure
        ii. Surgery/invasive procedure performed on the wrong patient
        iii. Surgery/invasive procedure performed on the wrong body part

C. POLICY

I. Blue Shield Promise provides continual reassessment of all acute inpatient care through concurrent review. Other levels of care such as partial day hospitalization or skilled nursing care may also require concurrent review. The authorization is given for the admission day and from then on, is reviewed concurrently based on the member's condition using approved criteria/guidelines.

II. Blue Shield Promise identifies and reports HCACs and provider preventable conditions (PPC) according to Section 2702 of the Patient Protection and Affordable Care Act of 2010, W&I Code 14131.11, and 42 CFR Parts 434, 438, and 447.

D. PROCEDURE

I. BLUE SHIELD PROMISE NOTIFICATION:

a. Blue Shield Promise shall be notified by the provider or facility prior to any elective admission, and as soon as possible for any non-elective admissions. Blue Shield Promise will ensure that Transitional Care Services (TCS) care managers are notified within 24 hours of admission, transfer, or discharge when an Admissions, Discharges, and Transfers (ADT) feed is available, or within 24 hours of a planned admission, transfer, or discharge when no ADT feed is available.

II. DISCHARGE PLANNING:

a. Discharge planning is an integral part of inpatient concurrent review. Planning for discharge needs begins at the time of notification of admission and continues throughout the hospital stay.

b. Discharge planning shall include ensuring that necessary care, services, and supports are in place in the community for the member once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver. Blue Shield Promise will ensure that members are connected to their new care manager through a referral if the member is enrolled in ECM or CCM, and if the care manager responsible for TCS will not continue as their ECM or CCM Lead Care Manager.

c. See UM policy 10.2.33 Discharge Planning for additional information.

III. ELECTIVE ADMISSIONS:

a. Elective admissions are reviewed prospectively. The date of first concurrent review will occur on the second hospital day. The benefit of this process is to identify further discharge planning needs the member may have due to unforeseen complications and or circumstances.

b. Clinical information may be obtained from the admitting physician, the facilities electronic medical records (EMR), or the hospital Utilization Review/Case Management (UR) nurse.

c. The UM nurse will compare the clinical presentation to approved criteria/guidelines. Blue Shield Promise applies a hierarchy of criteria for each UM review type to make medical necessity decisions . See Utilization Management Criteria and Guidelines Evidence-Based Medical Necessity Criteria Hierarchy document.

i. Blue Shield Promise has adopted MCG and other evidence-based utilization management criteria for use in making medical necessity determinations. Blue

Shield Promise's UM criteria complies with Medicare Managed Care's National Coverage Determination, general Medicare coverage guidelines, and written coverage decisions of local Medicare contractors.

ii. Guidelines are adopted with involvement from board-certified, actively participating health care providers; consistent with criteria or guidelines supported by sound clinical principles and processes; updated to the most current version available; and evaluated by the Medical Services Committee.

iii. See UM policy 10.2.22 Utilization Management Decision Making & Timeframes for additional information.

d. If approved criteria/guidelines are satisfied, an appropriate number of days will be authorized for that stay. If the patient is still in house, further concurrent review will be performed to establish ongoing medical necessity.
    i. The number of hospital days and level of care authorized for elective admissions are variable based on clinical presentation. They are based on the medical necessity for each day of the patient's stay and the application of approved criteria/guidelines and practitioner recommendations.
    ii. When considering approval of admission and continued stay, individual and local healthcare delivery system factors will be considered.

e. If the clinical information obtained does not satisfy approved criteria/guidelines, the UM nurse will contact the admitting/attending physician directly for additional information.
    i. If the approved criteria/guidelines are satisfied, authorization will be issued. If approved criteria/guidelines are not satisfied, authorization will be pended, and the case forwarded to the Blue Shield Promise Chief Medical Officer or physician reviewer for review.
    ii. The Blue Shield Promise Medical Director or physician reviewer may approve, modify, or deny the requested level of care.

f. In the event that the case involves the expertise of a specialist, the Blue Shield Promise Medical Director or physician reviewer may consult with a specialist selected from the Blue Shield Promise list of board-certified specialists.

g. The practitioner will be notified of the decision within the timeframes specified in UM policy 10.2.38 Authorization Denial, Pending/Deferral, and/or Modification Notification.

IV. FIRST CONCURRENT REVIEW:

a. Blue Shield Promise conducts initial concurrent review within 72 hours of notification of patient's admission to acute care facility.

V. SUBSEQUENT CONCURRENT REVIEW:

a. Blue Shield Promise will respond to a concurrent authorization request within 72 hours or less, consistent with the urgency of the member's medical condition and in accordance with H&S Code section 1367.01(h)(1) and NCQA UM5. Subsequent concurrent reviews are performed no later than the end of the currently authorized period. Information may be obtained from any of the sources as specified above.
b. Determination of satisfaction/non-satisfaction of criteria and authorization issuance occurs as specified above.
c. Additional days authorized are documented in the UM system of record reflecting all pertinent medical information.
d. If there is no information available to make a determination, the Blue Shield Promise Medical Director will review the request and potentially deny for lack of information. The practitioner will be notified within the timeframes specified in UM policy 10.2.38 Authorization Denial, Pending/Deferral, and/or Modification Notification.

VI. URGENT/EMERGENT ADMISSIONS:

a. As specified in the UM policy 10.2.43 Emergency Care Services, an inpatient stay may be authorized after hours by the on call licensed UM Clinicians at the time of admission notification.
b. If initial clinical information is not sufficient for the licensed UM Clinicians to authorize, he/she will issue a tracking number and request a concurrent
review with clinical details to occur within one business day or as soon as possible after initial Blue Shield Promise notification.

VII. CONCURRENT REVIEW NOT MEETING CRITERIA:

a. In the case of inpatient, intensive outpatient, or ongoing ambulatory services, care will not be discontinued until the enrollee's treating practitioner has been notified of Blue Shield Promise's decision, and a care plan has been agreed upon by the treating practitioner that is appropriate for the medical needs of that patient.
b. For concurrent review decisions that result in a denial or modification, the practitioner will be notified within the timeframes specified in UM policy 10.2.38 Authorization Denial, Pending/Deferral, and/or

Modification Notification.

VIII. IDENTIFYING PPCs/HCACs:
   a. UM clinicians will screen all cases for potential PPCs/HCACs.
   b. If a potential PPC/HCAC is identified, the UM clinician will seek the opinion of a Blue Shield Promise medical director.
      i. If agreed that a PPC/HCAC may have occurred, the UM clinician will submit a Potential Quality of Care (PQOC) referral to the Promise Health Plan Quality Review team. The Quality Review team will review and report PPCs as required per DHCS APL 17-009, LA Care, or other regulatory/oversight agencies.
      ii. The UM clinician will indicate the PPC/HCAC to Claims via claims payment instructions.

E. MONITORING

N/A

F. REPORTING

N/A

G. ATTACHMENTS

N/A

H. REFERENCES

1. 22 CCR § 51303(a)
2. 42 CFR § 447.26
3. 42 CFR § 438.210(a)(5)
4. 42 CFR Parts 434, 438, and 447
5. 42 USC §1396d(r)
6. APL 17-009
7. Centers for Medicare & Medicaid Services FY 2024 Hospital Acquired Conditions List
8. Federal Register, Vol 76, No. 108
9. Health & Safety Code § 1367.01(h)(1)
10. Institute for Healthcare Improvement
11. NCQA UM 5, Timeliness of UM Decisions
12. Patient Protection and Affordable Care Act of 2010, Section 2702
13. Clinical Access Programs P&P 70.29.5.1 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program
14. UM P&P 10.2.38 Authorization Denial, Pending/Deferral, and/or Modification Notification
15. UM P&P 10.2.22 Utilization Management Decision Making & Timeframes
16. UM P&P 10.2.43 Emergency Care Services
17. W&I Code §14132
18. W&I Code §14131.11

I. REVISION HISTORY

Date	Modification (Reviewed and/or revised)	E-Filing Number
6/2024	Annual review • Added content related to HCAC/OPPC • Added PPC reporting requirements per APL 17-009	
6/2023	Annual Review	
2/2023	Updated Regulatory Requirements DHCS	