

POLICY AND PROCEDURE

POLICY NAME: Concurrent Review	POLICY ID: LA.UM.36
BUSINESS UNIT: Louisiana Healthcare Connections	FUNCTIONAL AREA: Utilization Management
EFFECTIVE DATE: 02/01/2015	PRODUCT(S): Medicaid
REVIEWED/REVISED DATE: 11/14, 6/15, 3/16, 8/16, 2/17, 1/18, 1/19, 1/20, 10/20, 7/22, 1/23, 09/2023, 07/26/2024, 05/14/2025, <u>03/04/2026</u>	
REGULATOR MOST RECENT APPROVAL DATE(S): Please refer to system of record – Archer	

POLICY STATEMENT:

All Areas and Departments within Centene Corporation and its subsidiaries must have written Policies and Procedures that address core business processes related to, among other things, compliance with laws and regulations, accreditation standards and/or contractual requirements.

PURPOSE:

The purpose of this policy is to describe how plan prior authorization (PA), concurrent review, behavioral health (BH) review and clinical review employees work collaboratively to ensure appropriate extension of current course of outpatient treatment or addressing the needs of enrollees throughout an inpatient hospitalization.

SCOPE:

This policy applies to employees of Louisiana Healthcare Connections in the Utilization Management (UM) Department. This includes officers, directors, consultants, and temporary workers (collectively, the "Plan").

DEFINITIONS:

Inpatient Concurrent/Clinical Review: 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.

Inpatient concurrent review may include any request made while the member is in the process of receiving care, whether previously approved or not. Examples of requests considered as inpatient concurrent review:

- A continued stay review for an inpatient facility stay.
- A new admission to a facility when the plan is notified after the admission has occurred, but before the member has been discharged.

~~**Concurrent / Clinical Review:** Any utilization review conducted during an enrollee's course of treatment or inpatient stay, including an extension of a previously approved ongoing course of treatment over a period of time or number of treatments. Concurrent reviews are typically associated with inpatient care or ongoing ambulatory care.~~

~~Concurrent review may include any request made while the enrollee is in the process of receiving care, whether previously approved or not. Examples of requests considered as concurrent review:~~

- ~~• A specified course of allergy injections.~~
- ~~• A series of chemotherapy treatments.~~
- ~~• A continued stay review for an inpatient facility stay.~~
- ~~• A new admission to a facility when the Plan is notified after the admission has occurred, but before the enrollee has been discharged.~~

Post Service Review (Retrospective Review): Any utilization review performed after services have been rendered.

Pre-service Authorization Review: Authorization reviews requested in advance of the enrollee obtaining medical care or services. Preauthorization and pre-certification are pre-service organization reviews.

Review Criteria: Objective, quantifiable guidelines used to assess the appropriateness of specific health care decisions and services (See LA.UM.02 Clinical Decision Criteria and Application).

Urgent Care: Any request for medical care or treatment with respect to which the application of time periods for making nonurgent care determinations could result in the following circumstances:

- Could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, based on a prudent layperson's judgment, or

- In the opinion of a provider with knowledge of the enrollee's condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

POLICY:

In performing reviews, the review employees:

- Ensures a timely and accurate concurrent review process with appropriate documentation.
- Ensures enrollees in acute/subacute care settings receive appropriate services in the appropriate setting. This includes observation stays, where authorization is required for this service.
- Evaluates a continued inpatient hospital stay for medical appropriateness utilizing national recognized clinical criteria.
- Implements timely and efficient transfer to lower levels of care when clinically indicated and appropriate.
- Ensures appropriate referrals to care management (CM) and disease management (DM), when applicable.

Review criteria are utilized as guidelines and decisions that take into account the enrollee's medical condition and co-morbidities. The review process is performed under the direction of the Plan Medical Director.

The Plan does not deny continuation of higher-level services (e.g., inpatient hospital or psychiatric residential treatment facilities (PRTF) for failure to meet medical necessity unless the Plan can provide the service through an in-network or out-of-network provider at a lower level of care (Model Contract 2.12.8.2).

PROCEDURE:

Outpatient Concurrent Review

The Plan conducts medical necessity reviews for continuation/extension of current treatment and/or services such as home health, outpatient therapy services, and rental of durable medical equipment to monitor appropriate utilization and promote quality outcomes for enrollees. All review activities are conducted employing appropriate criteria, documentation standards, and in accordance with applicable timeframes. This team is comprised of reviewers who receive requests via telephone, portal, mail and/or fax.

Inpatient Clinical Review (Telephonic/Remote/Onsite)

The provider or facility notifies the Plan that an enrollee has been admitted to an inpatient or observation setting. All admissions must be reviewed in a timely manner consistent with applicable processes and timeframes. The clinical review team is comprised of reviewers who work and review requests remotely, and onsite reviewers who have facility access and review live charts.

- Concurrent review time frames must be applied if the enrollee is still currently inpatient or in an observation setting.
 - If a discharge date/time cannot be verified at the time of the initial request/notification of the admission, even if the Plan is notified of discharge once the concurrent review process is underway.
- If discharge can be confirmed at the time of the initial request/notification of the admission, post-service review time frames may be applied, if allowed per state requirement and/or facility contract.
- See LA.UM.05 Timeliness of UM Decisions and Notifications for timeframes.

Coordination of Benefits

All stays requiring authorization are reviewed for current eligibility and coordination of benefits (COB). Any other coverage (e.g., primary insurance, worker's compensation) must be documented in a COB note type in the clinical documentation system.

Medical Necessity Review Process

The clinical reviewer applies medical necessity criteria (National Coverage Determinations (NCD)/ Local Coverage Determinations (LCD), clinical policy, InterQual, and the American Society of Addiction Medicine (ASAM)) using the clinical information received. Both clinical inpatient criteria and level of care criteria are assessed during the review. Additional information on the review criteria is listed in LA.CP.CPC.05 Medical Necessity Review Criteria.

- If the inpatient stay meets medical necessity criteria:

- ~~The length of stay (LOS) should continue~~ to be monitored throughout the stay and any adjustments or information related to the LOS be documented within the authorization in the clinical documentation system.
- The average/anticipated LOS, impending outlier date, and targeted discharge date are considered in establishing the next review date.

- If the inpatient stay meets medical necessity criteria, the facility is notified of the approved days and the approval notification is documented in the clinical documentation system.
- ~~If the inpatient stay does not meet medical necessity criteria, the clinical reviewer requests additional information from the appropriate facility contact and/or the attending physician to obtain additional clinical information, if available, and enters this information in the clinical documentation system.~~
- If the admission is approved as requested, the Medical Director documents the decision and rationale in the clinical documentation system.
 - The Plan provides electronic or written (i.e., email, fax, mail, or EMR) notification of the approval to the requesting provider, not to exceed the original time frame. The facility or other treating provider is also notified, as applicable. The facility and attending/servicing provider must be notified of approved days and levels of care, (as applicable per the Plan) and date of next anticipated review (remote/onsite) with updated clinical information to support a continued length of stay, as necessary.
- If the inpatient stay does not meet medical necessity criteria, the clinical reviewer requests additional information from the appropriate facility contact and/or the attending physician to obtain additional clinical information, if available, and enters this information in the clinical documentation system.
- If the additional information is still insufficient for a level I approval, then the review process is followed according to LA.UM.02 Clinical Decision Criteria and Application.
- If the request is denied, the Medical Director documents the decision and rationale in the clinical documentation system, and the facility/practitioner is notified in a manner consistent with applicable processes and timeframes (see LA.UM.07 – Adverse Determination (Denial) Notices).

If the Medical Director recommends an alternative level of care, the Medical Director documents this determination in the clinical documentation system. The facility UM employees are notified of the level of care at which the enrollee is approved. During a level II review if the Medical Director recommends an alternative level of care, the Medical Director documents this determination in the clinical documentation system. The facility UM is notified of the level of care at which the enrollee is approved. ~~The enrollee is followed for discharge planning according to the policy LA.UM.16.03 Continued Stay and Discharge Planning.~~

Continued Stay Review

Frequency of case reviews are based on multiple factors including current level of care, severity, or complexity of the illness, expected length of stay, how close to discharge the enrollee is, discharge planning, etc. All hospitalized enrollees are reviewed based on guidelines and recommendations from the Medical Director or leadership of Population Health and Clinical Operations.

All admissions are checked for a previous, recent admission and processed in accordance with state, contract and/or NCQA re-admission regulations.

The enrollee is followed for discharge planning according to the policy LA.UM.16.03 Continued Stay and Discharge Planning.

REFERENCES:

Louisiana Medicaid MCO Model Contract:
2.12.8 Other Service Authorization Requirements
 NCQA Health Plan Standards and Guidelines UM 1: Program Structure; UM 4: Appropriate Professionals
 LA.UM.01 Utilization Management Program Description
 LA.UM.02 Clinical Decision Criteria and Application
 LA.UM.05 Timeliness of Utilization Management Decision and Notifications
 LA.UM.07 Adverse Determination (Denial) Notices
 LA.UM.16.03 Continued Stay and Discharge Planning
 LA.CP.CPC.05 Medical Necessity Review Criteria
 CC.UM.36 Inpatient Concurrent Review

ATTACHMENTS: N/A

ROLES & RESPONSIBILITIES: N/A

REGULATORY REPORTING REQUIREMENTS: LARS §46:460.54 applies to material changes for this policy.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Ad Hoc Review	LA Procurement 2015 Policy Update Revised to utilize LA specific policies	11/2014
Annual Review	Removed 72-hour references and replaced with 1 business day Changed language to match rfp: “verbally or as expeditiously as the member’s health condition requires but not more than” Changed calendar day to business day Updated NCQA reference	06/24/15
Annual Review	Added - unless otherwise given prospective days (no more than 2) based upon clinical judgment and clinical information obtained from the facility. Deleted – deleted authorization and replaced it with authorized. Deleted – number of units. Grammar corrections Calendar days changed to business days for LA requirements; “The Plan” changed to LHCC; grammar corrections	03/24/16
Ad Hoc Review	Added- Start Smart for Your Baby Neonate Admissions and Leveling of Care dated 8/6/2014 the prospective approval guidelines for NICU cases.	08/24/16
Ad Hoc Review	Updated prospective day guidelines Updated CM referrals Grammar corrections	02/24/17
Annual Review	Update Punctuation within the policy Added statement of where to locate clinical notes	01/24/18
Annual Review	Removed language no longer relevant to current process.	01/25/19
Annual Review	Added Residential setting Changed CCRN to UM Clinical Reviewer Changed Medical Director to Medical Advisor Added Policy title to LA.UM.05.01 Removed telephonic review Added PEC prospective day guidelines Grammatical Changes	01/24/20
Annual Review	Added residential facility Added documentation of clinical requested Added must make 1 attempt for clinical information Removed reviews received on Friday to be sent to MA Added change in member’s status to update the TDD and IQ benchmarks are only for PH LOC Added documentation of SSFB note Added approval notification to provider Added definition of Medical Advisor Updated CM referral process Formatting changes	10/26/20
Annual Review	Changed Medical Management to PHCO Updated NICU cadence for review based on Neonate path to home Added a min of 6 days for PAC LOC in case we auth more	07/28/22
Ad Hoc Review	Added observation level of care Updated Adult/Peds review cadence Updated NICU review cadence	10/28/22
Ad Hoc Review	Changed Member to Enrollee Reformatted to latest Policy Template	01/12/22

Annual Review	Fully rewritten to align with corporate policy while retaining LA specificity. Renumbered to LA.UM.36 from LA.UM.01.07	09/2023
Annual Review	Grammatical and formatting edits. Updated references. Added "concurrent review, behavioral health review" in purpose section. Added "post service review (retrospective review)" and updated "review criteria" in the definitions section. Under policy added contract language from Model contract 2.12.8.2. Added portal as a method of receiving request under "outpatient concurrent review" section. Under "inpatient clinical review" section added clarifying language about timeliness. Removed onsite facility review detail. Added bulleted section to "continued stay review" section.	07/26/2024
Annual Review	Removed information about medical necessity from the Continued Stay Review section and relocated to the Medical Necessity Review Process section. Removed information about the LOS tool from the Continued Stay Review section. Removed information about outlier date from the Continued Stay Review section.	05/14/2025
<u>Annual Review</u>	<u>Updated definition of Inpatient Concurrent/Clinical Review. Under the section Medical Necessity Review Process added statement about average/anticipated LOS. Under the section Medical Necessity Review Process rearranged information to have grouping of statements for when criteria "meets" medical necessity and when it does not meet medical necessity. Updated references</u>	<u>03/04/2026</u>

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

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