

POLICY AND PROCEDURE

POLICY NAME: Continued Stay and Discharge Planning <i>Review</i>	POLICY ID: LA.UM. 16.0331
BUSINESS UNIT: LA Healthcare Connections	FUNCTIONAL AREA: Utilization Management
EFFECTIVE DATE: 01/12	PRODUCT(S): Medicaid
REVIEWED/REVISED DATE: 09/13, 04/14, 11/14, 9/15, 11/16, 9/17, 9/18, 9/19, 7/20, 3/22, 01/23, 11/2023, 10/22/2024, 07/11/2025, <u>05/07/2026</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 ensure efficient utilization management and timeliness of continued hospital/facility stay and discharge planning related decisions.

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:

Discharge Planning: Facilitation of post-discharge services including short-term and skilled nursing facility care. Discharge planning includes evaluating for a lower level of care and maximizing the provision of services in a cost-effective manner. Services involved in the discharge plan may include durable medical equipment (DME); transfers to an appropriate level of care such as inpatient nursing rehabilitation (INR) facility, long term acute care (LTAC) or a skilled nursing facility (SNF); home health care; medications; and physical, occupational, or speech therapy; behavioral health partial hospitalization or intensive outpatient program.

POLICY:

It is the policy of the Plan, as part of its UM process, to assure continuity of care when transitioning enrollees from one level of care to another. An enrollee’s discharge plan includes a comprehensive evaluation of the enrollee’s health needs and identification of services and supplies required to facilitate appropriate care following discharge from a institutional hospital/facility setting, based on information received from the institution hospital/facility and/or provider. The UM designee performs the concurrent review process, coordinates discharge planning and post-discharge care with hospital and/or facility institution. For enrollees at high risk for readmission (such as those who have had major surgery, a chronic condition, limited or lack of caregiver support, etc.), a discharge screening is completed prior to discharge to ensure discharge needs are met (i.e., follow up appointments arranged, home health services in place, enrollee’s understanding of instructions, etc.).

PROCEDURE:

The discharge planning process begins at the time the Plan is notified by the hospital/facility of an admission. Communication by a UM designee with the hospital/facilities care management (CM)/UM department, is used to evaluate the enrollee’s ongoing needs at discharge.

- The UM designee contacts the hospital/facility UM/CM Department via phone, fax, e-mail, on-site, etc., requesting clinical information on the morning of the next review date, if updated clinical information is not already available.
- When the hospital/facility submits requested information, the UM designee reviews against InterQual or applicable criteria.
- If applicable, the UM designee requests to participate in the development of a discharge plan with the hospital/facility UM/CM employee to begin discharge planning for the enrollee at the time of the initial review. Collaborative efforts between the provider and the pPlan focuses on the enrollee’s health needs and identify any services and supplies required to facilitate a timely and appropriate discharge to an alternate level of care.
- When the UM designee anticipates discharge that may occur within a few days, the next review date for concurrent review does not exceed the anticipated discharge date.
- The UM designee works with the hospital/facility discharge planner to coordinate and authorize needed home support services such as medical supplies and DME, coordinate referrals to specialists or community resources,

including out of network as necessary to meet enrollee needs, and makes referrals to chronic care or complex CM as indicated.

- The provider has the option of initiating a request for services or DME through a call/fax/web request to a plan UM designee. Upon receipt of the authorization request for post-acute services, the UM designee checks the Plan's clinical documentation system for authorization of the approved services.
- If the UM designee receives an authorization request for post-acute services, the UM designee:
 - Reviews the clinical documentation system to see if authorization has been processed by the Prior Authorization Department.
 - If an authorization is not found, the UM designee confirms the authorization was faxed in by the provider and notifies the Prior Authorization Department for follow-up.
 - If an urgent/expedited request is made after hours, the UM designee contacts the on-call manager for review and processing of the requested services.
 - All requests received during business hours and standard requests follow the standard business process.
 - For approved authorizations, the provider receives a phone call and/or fax with the determination and the subsequent authorization number. For required timeframes, refer to LA.UM.05 Timeliness of UM Decisions and Notifications.
- Adverse determinations may be due to issues related to, but not limited to, benefits or an alternative level of care.
- Upon discharge, the post discharge enrollee outreach process is completed and documented (LA.CM.100 Post Discharge Member Outreach).
- Pertinent assessments are completed as needed.
- Any appropriate outreach or referrals should be made, i.e., behavioral health, disease/condition management, etc.

REFERENCES:

NCQA Health Plan Standards and Guidelines Med 5: Care Coordination
 LA.UM.05 Timeliness of Utilization Management Decisions and Notifications.
 LA.CM.100 Post Discharge Member Outreach
[CC.UM.31 Discharge Planning](#)

ATTACHMENTS: N/A

ROLES & RESPONSIBILITIES: N/A

REGULATORY REPORTING REQUIREMENTS: Louisiana Revised Statute §46:460.54 applies to material changes for this policy

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Annual review	Procedure 4 a: In no instance, may the review date be longer than five (5) business days (seven (7) calendar days for NICU stays) without the Medical Director's approval.	09/2012
Annual review	Correction: reference number on document header was changed from LA.UM.32 to LA.UM.16.03	09/2013
Annual review	Updated NCQA date	04/24/14
Annual review	LA Procurement 2015 Policy Update	11/19/14
Annual review	Added CCL.219 to references and Policy section Updated NCQA date to current	09/29/15
Annual review	Removed duplication in #3 and restated verbiage in #5 regarding: As part of the process, the CRN requests participation in the development of a discharge plan with the hospital staff in UM/CM.	11/14/16
Annual review	Grammatical Changes Removed chronic and complex case management and replaced with care management Removed specific RFP reference	09/25/17

Annual review	Changed verbiage throughout to reflect current process. Removed verbiage from LA.UM.01.07 and replaced with a policy reference. Removed the reference to MCO Contract from References	09/25/18
Annual review	Minor grammatical changes Replaced Concurrent Review Nurse (CRN) or Behavioral Health Inpatient Utilization Manager (BH IP UM) with appropriate Utilization Management (UM) Clinical Reviewer (CR) Added LA.UM.01.07 – Concurrent Review Work Process to References Procedure Section 3.b updated with Behavioral Health Post Discharge Outreach as follows: “the initial (first outreach) for Post Discharge Outreaches (PDO) is required within 72 hours of discharge from an inpatient facility. As part of PDO outreaches, Care Management Team employees attempt to ensure members discharging from a Behavioral Health Inpatient Facility have a Behavioral appointment within 7days of discharge and to confirm attendance of that appointment. If unable to meet the 7 day goal, Care Management team members attempt to ensure a member has a behavioral health appointment within in 30days of discharge from a BH Inpatient facility and to confirm attendance of that appointment.”	09/24/19
Annual review	Grammatical changes Changed DCP team to TOC team Updated PDO process and referred to CM policies	07/24/20
Annual review	Grammatical changes	03/28/22
Annual review	Updated policy template and Reference section, along with grammatical changes and added Policy Statement	01/13/23
Annual Review	Updated policy statement and scope, style guide changes, added definition for discharge planning, reorganized policy information for clarity and consistency.	11/2023
Annual Review	Grammatical and formatting edits. Updated references. Changed LA.UM.24 to LA.CM.100.	10/22/2024
Annual Review	Grammatical and formatting edits. Updated references.	07/11/2025
<u>Annual Review</u>	<u>Updated the policy ID numbering from 16.03 to 31. Updated the discharge planning definition to include behavioral health. Updated term facility to institution. Updated references.</u>	<u>05/07/2026</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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