# SMSO Policy Manual
# ACUTE CONCURRENT INPATIENT REVIEW AND DISCHARGE PLANNING PROCESS

Executive Sponsor: Chief Medical Officer

Issuing Department: Clinical Management

Gate Keeper: Director, HSM Clinical Management

## COMPLIANCE STATEMENT:

**Enforcement:** All members of the workforce are responsible for compliance with this policy. Failure to abide by the requirements of this policy may result in corrective action, up to and including termination. Workforce members are responsible for reporting any observed violations of this policy.

**Review Schedule:** This policy will be reviewed and updated as necessary and no less than every two years.

**Monitoring and Auditing:** The Issuing/Collaborating Department(s) is responsible for monitoring compliance with this policy.

**Documentation:** Documentation related to this policy must be maintained for a minimum of 10 years.

## Applies to:

- ☒ SummaCare Apex
- ☐ Summa Management Service Organization (SMSO)
- ☒
- ☒ Summa Insurance Company

## Line of Business:

- ☒ Commercial Groups Medicare
- ☐ Medicare Supplemental On-
- ☒ Off-Exchange Self-Funded
- ☒
- ☒ Exchange
- ☒

## 1.0 Purpose:

1.1 To efficiently manage acute care with regard to length of stay, discharge planning, and disposition.

1.2 To ensure members and providers that the Plan follows and adheres to all federal and state guidelines pertaining utilization and prior authorizations.

## 2.0 Policy:

2.1 The Plan requires Utilization Management (UM) staff to conduct simultaneous review and discharge planning on a prospective and concurrent basis beginning at the time that services are initiated in a hospital, inpatient psychiatric unit, acute rehabilitation, skilled nursing facility or inpatient setting.

2.2 For Medicare Advantage (MA) members, coverage decisions follow Medicare rules and regulations pertaining to MA plans, as well as federal and state regulations, and the member's evidence of coverage (EOC) document. When appropriate, relevant current clinical guidelines, SummaCare's internal policies/procedures and drug formularies may be utilized in the absence of Medicare guidance.

2.3 For non-Medicare members, coverage decisions follow appropriate federal and state requirements and the member's evidence of coverage (EOC) document. Additionally, SummaCare's internal policies/procedures, and drug formularies are followed when appropriate.

## 3.0 Procedure:

3.1 Concurrent review is performed using evidence based criteria for the purpose of deciding approval or denial of continued stay.

3.2 Upon receipt of a concurrent request, the plan:

- 3.2.1 Creates a record of the request, including the date and time received by SummaCare.
- 3.2.2 Attaches any incoming fax and associated records to the electronic record in the utilization management software system.
- 3.2.3 Promptly reviews the request and decides if the situation requires medical necessity review.
  - 3.2.3.1 Status orders are required for any inpatient admission.
  - 3.2.3.2 Additionally, a status order is required if the inpatient admission is downgraded to an outpatient status or if an outpatient status is upgraded to an inpatient admission
- 3.2.4 SummaCare makes reasonable and diligent efforts to obtain all necessary medical records and other pertinent information within the required time limits. If the determination requires medical necessity review and there is not enough information provided to make a determination, 1 attempt is made to obtain the necessary information. When the plan has to request information they will document the attempt. Documentation should include the following:

3.2.4.1 A specific description of the required information;
3.2.4.2 The name, phone number, fax number, e-mail, and/or mailing address, as applicable, for the point of contact at the plan; ***and***
3.2.4.3 The date and time of each request, documented by date and time stamps on copies of a written request, call record, facsimile transmission, or e-mail. Call records should include specific information about who was contacted, what was discussed/requested, and what information was obtained by the plan. Requests for clinical information will be made by different methods (telephone, fax, email, mail). Staff make at least 1 attempt to obtain the missing information from the appropriate provider(s) or to verify that the needed information is not available. When there is still lack of response, SummaCare will contact the member, when appropriate, for records or assistance in reaching the provider. When efforts have been exhausted and a decision is required to meet timeliness, the determination will be made according to the information available and the member's available benefits. The plan will track the number of requests made for additional information by providers. Provider Services will contact the providers who did not send clinical information after 1 attempt. Extensions are taken following the appropriate regulatory/accreditation guidelines if the member requests them (see section below)

3.2.5 The service requested will either be approved or denied. Medical necessity denials are made by a physician, psychiatrist, pharmacist or dentist, as appropriate for the type of request. A utilization management nurse may issue a benefit denial that is unrelated to medical necessity such as when benefits are exhausted or the request is not a covered benefit.

3.2.6 Notifies the beneficiary and provider of the determination

3.3 Notification of the plan decision on requests for services

3.3.1 The plan notifies beneficiaries (or their representatives) of standard determinations in the most efficient manner (mail, fax, courier/hand delivery) that allows the beneficiary time to act. Requesting providers are notified by the SummaCare Authorization Portal, and also receive a copy of the beneficiary letter.

3.3.2 Approval notifications contain the following:
3.3.2.1 Service or item requested,
3.3.2.2 Date(s) approved, and
3.3.2.3 Name of the requesting provider.

3.3.3 Denial notifications are written using the Denial Notice and contain the following:
3.3.3.1 Service or item requested
3.3.3.2 Date(s) requested
3.3.3.3 Name of the requesting provider
3.3.3.4 Reason for the denial; the reason for the denial takes into consideration the Beneficiary's presenting medical condition, disabilities, and special language requirements, if any. The explanation of the denial must be written in a manner that the beneficiary can understand why the request was denied, be specific to the beneficiary's case, and provides enough detail to guide the beneficiary on any further action, if indicated

3.3.3.5 Reference to the medical criteria or benefit coverage document(s) used to help make the determination.
3.3.3.6 Notice of denial and appeal rights and a description of the standard and expedited reconsideration processes
3.3.3.7 Description of the beneficiary's right to submit additional evidence in writing or in person.

3.3.4 Discharge planning occurs in coordination with, and complementary to, concurrent review of all other admissions. Goals of clinical review and discharge planning activity include:
3.3.4.1 Performing clinical review and help in managing the length of stay.
3.3.4.2 Assisting with movement of the member to the most appropriate next level of care.
3.3.4.3 Provide assistance to the hospital staff for coordination of in-network (or out-of-network, if necessary), homecare, DME, and/or transportation.
3.3.4.4 Results of discharge planning assessments and interventions are documented and communicated to the appropriate entities.

3.3.5 In the case of readmission the UM reviewer will:
3.3.5.1 Investigate the readmission to determine all factors/barriers identified (e.g., transportation, medication cost issues, and home barriers);
3.3.5.2 Assist the hospital staff with alleviating all factors/barriers when possible;
3.3.5.3 Review referral/enrollments for all applicable plan enhanced case management programs.

3.4 Jacquie Potelicki, Director, HSM Clinical Management, has the authority and responsibility for the activities in this policy or procedure.
3.5 The Issuing Dept. is responsible for monitoring/enforcing the compliance with this policy.

**4.0 References:**

4.1 Source of the policy (regulatory citation, accreditation standard, nd internal standard)
4.1.1 NCQA UM 6 Element B
4.1.2 CMS Standard: Medicare Managed Manual: Chapter 13 Part C & D Enrollee Grievances, Organization/Coverage Determinations and Appeal Guidance 40
4.1.3 CFR 422.138
4.1.4 CFR 422.101
4.2 Are there any references to other documents, regulations, or intranet locations?
4.2.1 Utilization Management Policy

4.3 Are there other policies that work in conjunction with this policy?
4.3.1 None

4.4 Replaces (if applicable):
4.4.1 None

**5.0 Definitions:**

A Benefit Determination: is an approval or denial of a requested service that is specifically excluded from a member's benefit plan, which the plan is not required to cover under any circumstances. Benefit determinations include decisions about services that are limited by number, duration or frequency in the member's benefit plan, denials for extension of treatments beyond the specific limitations and restrictions imposed in the member's benefit plan, and decisions about care that do not depend on any circumstances, such as the member's medical need or a practitioner's order.

**6.0 Key Words or Aliases (Optional):**

6.1 Acute concurrent inpatient review and discharge
6.2 Hospital
6.3 Inpatient psychiatric unit
6.4 Acute rehabilitation
6.5 Skilled nursing facility

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