Purpose: Outlining the process for concurrent review of inpatient admissions.

Responsibility: The Initial Clinical Reviewer and the Clinical Peer Reviewer (CPR)

Policy and Procedure:

Definition of Urgent/Emergent Care

1. The Clinical Services Department (Clinical Services) uses the following definitions related to urgent/emergent services. When considering concurrent review, it is important to consider the urgent nature of the case to determine the correct timeframe in which to operate. (See *Policy and Procedure # MBH 911: Turnaround Timeframes*.)

   - Emergency condition is a mental disorder or substance use disorder manifesting itself by acute symptoms of sufficient severity, including pain, such that the absence of immediate behavioral health services could reasonably be expected to result in any of the following:

     a. Immediate harm to self or others
     b. Serious and permanent dysfunction to the consumer
     c. Serious impairment of the consumer's functioning
     d. Placing the consumer's health in serious jeopardy

   - Urgent and emergent services are covered without prior authorization in cases where a prudent layperson, acting reasonably, would have believed that an urgent or emergency medical condition existed.

   - Examples of an emergency include:

     a. A consumer who is in imminent danger of suicide, as evidenced by a clearly defined plan and history of suicide attempts requiring medical or psychiatric treatment
     b. A consumer who threatens to seriously injure a named or clearly designated person within a specified period of time,

   - Emergency treatment is the immediate and unscheduled behavioral health screening, examination and evaluation of a consumer by a physician to determine if an Emergency

condition exists and, if it does, the care and treatment necessary to relieve or eliminate the emergency condition.

- Emergency admission is medically necessary behavioral health services which are immediately required because the consumer is experiencing a severe level of symptoms according to a DSM-IV diagnosis and is impaired in his or her functioning to the extent that he or she presents an immediate danger of harm to self or others.

2. A consumer requiring emergency services usually comes to the attention of Clinical Service in one of the following ways:

- The consumer contacts Clinical Services, and in the course of the assessment the patient evidences need for emergency intensive services
- A facility contacts Clinical Services and requests emergency services
- An American Behavioral provider requests a step up to emergency services from a lower level of care (e.g. routine outpatient services)
- The consumer's physician or provider has identified symptoms or behaviors requiring an emergency assessment

3. Urgent and emergent services are covered without prior authorization in cases where a prudent layperson acting reasonably would have believed that an urgent or emergency medical condition existed.

4. The initial clinical reviewer or CPR may decide whether a case is urgent or emergent according to accepted definitions of the terms. An exception is when the physician with knowledge of the consumer's medical condition states that the non-urgent time frame would jeopardize the consumer's health.

6. The initial clinical reviewer and CPR follow all applicable regulatory timeframes for emergent or urgent continued length of stay requests (See *Policy and Procedure # MBH 911: Turnaround Timeframes*.)

Concurrent Review Process

1. Concurrent review of inpatient admissions provides the following:

   - A daily evaluation of the medical necessity of care;
   - Verification that the hospital setting is consistent with consumer's needs;
   - Monitoring in order to ensure efficient use of healthcare services;
   - Evaluation of the course of treatment and length of stay;
   - Assessment of the quality of care in relation to professional standards; and
   - Identification of those consumers whose condition would benefit from case management.

2. The attending physician is responsible for calling American Behavioral and updating the organization on the consumer's clinical condition.

3. The attending physician and the facility may agree to allow the facility's review department to update American Behavioral on the consumer's clinical condition.

4. An initial clinical reviewer or designee is responsible for on-site and telephonic concurrent review during regular business hours to assess the current treatment and therapies.

5. Telephonic review is the preferred review procedure for initial clinical reviews

6. If a facility requires onsite review or additional information is necessary for certification, the initial clinical reviewer follows the hospital's requirements for performing concurrent review.

7. The initial clinical reviewer or designee carries proper identification when doing onsite concurrent review. The identification includes:

   - The initial clinical reviewer or designee's full name and title;
   - The initial clinical reviewer or designee's picture; and
   - The name of the organization.

8. Onsite review is scheduled according to the timeframe in *Policy and Procedure # MBH 911: Turnaround Timeframes*.

9. While performing on-site review, the initial clinical reviewer or designee follows all facility procedures, i.e. sign-in procedures or wearing a facility badge.

10. Onsite reviews shall be conducted in the facility's designated areas.

11. The initial clinical reviewer documents in the American Behavioral System the date and time the updated information is received.

12. The initial clinical reviewer, or designee, reviews the consumer's clinical information via telephonic updates.

13. The initial clinical reviewer speaks with the attending physician, if necessary, to get a complete and current picture of the consumer's condition, treatment, and prognosis

14. Hospitals, physicians and other providers are not required to provide numerically coded diagnoses or procedures

15. The initial clinical reviewer or designee utilizes the medical necessity criteria, applying the guidelines to all inpatient cases. He or she compares the consumer's hospital course with the criteria, looking for correlations between the consumer's clinical status and the therapeutic requirements.

16. If criteria for continued length of stay are being met, the initial clinical reviewer or designee notes the consumer's condition, therapies and other pertinent information in the daily notes screen of the American Behavioral System.

17. Continued length of stay requests that meet criteria are certified as quickly as the patient's health requires and within applicable regulatory timeframes. (See *Policy and Procedure # MBH 911: Turnaround Timeframes.*)

18. The next review date is determined based upon the severity of the consumer's condition, the treatment, and discharge planning activity. It is not routinely conducted on a daily basis. This process continues until the consumer is discharged.

19. The initial clinical reviewer documents the information in paragraph 21 in the American Behavioral System.

20. The initial clinical reviewer provides written notification of any continued length of stay certification upon request of the attending physician, any other ordering provider and/or the facility rendering services.

21. The initial clinical reviewer confirms the certification for continued length of stay by communicating the following to the provider, the hospital and/or the patient or patient's designee:

    - The date of admission or onset of services;
    - The number of extended days or units of service;
    - The next anticipated review date; and
    - The new total number of days or services approved.

22. Issuance of a certification number does not guarantee benefits.

23. A certification number is issued based on information received at the time of precertification. Upon discovery of any new or omitted information, the authorization may be withdrawn. The pre-certification process begins again using the new information.

24. The initial clinical reviewer completes the "UR Notes" screen in the American Behavioral System for every continued length of stay request

25. The requesting provider does not receive a certification number if the continued length of stay does not meet admission criteria. However, the initial clinical reviewer enters the authorization request into the American Behavioral System for tracking purposes.

26. If a continued length of stay request does not meet criteria, the initial clinical reviewer may call the attending physician to collect further information that may justify authorization.

    If new information causes the request to meet criteria, the initial clinical reviewer, or designee, authorizes more days as appropriate.

27. The initial clinical reviewer follows *Policy and Procedure # MBH 7: Lack of Information* for any case that requires additional information for reaching a decision.

    The initial clinical reviewer or CPR may request an extension for an non-urgent decision as long as the consumer's health is not in jeopardy. (See *Policy and Procedure # MBH 911: Turnaround Timeframes*.)

28. If new information does not cause the continued length of stay request to meet criteria, the initial clinical reviewer immediately refers the case CPR or designee.

33. The CPR or designee reviews the initial clinical reviewer's documentation. He or she either:

    - Immediately approves the admission or
    - Talks directly to the ordering physician to obtain further justifying information and clarification; or
    - Renders a non-certification.

29. When appropriate, the CPR may request an expert opinion on the appropriateness of a continued hospital stay. The expert opinion is from a physician of the same specialty as the attending physician.

30. Upon request, information about the admission criteria is made available to the attending physician and to the consumer as copyright law allows.

31, The initial clinical reviewer or designee notifies the admitting physician by telephone of the certification or non-certification decision as quickly as the consumer's health requires and within applicable regulatory timeframes (See *Policy and Procedure # MBH 911: Turnaround Timeframes.*)

32. When a determination is made to issue a non-certification and no peer-to-peer conversation has occurred, the initial clinical reviewer tells the provider about the opportunity to discuss the non-certification decision with the CPR making the initial determination or designee. (See *Policy and Procedure # MBH 11: Peer-to-Peer Conversation (Was Request For Reconsideration*.)

33. The initial clinical reviewer sends the provider and patient written notification (via fax or postal service) of any non-certification decisions within applicable regulatory timeframes (See *Policy and Procedure # MBH 911: Turnaround Timeframes.*)

34. Only the CPR or designee may non-certify a continued length of stay based on clinical judgment and approved criteria.

35. For tracking purposes, the initial clinical reviewer documents in the American Behavioral System the date and time the decision is made.

36. For tracking purposes, the initial clinical reviewer documents the turnaround time for each continued length of stay review in the American Behavioral System.

37. For easy data extraction and concise reporting, the initial clinical reviewer uses the continued length of stay formatted charting.

38. Concurrent review records are entered in the American Behavioral System, ensuring confidentiality. Only aggregate data in the quarterly and annual reports are distributed outside the department

39. The initial clinical reviewer or designee analyzes certified inpatient days for potential over, under, or incorrect utilization of healthcare services by consumers and providers.

42. The initial clinical reviewer automatically updates the daily census report when he or she admits or discharges cases from the American Behavioral System.

43. The daily census report is referenced as often as necessary to reflect an accurate accounting of hospitalized consumers.

44. The daily census report serves as the starting point for reviews each day.

45. The initial clinical reviewer or designee continually assesses the hospital course for quality issues and records this information as required by Utilization Management Quality Improvement (UMQI) Committee.

46. The hospital bed days are reported monthly using this calculation:

$$DPT = \frac{\text{(Raw \# Inpatient Days) x 365,000}}{\text{(Days in time period) x (membership)}}$$

47. Each case is coded with "Quality of Care" indicators.

48. The initial clinical reviewer or designee conducts a discharge review to ensure appropriate discharge measures were in place at the time of discharge.

49. During the course of the hospitalization, the initial clinical reviewer or designee refers cases to case management when appropriate.

50. The initial clinical reviewer or designee and the CPR or designee hold weekly review sessions to discuss the progress and prognosis of hospitalized consumers.

51. The initial clinical reviewer and the CPR discuss each case, as well as any quality of care or service issues, while maintaining the confidentiality of protected health information.