PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="4">Guideline/Procedure Number: MCUG3024 (previously UG100324)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Guideline/Procedure Title: Inpatient Utilization Management</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/25/1994</td><td colspan="4">Next Review Date: 04/08/2027
Last Review Date: 04/08/2026</td></tr>
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<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 04/08/2026</td></tr>
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I. RELATED POLICIES

A. MCUP3037 - Appeals of Utilization Management/Pharmacy Decisions
B. MCUP3041 - Treatment Authorization Request (TAR) Review Process
C. MPUP3139 - Criteria and Guidelines for Utilization Management
D. MCUP3124 - Referral to Specialists (RAF) Policy
E. MCUG3058 - Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
F. MCUG3038 - Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled or Subacute) Facilities
G. MPUP3018 - Health Services Review of Observation Code Billing
H. MPAP7003 - CalAIM Community Supports (CS)
I. MPUP3078 - Second Medical Opinion
J. MPUP3138 - External Independent Medical Review
K. MPUD3001 - Utilization Management Program Description
L. MPBP8003 - Mental Health Services
M. MCUP3141 - Delegation of Inpatient Utilization Management
N. CMP36 - Delegation Oversight and Monitoring

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Provider Relations

III. DEFINITIONS:

A. Acute inpatient administrative days are days approved at an acute inpatient facility, which provides a higher level of medical care than currently needed by the Member, or when a Member is awaiting placement in a transitional care setting, such as a Skilled Nursing Facility (SNF), Subacute Facility, or Intermediate Care Facility (ICF).
B. Acute inpatient care is defined as that care provided to persons sufficiently ill or disabled who require the following:
    1. Constant availability of medical supervision by the attending physician or other professional medical staff
    2. Constant availability of licensed professional nursing personnel
    3. The availability of other diagnostic or therapeutic services and equipment which are ordinarily immediately available only in a hospital setting to ensure proper medical management

C. Elective as a guideline for admission is defined as planned treatment that can be delayed without risk to permanent health. Also known as a scheduled admission.

D. Emergency Medical Condition as a guideline for admission is defined as:
A condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could result in:
   1. Placing the health of the individual (or, the case of a pregnant Member, the health of the Member or the unborn child) in serious jeopardy
   2. Serious impairment to bodily functions
   3. Serious dysfunction of any bodily organ or part

E. Inpatient admission locations include:
   1. Acute Hospitals: These hospitals treat patients with severe or brief illnesses, injuries, or during recovery from surgery. They often have specialized units like ICUs, trauma centers, and emergency departments.
   2. Acute Rehabilitation Centers (ARUs): Inpatient facilities that provide intensive rehabilitation services to individuals who need to regain maximum independent function after a physical or cognitive impairment. These centers focus on restoring mobility, self-care, and independent living skills, enabling patients to return home or transition to a lower level of care.
   3. Long Term Acute Care (LTAC) Facility: A type of healthcare setting or facility that provides extended, intensive medical care for patients with serious, complex conditions who require ongoing treatment and monitoring with a longer recovery period than typically provided in a traditional acute care hospital.
   4. Subacute Care Facilities: Facilities with a level of care that is less intensive than acute care, but more intensive than skilled nursing care (e.g. Members who require ventilators at stable settings, tracheostomies, total parenteral nutrition, tube feeding, complex wound management care, etc.).
   5. Skilled Nursing Facility (SNFs): A facility or part of a hospital that provides short-term medically necessary skilled services provided by nurses, therapists, and/or physicians.
   6. Hospice Facility: A licensed facility providing care for terminally ill individuals 24 hours per day, 7 days per week, that is focused on comfort and symptom management rather than curative treatment. Medi-Cal hospice providers must be Medicare-certified and enrolled with Medi-Cal.

F. Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

G. Urgent as a guideline for admission is defined as:
   1. Patient requires immediate attention for the care and treatment of a physical disorder. An unscheduled admission.
   2. Medical situations that require prompt medical attention, but do not endanger the patient's life or risk permanent health if care is not obtained in a reasonable period of time.
   3. The immediate treatment of a medical condition that requires prompt medical attention, but where a reasonable lapse of time before medical care is obtained would not endanger life or cause significant impairment.
   4. A non-emergency admission that is neither life threatening nor elective, but requires immediate attention for optimal outcome.

H. Utilization Management (UM) is the process of reviewing medical services prior to and during confinement to evaluate the following:
   1. Medical necessity - meaning reasonable and necessary service to protect life, prevent significant illness or disability or alleviate severe pain through the diagnosis or treatment of disease, illness or injury
   2. Ongoing review of patient response to treatment
   3. Appropriate level of care
   4. Therapeutic decisions to determine if more effective, efficient avenues are available.
   5. Use of Partnership HealthPlan of California (Partnership) contracted providers and facilities

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IV. ATTACHMENTS:

A. Request for Reconsideration of Inpatient UM Decision (RRIU): Post Discharge Review for Inpatient Services

V. PURPOSE:

To provide guidelines for the Partnership HealthPlan of California's inpatient utilization management activities. These activities are performed by the Utilization Management Department under the direction of the Chief Medical Officer (CMO) or Physician Designee.

VI. GUIDELINE / PROCEDURE:

A. The Objectives of the Utilization Management Program are as follows:
   1. Reduce unnecessary or inappropriate admissions
   2. Ensure that services are provided in the appropriate setting or manner required for the patient's medical condition - the right care at the right time, in the right setting
   3. Reduce medically unnecessary inpatient days
   4. Identify and report potential quality of care issues
   5. Evaluate the anticipated course of treatment and length of stay for appropriateness and efficiency
   6. Integrate second opinion guidelines when appropriate
   7. Ensure participating providers who are contracted with Partnership are appropriately utilized
   8. Collaborate with facility staff and Member's physician to address, plan, and coordinate needs of the patient prior to discharge, including identification of cases appropriate for referral to an appropriate case management program. The Nurse Coordinator utilizes the historical information provided by the facility in the decision making process as well as InterQual® which is the department's evidenced-based practice tool. Some of the information utilized includes but is not limited to:
      a. Age
      b. Comorbidities
      c. Complications
      d. Progress of treatment
      e. Psychosocial situations
      f. Home environment, when applicable

B. CRITERIA
   1. Acute inpatient cases are reviewed according to guidelines set forth by the California Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), clinical guidelines such as InterQual® and National Comprehensive Cancer Network (NCCN) and other broadly accepted standards of care. Please see policy MPUP3139 Criteria and Guidelines for Utilization Management for further information.
   2. If a request is received for review of services that varies from such guidelines, or for which review criteria have not been developed, the CMO/Physician Designee will use clinical judgment and discussion using a specialty matched board certified specialist as necessary to make a determination based on medical appropriateness.
      a. Utilization management staff will provide the InterQual® information, as well as a patient summary developed from the facility's discharge planning or UM staff (including the applicable policies), for the Medical Director to reference.
      b. Information from the attending physician will also be considered. The attending physician can be the primary care physician, hospitalist, or the specialist physician (or all three as necessary).
   3. The needs of individual patients and the characteristics of the local delivery system are taken into account when determining the medical necessity of an inpatient hospitalization.

C. URGENT AND NEWBORN ADMISSION AUTHORIZATION PROCESS
   1. Urgent or Emergency Admission
      a. In the case of an urgent or emergent admission, the hospital is required to notify the Health Services Department within 1 business day of the admission.
      b. All declared emergency admissions will be followed by a Nurse Coordinator who will perform the initial review within 72 hours of notification to Partnership. The Nurse Coordinator will then follow concurrent review procedures.
      c. Refer to III.G. and III.D. above for definitions of urgent and emergency.
   2. Newborn Admissions
      a. All initial inpatient newborn care is automatically authorized if care rendered to the mother is approved. The neonate is assigned the same number as the mother if the mother and baby are discharged on the same day. If mother is discharged and the infant remains in the hospital, a new authorization number will be assigned for the baby.
      b. If the newborn is admitted to the intensive care nursery, an authorization number must be assigned at the time of admission to NICU and the appropriate capitated provider, if applicable, notified.

D. ELECTIVE/SCHEDULED ADMISSION AUTHORIZATION PROCESS
   1. This type of review requires justification of medical necessity before a patient can be admitted to an acute care facility. It is a process to assure that elective or non-emergency hospitalization is medically necessary and arranged in the appropriate facility. Authorization is required for all elective/scheduled admissions as follows:
      a. Prior authorization should be obtained by the admitting physician as soon as possible but not less than five (5) to ten (10) days prior to the planned admission.
      b. Preadmission authorization is the process in which the Nurse Coordinator evaluates a request for an elective admission to a health care facility. The procedure involves the admitting physician furnishing the pertinent information such as diagnosis, age, indication for admission, and any planned surgical procedure. For elective surgeries in which a post-operative admission directly to an acute inpatient rehabilitation facility is recommended instead of an initial inpatient stay, the prior authorization should be submitted prior to surgery to ensure timely placement.
      c. If a specialist is planning to admit the Member, a Referral Authorization from the Primary Care Physician is required. (see policy MCUG3124 Referral to Specialists (RAF) Policy)
      d. Preadmission testing will be performed prior to elective admissions.
      e. Early morning admission on the day of a proposed surgical procedure should be utilized. If the patient's problem precludes such utilization, the admitting physician must document the need for a preoperative review and a determination of medical necessity and appropriateness will be included in the prior authorization of the proposed admission. Using established criteria, most confinements can be pre-approved by the Nurse Coordinator. If a less expensive but equally effective care alternative is available and the patient's condition permits, Partnership's CMO/Physician Designee will approve treatment at that level of care. If medical necessity is not clear, the request will be escalated to the CMO/Physician Designee for review.
      f. It is the admitting facility's responsibility to verify (prior to admission) that the required prior authorization has been completed and approved. The admitting facility is required to notify Partnership of the actual admission within one business day of the admission, even though the admission has been pre-approved. (In the event that a prior-authorization request is not submitted for an elective procedure, a review for medical necessity is still performed.)
      g. The purpose of this process is to arrive at the most cost efficient manner for Partnership HealthPlan's patients to obtain quality care as well as screen patients for medical necessity and appropriateness of admission to an acute care facility.
      h. Refer to III.C. above for definition of elective.

E. CONTINUED STAY REVIEW/CONCURRENT REVIEW AUTHORIZATION PROCESS

1. Concurrent review is the process of review for the assessment of ongoing medical necessity and appropriateness of continued hospitalization in an inpatient facility. All hospital admissions are subject to the concurrent review process.
2. All patients in acute or subacute facilities are reviewed concurrently, either telephonically, electronically, or via faxed reviews, for appropriateness of care and use of hospital services in an effort to assure cost efficient delivery of care as well as medical necessity and quality of care.
3. Objectives of Concurrent Review
   a. Evaluate medical necessity
   b. Monitor and ensure the efficient us of health care services
   c. Determine if the hospital setting is consistent with care being rendered
   d. To evaluate the course of treatment and length of stay
   e. To identify and report any potential quality of care issues
   f. To reduce length of stay by proactively working with hospital discharge planners and Case Managers to facilitate timely discharge planning and needed follow up
   g. Identify cases requiring CCMO/Physician Designee review and/or intervention
4. CMO/Physician Designee referrals include but are not limited to cases:
   a. Which appear to fail to meet criteria
   b. For which medical information provided is insufficient to make a decision
   c. For which a level of care determination may be required
   d. For which physician to physician consultation is deemed necessary, e.g., procedures that may not be considered standard medical practice, questionable procedures/treatment
5. Continued Stay/Concurrent Review Process
   a. Partnership maintains electronic records on all hospital admissions and monitors the Member's care throughout the length of stay using established criteria as defined in Section VI. B, the Nurse Coordinator determines the medical necessity and appropriateness of continued hospitalization.
   b. Partnership will render a decision (approve, modify, defer/pend, deny) within 72 hours of receipt of notification of admission. The Nurse Coordinator will continue to concurrently review the authorization within 72 hours of receipt each time clinical information is received throughout the remainder of the stay.
   c. If continued hospitalization meets InterQual criteria, the next/frequency of review is determined by the Member's acuity level, individual circumstances, and InterQual criteria.
   d. If the stay does not meet the criteria due to lack of documentation/information, further information from the nursing staff/appropriate departments/personnel may be requested.
   e. If, after all available information has been reviewed, and the stay does not appear to meet criteria, the authorization is escalated by the Nurse Coordinator to the CMO/Physician Designee for review of medical necessity.
   f. The CMO/Physician Designee reviews the medical record documentation and makes the decision to approve or deny continued hospitalization within 24 hours (1 calendar day).
   g. If the CMO/Physician Designee approves continued stay, the Nurse Coordinator will continue the concurrent review process.
   h. The CMO/Physician Designee may contact the attending physician to discuss the case. The result of the review is documented on the appropriate review form and includes the rationale for the decision.
   i. If the CMO/Physician Designee determines the stay is not medically necessary, the provider is notified verbally, via the telephone, that the facility stay is denied, followed by electronic or written notice of denial within 24 hours from the verbal notification. The CMO/Physician Designee signs the denial letter.
   j. Attending clinicians of inpatient facilities may request a Peer to Peer for a Member currently admitted to the facility or within 3 business days of discharge if the determination of the case in

concurrent review by the CMO/Physician designee does not meet criteria for medical necessity for the level of care requested, and the stay is not approved.

k. After 3 business days after a member is discharged from the hospital, if a hospital has a disagreement with a denial of medical necessity for a hospital admission, or one or more inpatient days of an admission, the hospital should submit a Request to Reconsider an Inpatient UM Determination. Please see Attachment A for the information we require to consider.

F. INTER-FACILITY TRANSFERS OF MEMBERS

1. Partnership UM staff may facilitate the transfer of a Member from a non-contracted hospital to a contracted hospital. Criteria for consideration of transfer include:
   a. A benefit analysis of care offered for the patient.
   b. The Member is medically stable for transfer.
   c. There is a contracted facility available that can meet the Member's medical needs.
   d. The estimated length of stay at the receiving hospital is greater than three days.
   e. The attending physician at the transferring hospital is agreeable to the transfer and willing to sign the necessary documents.
   f. The attending physician and the hospital staff at the accepting hospital are willing to accept the Member in transfer.
   g. There is agreement of agencies responsible for authorizing services (e.g. California Children's Services [CCS] or the Genetically Handicapped Persons Program [GHPP]).
   h. The consent of the parent or authorized caregiver for children under the age of 21 hospitalized under the CCS program is required prior to the transfer.
   i. In each of the above situations, the utilization management forms and appropriate electronic record screens are documented as applicable.
2. Partnership may coordinate other inter-facility transfers of Members when deemed medically necessary.
3. For further discussion of services for Members capitated to contracted hospitals, please see policy MCUP3141 Delegation of Inpatient Utilization Management.

G. ACUTE INPATIENT ADMINISTRATIVE DAYS

1. A Partnership Member may be approved for acute inpatient administrative days when, after review of information from the attending physician and the medical record, it is the professional judgment of the Partnership CMO/physician designee that the Member's care no longer meets acute inpatient criteria, and medical and nursing care is required at a lower level of care, but placement is not available at the present time.
2. Inpatient acute facilities must provide documentation to demonstrate that active inquiries are being made to potential facilities for the appropriate level of care as determined by medical necessity. The Member's record must reflect the outreach efforts to achieve placement at a SNF, Subacute facility, Long Term Care Facility (LTC), Medical Respite, Acute Inpatient Rehabilitation, Subacute Rehabilitation or ICF.
3. For Members who require placement for continued management, the acute inpatient facility must initiate inquiries and contact with facilities that are appropriate for the Member's needs.
   a. The acute inpatient facility must continue placement efforts until placement occurs.
   b. The Member's record must reflect the outreach efforts to achieve placement. Once begun, a daily assessment of placement status is expected, summarized in progress notes no less frequently than every 3 calendar days.
   c. Partnership will review documentation of placement efforts on a regular basis for ongoing approval of acute inpatient administrative days.
   d. If a member meets the criteria for acute inpatient administrative days (as defined in this section), but no placement is achieved and the patient ends up being discharged to a non-covered setting (e.g. home, congregate living, homeless shelter), administrative days can still be assigned for those days that met criteria while outreach efforts were being made.
4. For Members with a terminal illness, administrative days may be considered while the facility finalizes

an appropriate discharge disposition (SNF with hospice, home with hospice) for a patient with a terminal illness who, when admitted, met acute inpatient criteria, and the records show that the goals of care for the Member have transitioned to comfort care measures.

5. If the Member is pending placement at a level of care that is not Partnership's responsibility, acute inpatient administrative days do not apply. Examples include, but are not limited to, Members who are the responsibility of the criminal justice system or being discharged home or to a board and care facility.

H. INPATIENT PSYCHIATRIC ADMISSIONS

1. For Partnership Medi-Cal Members: Specialty mental health services are not a Partnership covered benefit.
   a. Partnership Medi-Cal Members determined to have moderate to severe mental health conditions which require specialty mental health services are referred to the County Behavioral Health Plan in the Member's county of residence. The administration of such referrals is addressed in the respective Memorandum of Understanding (MOU) with each County Mental Health Plan, consistent with California statutes and regulations.
   b. Acute inpatient administrative days do not apply when the Partnership Medi-Cal Member is pending evaluation on a psychiatric hold or awaiting placement at a mental health facility. Specialty mental health services are not a Partnership responsibility.
2. For further information, see policy MPBP8003 Mental Health Services.

I. CASE REVIEW CONFERENCES

1. Case Review Conferences provide a forum to promote and ensure consistent application of criteria and decision-making between and among Nurse Coordinators and the CMO/Physician Designee. They are also used as an educational tool for research, discussion of unique and difficult cases, and pertinent, new treatment innovations and pharmaceuticals. The goal is to keep the staff up to date on current medical care.
2. Case Review Conferences occur weekly, at a minimum and often include facility care management staff (e.g. case managers, discharge planners).
3. The meetings are conducted in a private area, either an office or conference room. This serves to encourage frank discussion of cases while protecting and preserving patient confidentiality.
4. The meetings are conducted by the Director of UM or Designee, and attended by the Health Services Nurse Coordinator staff and Managers involved in the in-patient review process, appropriate Care Coordination staff and the CMO/Physician Designee.
5. Identified cases (e.g. patients with long lengths of stay, typically over seven (7) calendar days from the date of admission are discussed in detail by the team with a focus on creative, innovative solutions and remedies to move patients through the health care continuum in the most efficient manner.
6. Nurse Coordinators are expected to follow the review guidelines outlined in this policy.
7. The objectives of case conferences are to:
   a. Reduce unnecessary or inappropriate admissions and inpatient days.
   b. Ensure that services are provided in the appropriate setting or manner required for the patient's medical condition
   c. Improve the quality of care rendered
   d. Evaluate the anticipated course of treatment and length of stay
   e. Evaluate Members for transfer from non-contracted to contracted hospitals
   f. Ensure participating providers who are contracted with Partnership are appropriately utilized
   g. Address, plan, and coordinate needs of the patient upon discharge, including identification of cases appropriate to case management intervention
   h. Ensure the provision of efficient, quality care and assist in assessing alternative treatments
   i. Provide appropriate support and recommendations to the Inpatient UM Nurse Coordinators

J. PROCESS FOR A PROVIDER TO APPEAL AN ADVERSE BENEFIT DETERMINATION ON BEHALF OF A MEMBER

1. Refer to Partnership's policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions.

K. POST-SERVICE OR RETROSPECTIVE REVIEW

Retrospective review applies the same process and criteria as continued stay/concurrent review, only AFTER the patient has been discharged.

1. Objective
   Retrospective review is used to identify medically unnecessary admissions and bed days that have been incurred.
2. Process
   a. For post-service/retrospective review, Partnership will render a decision (approve, modify, defer/pend, deny) no later than 30 calendar days from the receipt of the request.
   b. When the clinical information is received, the acute care hospitalization is evaluated, day by day, to determine the appropriateness of admission and length of stay given the patient's clinical status and the course of treatment.
   c. Identified problem areas are presented to the CMO/Physician Designee as with continued stay review/concurrent review.
   d. Electronic or written notification of the decision and how to initiate a reconsideration or provider appeal is communicated to the provider within 24 hours of decision, but no later than 30 calendar days from the date of the receipt of the request. Written notification is mailed to the Member within two (2) business days of the decision.

L. COMMUNICATION SERVICES

1. Partnership provides access to staff for Members and practitioners seeking information about the UM process and the authorization of care as described in the Communication Services section of policy MPUD3001 Utilization Management Program Description.
2. Note that Partnership also has a dedicated after-hours local phone number (707) 430-4808 or toll free number (866) 828-2304 to receive calls from physicians and hospital staff for addressing post-stabilization care and inter-facility transfer needs 24 hours per day, 7 days per week. Calls are returned within 30 minutes of the time the call was received. Partnership's CMO/physician designee is on call 24 hours per day 7 days per week to authorize medically necessary post-stabilization care services and to respond to hospital inquiries within 30 minutes. Partnership clinical staff are available 24 hours per day 7 days per week to coordinate the transfer of a Member whose emergency medical condition is stabilized.

M. DELEGATION OVERSIGHT AND MONITORING

1. Partnership delegates UM functions to select contracted hospitals. Please see policy MCUP3141 Delegation of Inpatient Utilization Management.

VII. REFERENCES:

A. InterQual® criteria
B. Medi-Cal Provider Manual/ Guidelines
C. National Committee for Quality Assurance (NCQA) Guidelines for Timeliness of UM Decisions
D. DHCS All Plan Letter (APL) 21-011 *Revised* Grievance and Appeals Requirements, Notice and "Your Rights" Templates (08/31/2022)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

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X. REVISION DATES:

03/23/95; 08/98; 06/21/00; 06/20/01; 09/18/02; 04/16/03; 05/21/03; 10/20/04; 02/16/05; 08/20/08; 11/18/09; 05/18/11; 05/20/15; 08/19/15; 05/18/16; 04/19/17; *08/08/18; 04/10/19; 04/08/20; 04/14/21; 06/09/21; 06/08/22; 08/09/23; 09/11/24; 09/10/25; 04/08/26

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

MCUP3053 Acute Inpatient Administrative Days (06/20/2001 – 09/10/2025)

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.