PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

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<tr><td colspan="5">Guideline/Procedure Number: MCUG3024 (previously UG100324)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="5">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="5">Next Review Date: 09/11/2025
Last Review Date: 09/11/2024</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="3">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="4">Approval Date: 09/11/2024</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. MCUP3139 - 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. MPUP3078 - Second Medical Opinion
G. MCUP3138 - External Independent Medical Review
H. MPUD3001 - Utilization Management Program Description
I. MCUP3028 - Mental Health Services
J. MCUP3141 - Delegation of Inpatient Utilization Management
K. CMP36 - Delegation Oversight and Monitoring

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. 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
B. Inpatient admission locations include:
   1. Acute Hospital
   2. Skilled Nursing Facility
   3. Sub-acute Facility
   4. Long Term Acute Care Facility
   5. Acute Rehabilitation Center
   6. Hospice Facility

C. 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

D. 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.

E. 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.

F. 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

G. 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.

IV. ATTACHMENTS:

A. N/A

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 or Physician Designee.

VI. GUIDELINE / PROCEDURE:

A. The Objective of the Utilization Management Program is to:
   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. Current InterQual® criteria sets are used as the main review guidelines. Other resources as necessary are used to help in determining review decisions, these include, but are not limited to, Medi-Cal (State of California) guidelines and Partnership internally developed and approved guidelines. Partnership does not reward practitioners or other individuals for issuing denials of coverage. There are no financial incentives for UM decision makers to deny care; and Partnership does not encourage decisions which would result in underutilization, but rather bases decisions solely on the appropriateness of care or service and the existence of coverage.
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 Chief Medical Officer or 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.
3. Decisions are based on information derived from the following sources:
   a. Clinical records
   b. Medical care personnel
   c. 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.
   d. Attending physician (attending physician can be the primary care physician, hospitalist, or the specialist physician (or all three as necessary)
4. 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. E – F 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.
   c. If a specialist is planning to admit the Member, a Referral Authorization from the Primary Care Physician is required. (see policy MCUG3024 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 Chief Medical Officer or Physician Designee will approve treatment at that level of care. If medical necessity is not clear, the request will be escalated to the Chief Medical Officer or 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. D. 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 on site, 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 Chief Medical Officer or Physician Designee review and/or intervention
4. Chief Medical Officer or 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 24 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 Chief Medical Officer or Physician Designee for review of medical necessity.
   f. The Chief Medical Officer or 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 Chief Medical Officer or Physician Designee approves continued stay, the Nurse Coordinator will continue the concurrent review process.
   h. The Chief Medical Officer or 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 Chief Medical Officer or Physician Designee determines the stay is not medically necessary, the patient's stay is not approved and the Nurse Coordinator verbally notifies the facility that the stay is denied, followed by electronic or written notice of denial within 24 hours from the verbal notification. The Chief Medical Officer or Physician Designee signs the denial letter.

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. INPATIENT PSYCHIATRIC ADMISSIONS
1. Members determined to have moderate to severe mental health conditions which require specialty mental health services are referred to the County Mental Health Plan in the Member's county of residenceMember. 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.
2. MembercapitaFor further information, see policy MCUP3028 Mental Health Services.

H. 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 Chief Medical Officer or 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.
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 Chief Medical Officer or 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

I. 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.

J. 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 Chief Medical Officer or Physician Designee as with continued stay review/concurrent review.
d. Electronic or written notification of the decision and how to initiate a routine or expedited appeal if applicable 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.

K. COMMUNICATION SERVICES

1. Partnership provides access to staff for Members and practitioners seeking information about the UM process and the authorization of care in the following ways:
   a. Calls from Members are triaged through Member service staff who are accessible to practitioners and Members to discuss UM issues during normal working hours when the health plan is in operation (Monday - Friday 8 a.m. – 5 p.m.).
   b. Members and Providers may contact the Partnership voice mail service to leave a message which is communicated to the appropriate person on the next business day. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday-Friday are returned on the same business day.
   c. After normal business hours, Members may contact the advice nurse line at (866) 778-8873 for clinical concerns.
   d. Practitioners, both in-network and out-of-network, may contact UM staff directly either through secure email or voicemail. Each voice mailbox is confidential and will accept messages after normal business hours. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
      1) Partnership 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 Chief Medical Director or 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.
      2) For information on utilization management procedures (prior authorization requirements, Clinical Protocols and Practice Guidelines) refer to Partnership's Provider Manual, Section 5: Health Services at www.partnershiphp.org. For information on how to submit claims, refer to Partnership's Provider Manual, Section 3: Claims at www.partnershiphp.org.
   e. Partnership has a toll free number (800) 863-4155 that is available to either Member or practitioners.
   f. UM staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues. For a list of UM Program Staff and Assigned Responsibilities, please refer to policy MPUD3001 Utilization Management Program Description.
   g. Members can view information about Partnership's language assistance services and disability services in the Member Handbook which is mailed to Members upon enrollment and is always available online at http://www.partnershiphp.org/Members/Medi-Cal/Documents/MCMemberHandbook.pdf Additionally, Partnership provides annual written notice to Members about our language assistance services and disability services in our Member Newsletter.
2. Linguistic services to discuss UM issues are provided by Partnership to monolingual, non-English speaking or limited English proficiency (LEP) Medi-Cal beneficiaries for population groups as determined by contract. These no cost linguistic services include the following:

a. Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries
b. Written informing materials (to include notice of action, grievance acknowledgement and resolution letters) are fully translated into threshold languages in accordance with regulatory timeframes and into other languages or alternative formats as indicated in the Member's record or upon request. Material formats include audio, large print and electronically for Members with hearing and/or visual disabilities. Braille versions are available for Members with visual disabilities. The organization may continue to provide translated materials in other languages represented by the population at the discretion of Partnership, such as when the materials were previously translated or when translation may address Health Equity concerns.
c. Use of California Relay Services for hearing impaired (TTY/TDD: [800] 735-2929 or 711)

3. Partnership regularly assesses and documents Member cultural and linguistic needs to determine and evaluate the cultural and linguistic appropriateness of its services. Assessments cover language preferences, reported ethnicity, use of interpreters, traditional health beliefs and beliefs about health and health care utilization.

L. DELEGATION OVERSIGHT AND MONITORING

1. Partnership delegates UM functions to select contracted hospitals. For any services delegated, the following procedures apply:
   a. A formal agreement is maintained and inclusive of all delegated functions.
   b. Partnership conducts an audit of delegated entities no less than annually to ensure the delegate is following the appropriate policies and procedures for all UM functions.
   c. Results from the annual delegation oversight audit shall be presented to Partnership's Delegation Oversight Review Sub-Committee (DORS) for review and approval and reviewed by the CMO or physician designee.

VII. REFERENCES:

A. InterQual® criteria
B. Medi-Cal Provider Manual/ Guidelines
C. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 2024) UM 5 Timeliness of UM Decisions Elements A and E
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

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

*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: N/A

Guideline/Procedure Number: MCUG3024 (previously UG100324)			**Lead Department: Health Services**
Guideline/Procedure Title: Inpatient Utilization Management			☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/25/1994		**Next Review Date: 09/11/2025** **Last Review Date: 09/11/2024**	
Applies to:	☒ **Medi-Cal**		☐ **Employees**

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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.