STANDARD OPERATING PROCEDURES MANUAL

FOR

INPATIENT CONCURRENT REVIEW AND DISCHARGE PLANNING AT

VERMONT HOSPITALS

AND

IN-NETWORK BORDER HOSPITALS

Department of Vermont Health Access
Vermont Agency of Human Services
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I. Introduction

Concurrent Review is the review of the medical appropriateness and necessity of continued hospitalization. For Vermont hospitals and in-network border hospitals, concurrent review is conducted for inpatient stays that exceed 13 days using nationally recognized evidence-based criteria to evaluate the appropriateness of continued hospital level of care.

Concurrent review also helps ensure effective discharge planning and care transitions. Discharge planning focuses on collecting information related to clinical needs and psychosocial concerns and supports the transition of the beneficiary to an appropriate care setting. Discharge planning must begin at the time of admission.

II. Concurrent Review Procedures

1) All Vermont hospitals, including in-network border hospitals, are not required to submit faxed daily census sheets to the Department of Vermont Health Access (DVHA) Clinical Operations Unit (COU).

Please note: Continue to use the File Transfer Protocol (FTP) for submitting information as required by other DVHA programs.

2) Inpatient stays greater than 13 days will require concurrent review by the DVHA COU concurrent review nurse.

The admitting facility must fax a completed Inpatient Concurrent Review Notification Form to the DVHA COU at (802) 879-5963 for all inpatient admissions that have an expected length of stay exceeding 13 days, including time in the emergency department and/or observation by day 13, but no earlier than day 10 of the admission. The form is posted on the DVHA website at http://dvha.vermont.gov/for-providers/forms-1.

Any claim submitted for a length of stay greater than 13 days that does not have an authorization will be automatically denied by the MMIS.

3) Concurrent reviews will be conducted over the phone, via secure email, electronic health record, and/or by fax with additional clinical documentation faxed or emailed to the DVHA upon request or obtained using remote electronic health record access.

The DVHA COU concurrent review nurse will collaborate with the hospital case management department to assess the discharge plan and beneficiary readiness.

4) Frequency of concurrent review is determined by:
   - Level of care
   - Intensity of services
   - Severity of symptoms

   If discharge is imminent, reviews will be conducted more frequently.
5) The concurrent review process will continue as long as at least one condition is met: the DVHA concurrent review nurse determines if the hospital stay is medically necessary and appropriate, based on nationally recognized evidence-based criteria (e.g., InterQual severity of illness/intensity of illness) and/or the beneficiary’s level of care has been changed to waiting placement and active discharge planning is in progress.

6) The DVHA concurrent review nurse will render an authorization decision to the inpatient facility within 3 days of receipt of all the clinical information required to make the review decision. Clinical documentation must be included with the notification, unless DVHA COU has access to your electronic health records.

All inpatient admissions that exceed 13 days will be forwarded to the DVHA Medical Director for review and decision.

If the facility does not agree with the determination of level of care, a peer-to-peer review with the attending physician can be arranged. Additional information to justify a continued stay can be provided at that time.

7) When the beneficiary is discharged, the DVHA concurrent review nurse will enter a prior authorization into the MMIS for the approved length of stay and appropriate level of care. The Prior Authorization will contain the date of admission through the approved discharge date.

8) Inpatient concurrent review is performed on Medicare/Medicaid dual eligible beneficiaries under two conditions: Medicare benefits have been exhausted and/or level of care has been changed to waiting placement. It is these conditions where Medicaid becomes the primary insurer. The admitting facility must fax a completed Inpatient Concurrent Review Notification Form to the DVHA COU once the combined Medicare/Medicaid length of stay exceeds 13 days, and Medicaid becomes the primary insurer. The form is posted on the DVHA website at http://dvha.vermont.gov/for-providers/forms-1.

9) A Notice of Decision (NOD) will be sent to the admitting facility, the admitting provider, and the beneficiary.
III. Retrospective Reviews

1. The DVHA COU will not perform retrospective reviews when DVHA is not notified of an inpatient admission by day 13, but no earlier than day 10 from the date of admission. Notification must be on a completed Inpatient Concurrent Review Notification Form.

2. This does not exclude providers from possible medical records review by DVHA Program Integrity to detect and prevent fraud, waste and abuse.

IV. Appeal of Service Denial

1) Vermont Medicaid beneficiaries may request an internal MCO appeal for any level-of-care payment authorization decision that results in a denial or reduction of services. If requested by the beneficiary, a provider may ask for an appeal on behalf of the beneficiary. Appeals are made by telephone or in writing to DVHA. An appeal occurs only after all means to come to agreement about the most appropriate course of treatment are exhausted.

An expedited appeal can be requested if a delay would adversely affect the beneficiary’s health.

2) Appeal responses are issued in writing and include the following:
   • The reviewers’ understanding of the issues under review.
   • Reference to the information used to make the determination.
   • The clinical criteria used to render the decision.

If the beneficiary disagrees with the decision from the appeal, they may request a fair hearing. Fair hearing requests must occur within 90 days from the date of the original notice of decision or action, or within 30 days from the date of an appeal decision. Appeal rights are provided in all Notices of Decision (NOD), which go to both the provider and the beneficiary.

The beneficiary may request both an appeal and a fair hearing at the same time, just an appeal, or just a fair hearing. The beneficiary also may call the Office of Health Care Ombudsman at 1-800-917-7787 for help with any part of this process or for help in deciding what to do.


Beneficiaries may access the appeals process in the DVHA Health Care Programs Handbook at: http://www.greenmountaincare.org/member-information/member-handbooks
Contact Information

1. DVHA Clinical Operations Unit
   280 State Drive, NOB 1 South
   Waterbury, Vermont 05671-1010
   FAX: 802-879-5963

2. Green Mountain Care Member Services
   DVHA
   101 Cherry Street, Suite 320
   Burlington, VT 05401
   PHONE: 800-250-8427
   TDD/TTY: 888-834-7898

3. Office of Health Care Ombudsman
   PHONE: 800-917-7787

4. DXC
   P.O. Box 888
   Williston, VT, 05495
   PHONE: Provider Services: 802-857-2964
         Help Desk: 800-925-1706