

**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.

II. Concurrent Review Procedures

- 1) All Vermont hospitals, including in-network border hospitals, will notify the Department of Vermont Health Access (DVHA) clinical unit of all inpatient admissions within 24 hours of admission or by the next business day.

Notification may be telephonic or in the form of a census sheet and shall include the following:

- Date of Admission
- Patient Name, Date of Birth and Medicaid ID
- Admitting Diagnosis
- Admitting Provider
- Admitting Status

- 2) The DVHA concurrent review nurse will review all admission notifications.

Beneficiaries that meet the criteria for the Vermont Chronic Care Initiative (VCCI) will be referred to the appropriate local VCCI Nurse Case Manager or Social Worker.

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

The admitting facility must fax a completed inpatient authorization request form to the DVHA clinical unit at (802) 879-5963 by day 14. The form is posted on the DVHA website at <http://dvha.vermont.gov/providers/forms-1>.

- 4) Concurrent reviews will be conducted over the phone and/or by fax with additional clinical documentation faxed to the DVHA upon request.

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

- 5) Reviews by the DVHA concurrent review nurse will be performed using nationally recognized evidence-based clinical criteria.
- 6) 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.

- 7) The concurrent review process will continue as long as the DVHA concurrent review nurse determines the hospital stay is medically necessary and appropriate, based on nationally recognized evidence-based criteria (e.g., InterQual severity of illness/intensity of illness).
- 8) The DVHA concurrent review nurse will render an authorization decision to the inpatient facility within 24 hours or 1 business day of receipt of the clinical information.

Inpatient stays that do not meet clinical criteria for continued stays will be forwarded to the DVHA Medical Director for review and decision. If the facility does not agree with the determination, 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.

- 9) When the beneficiary is discharged, the DVHA concurrent review nurse will enter a prior authorization into the MMIS for the approved length of stay, starting with the date of admission through the approved discharge date.

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.

- 10) A Notice of Decision (NOD) will be sent to the admitting facility, the admitting provider and the beneficiary.

III. Retrospective Reviews

- 1) The DVHA will not perform retrospective reviews for the purpose of reviewing authorization decisions and recoupment of payments except in the case of material misrepresentation or fraud.
- 2) Retrospective reviews will not be performed when DVHA is not notified of an admission.

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.

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Providers may access the appeals process in the *Green Mountain Care Provider Manual* at:

<http://www.vtmedicaid.com/Downloads/manuals/ProvManual%206-1-2012.pdf>

Beneficiaries may access the appeals process in the *DVHA Health Care Programs Handbook* at:

<http://dvha.vermont.gov/for-consumers/healthcare-programs-handbook.pdf>

- ATTACHMENT #1 -

Contact Information

1. DVHA Clinical Operations Unit
312 Hurricane Lane, Suite 201
Williston, VT 05495
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. HP Enterprise Services (HPES)
P.O. Box 888
Williston, VT, 05495
PHONE: Provider Services: 802-857-2964
Help Desk: 800-925-1706