12.6 Concurrent Review

Healthfirst has implemented a concurrent review program to monitor the allocation of resources during an episode of care. The program uses evidence-based criteria including, but not limited to; InterQual (IQ)/Milliman Care Guidelines (MCG) and Healthfirst Medical Policies to review services provided to members. These criteria are available to providers upon request.

Inpatient Concurrent Review

The inpatient concurrent review program comprises three (3) basic components. They are:

Admission Review: Admission review is based on clinical information provided to verify the appropriateness and medical necessity of the hospitalization. Emergency admissions that occur during weekends or holidays, when Healthfirst is closed, will be reviewed when the office reopens, and a medical-necessity determination will be made, provided that the hospital has complied with the Healthfirst notification policy. Please refer to Section 12 for more information on this policy.

Continued Stay Review: Continued stay review is conducted to re-establish that inpatient hospitalization continues to be appropriate and medically necessary. Providers requesting continuation of service authorization will receive a verbal determination, followed by written confirmation, within one (1) day of Healthfirst receiving the necessary information. The notice will include the authorized service(s), the number of authorized visits or sessions, and the next expected review date.

Discharge Planning: Discharge planning begins prior to admission for elective admissions. For an emergency admission, the process begins with the first review of the case. The goal of discharge planning is to move members efficiently and effectively through the different levels of care required to manage and treat their medical condition.

Outpatient Concurrent Review

Medical/Surgical/Behavioral Health Services: Outpatient concurrent review focuses on the effective allocation of resources during an episode of care to ensure that care is provided at the most appropriate level is coordinated among all disciplines, that continued benefits exist for the service, and that problematic cases and quality issues have been identified. Providers must furnish clinical information to Utilization Management to support continued authorization of services before the expiration of the authorized treatment period. Providers requesting continuation of service authorization will receive a verbal determination, followed by written confirmation, within one (1) day of Healthfirst receiving the necessary information. The notice will include the authorized service(s), the number of authorized visits or sessions, and the next expected review date.

Community-Based Services Concurrent Review

Community-Based Services: These services, which include Long Term Services and Supports (LTSS), are typically ongoing services in the home, with a special focus on either rehabilitation or helping an LTSS-eligible beneficiary remain in their home. Concurrent review of these services is defined as a request for continued services, or a request for change in the level of care. Providers must furnish required information, which may include clinical information from a treating physician or primary care provider, as well as progress notes or status reports from an agency providing the services. Some community-based services may be terminated in accordance with state requirements if necessary documentation is not received in time to perform a concurrent review.