

12.7 Concurrent Review

Healthfirst has implemented a concurrent review program to monitor the allocation of resources during an episode of care. The program uses evaluation criteria from InterQual and Medicare guidelines 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 as follows:

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 be 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 Medical 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.