Utilization management guide

BOOKLET 2:

Inpatient coordination of care/concurrent review

Humana

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Utilization management

Our utilization management (UM) program works to improve healthcare quality, reduce costs and improve the overall health of the population. It is a process that evaluates the efficiency, appropriateness and medical necessity of the treatments, services, procedures and facilities provided to patients on a case-by-case basis. Humana does not reward physicians, other individuals or Humana employees for denying coverage or encouraging under-use of services.

Inpatient coordination of care/concurrent review

The concurrent review process determines coverage during the inpatient stay. That includes, but is not limited to, acute inpatient facility, skilled nursing facility (SNF), long-term acute care hospital (LTAC), inpatient rehabilitation facility and behavioral health partial hospital/residential treatment facilities. Each admission will be reviewed for medical necessity and compliance with contractual requirements. Humana will contact the provider if additional clinical review is required. In addition to information supplied for the initial admission, providers should indicate any complicating factors that prevent discharge. Providers also must contact Humana with the discharge date and discharge disposition upon patient release.

For certain plans, if coverage guidelines for an inpatient stay are not met and/or the patient's certificate does not provide the benefit, a licensed medical professional from Humana will consult with the primary care physician (PCP) and/or facility UM and discharge planning staff. If necessary, the Humana professional will refer the case to a health plan medical director for review and possible consultation with the attending physician. If the medical director determines that coverage guidelines for continued hospitalization are no longer valid, the patient, attending physician, hospital and the patient's primary care office, as appropriate, will be notified in writing that benefits will not be payable for the patient after the effective date of the nonapproval.

Discharge planning

The Humana UM team collaborates with the Humana-covered patient and the patient's family or guardian, the hospital's UM and discharge planning departments, and the patient's attending physician/PCP. Together, they facilitate the discharge plan and identify the appropriate post-discharge level of care.

FREQUENTLY ASKED QUESTIONS

What is inpatient concurrent review?

Concurrent review is a method of reviewing patient care and services while admitted to a facility. It puts an oversight process in place that permits the scrutiny of the type of care being delivered, the necessity for that care, and the level and setting of that care.

A concurrent review also determines if the person's plan covers the treatment under review.

What is the purpose of a concurrent review?

The goal of a concurrent review is to ensure the delivery of efficient and effective healthcare, to reduce the misuse of inpatient services, and to promote high quality and safe patient care during the inpatient component of the care.

How does this differ from preauthorization?

The concurrent review takes place while the patient is receiving care while admitted to a facility, while prior authorization, or pre-auth, is done before a clinical intervention is delivered.

Similar to prior authorization, the concurrent review can also facilitate communication about the patient to other components of the health care organization which permits quality monitoring. The concurrent review can identify patients who could benefit from case management, disease management, or from a variety of population health strategies for their specific diagnosis or clinical situation.

Who performs concurrent review?

Concurrent review is performed by nurses while a patient is in the hospital to try to make sure the patient is in the most appropriate setting.

What is the concurrent review process?

The concurrent review process includes:

- Collecting information from the care team about the person's condition and progress
- Determining coverage based on this information
- Informing everyone involved in the patient's care about the coverage determination
- Identifying a discharge and continuing care plan early in the stay
- Assessing this plan during the stay
- Identifying and referring potential quality of care concerns and patient safety events for additional review
- Identifying people for referral to other programs

Concurrent review may be done by phone, fax or on-site at the facility.

What is the role of a Humana medical director?

Humana's medical directors actively use their medical background, experience and judgement to determine whether the requested services, level of care and/or site of service should be authorized. All work occurs within a context of regulatory compliance, and work is assisted by diverse resources, which may include national clinical guidelines, CMS policies and determinations, clinical reference materials, internal teaching conferences and other reference sources.

Important note: Nurses do not make denial determinations based on medical necessity.

What is a UM nurse and what is their role?

A UM nurse ensures that healthcare services are administered appropriately. The primary role of a utilization review nurse is to analyze the condition of the patient and decide if they need to stay in the hospital or can be discharged. They work with patients' relatives, physicians and insurance companies. The UM nurse usually works in a hospital but can also work in a health practice or other clinical setting. The UM nurse reviews patient clinical records, drafts clinical appeals and manages other administrative utilization management responsibilities.

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