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| Utilization Management Program: Concurrent Review |  |
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**Concurrent Review Process**

The Payer Compass Utilization Review Department assumes the following responsibilities during the concurrent review process:

* Ensure a timely evaluation of the medical necessity, appropriateness, and efficiency of the requested health care services, procedures, and facilities under the provisions of the participant’s health benefits plan and in accordance with Employee Retirement Income Security Act (ERISA) or state-specific regulations whichever is the more stringent.
* Facilitate medically appropriate discharge of hospitalized participants
* Identify participants who may benefit from further medical management intervention

### The following outlines the Concurrent Review procedure:

1. The Concurrent Review determination is based on medical information obtained at the time of the Concurrent Review.
2. Pertinent medical information may be obtained from reliable sources, including the patient’s medical records or treating providers, to provide evidence supporting medical necessity, appropriateness of the admission or extension of stay, frequency, or duration of service.
3. After initial certification, the provider/facility is contacted via telephone or facsimile and given an authorization number and number of extended days or units of service authorized, the next anticipated review, the total number of days or units of service authorized, and confirmation of admission date or onset of services. Upon request, written notification is provided to the ordering physician/provider, the facility rendering the service, and the patient.
4. The review frequency for extending the stay is based on the criteria and guidelines found in the Clinical Criteria Selection and Maintenance Policy.
5. For requests to extend a current course of **inpatient** treatment, the Payer Compass Clinical Reviewer issues the determination within:
	1. Twenty-four (24) hours of the request for a Utilization Management determination, if it is a case involving urgent care and the request for extension was received at least twenty-four (24) hours before the expiration of the currently certified period or treatments.
	2. Seventy-two (72) hours of the request for Utilization Management determination, if it is a case involving urgent care and the request for extension was received less than twenty-four (24) hours before the expiration of the currently certified period or treatments.
6. For requests to extend a current course of **outpatient** (both urgent and non-urgent) treatment, see the Precertification Review Policy.
7. When continued stay criteria is met, the process repeats until the patient is discharged for one or more reasons (termination of benefits, no longer meet the criteria, or patient is discharged to an alternate level of care).
8. When continued stay criteria is not met, the case is referred the Payer Compass Medical Director or IRO (Independent Review Organization) for a determination including peer-to-peer review and/or appeal of adverse determination as indicated in the Peer-to-Peer Denial of Authorization Requests Policy.
9. If the patient is discharged prior to approving the next course of stay, the request would be treated as a Retrospective Review (see the Retrospective Review Policy).
10. Payer Compass does not reverse a certification determination unless it receives new information relevant to the certification that was not available at the time of the original certification.