Department:	Utilization Management	**Original Approval:**	01/12/1999
Policy No:	UM211	**Last Approval:**	01/04/2024
Policy Title:	Hospital Admission Patient Management Policy		
Approved By:	Clinical Services Leadership Team		
Dependencies:	CM527 Complex Discharge Program Policy UM440 Transition of Care 72 Hour Post Discharge Call Program		

Purpose

This policy outlines the process used by Community Health Plan of Washington (CHPW) to manage inpatient hospital admissions.

Policy

CHPW requires notification of inpatient admission from all inpatient care facilities. Contracted facilities are required to notify CHPW within twenty-four (24) hours or the next business day of inpatient admission. Since out-of-state facilities are not contracted with CHPW, notification of admission is accepted outside of the one business day time frame.

The facility shall notify CHPW of inpatient admissions by fax via a secure web-based fax server or by direct entry into the CHPW Care Management portal. Facilities may provide notification 24 hours a day and 7 days a week. Facilities may leave a voicemail, written, faxed, and electronic communication 24 hours per day, every day, and CHPW shall respond by the next business day. Staff members are available during regularly scheduled work hours to process notifications and return communications.

Eligibility, benefit, and medical necessity evaluation may be done prior to admission, concurrently, or through the review of claims, as applicable. For all CHPW members, including Medicare beneficiaries, Clinical Services staff shall coordinate the delivery of denial or decertification notices to members with hospital Utilization Review (UR) staff.

Clinical reviewers shall use CHPW approved criteria specific to the line of business. This includes CMS LCD/NCD (for Medicare), CHPW Clinical Coverage Criteria, MCG ™ guidelines, LOCUS, CALOCUS, ASAM, and industry-standard clinical criteria sets. If clinical reviewers are unable to approve requests based on the above criteria, the requests shall be reviewed by the CHPW Senior Medical Director and/or Senior Behavioral Health Medical Director, their physician level

designee, or a delegated physician level reviewer.

Fax Notifications

Notification Details
A hospital may use CHPW's Hospital Notification form or may submit its own form as long as the following information is included:

- Member's full name and date of birth
- Member Community Health Plan ID number
- Date and time of admission
- Discharge date (if known)
- Admitting provider name
- Admitting diagnosis
- Admit type
  - Planned (routine/elective admission)
  - Emergent (admitted through the emergency department)
- Status (inpatient, observation, other)
- Newborn information (if applicable)
  - Sex
  - Date delivered
  - Type of delivery (vaginal or C-section)
  - Bed type (regular or special care nursery / neonatal intensive care unit)
  - Mother's name, DOB, member ID/ProviderOne number
- Facility name, facility contact's name, phone, and fax numbers (usually the person responsible for submitting the notification)

Late Notification
If the hospital does not notify CHPW within twenty-four (24) hours or the next business day of admission, the admission is entered into the Care Management data system as a failure to complete timely admission notification, and the hospital will be sent a denial notification. The exception to this are facilities out of state that are not contracted with CHPW.

CHPW Record Keeping & Fax Acknowledgements
Clinical support staff shall enter hospital notifications into the Care Management data system. Entry of the faxed notification is done no later than one business day from receipt. In response, CHPW shall send the facility an Admission Notification Acknowledgment with a reference number by return fax.

When the facility enters the admission notification directly into the Care Management portal, the facility uses the Episode Abstract to document the Admission Notification.

Admission, Concurrent & Retrospective Review

CHPW shall use the following standards to review hospital admissions and make determinations about a member's clinical progress, as appropriate for product and type of admission:

- Medicaid, Cascade Select, or Medicare specific criteria, including:
  - Health Technology Assessment (HTA) for Medicaid and Cascade Select members
  - National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) for Medicare members
- CHPW-developed Clinical Coverage Criteria (CCC), which are reviewed and updated at least annually
- External clinical guidelines, including:
  - MCG guidelines®
  - Level of Care Utilization System (LOCUS)
  - Child & Adolescent Level of Care Utilization System (CALOCUS)
  - American Society of Addiction Medicine (ASAM) Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions criteria
  - Member Benefit Coverage Guidelines
  - Other industry-standard criteria as appropriate.

Clinical Progress Review

The member's clinical progress is reviewed by licensed clinical staff:

- Upon notification of admission to determine if the admission is medically necessary using approved clinical criteria,
- During care (concurrent review) to ensure medical necessity using approved clinical criteria and/or
- Retrospectively through the review of claims and application of approved clinical criteria to determine the medical necessity of the facility stay.

Frequency of reviews varies based on the member's clinical course. Reviews are accomplished through review of records or telephonic information provided by the facility or treating provider.

Discharge Planning Coordination

Discharge planning needs are identified through the inpatient admission and concurrent review process by licensed clinical staff and, actively refer members needing discharge planning who require assistance in transitioning from inpatient care, or administrative days to the next lower level of care, including home. The licensed clinical staff will support and ensure appropriate discharge planning is occurring throughout the member's stay and that post-discharge care arrangements are occurring in a timely manner prior to discharge.

If the member is determined to be in an observation level of care or non-skilled nursing facility care, and the hospital facility has requested assistance with discharge planning or referral was received from a representative of the member's care team, the licensed clinical staff will create a referral to the appropriate program or department (i.e., Care Management, Provider Relations, Tribal Liaison, etc.) to support member needs and assist in coordinating care, such as:

- Treatment availability and community support necessary for recovery, including, but not limited to: housing, financial support, medical care, transportation, employment and/or educational concerns, and social supports.
- Barriers to access to and/or engagement with post-discharge ambulatory appointments, including Medication Management and other interventions.
- Procedures for Concurrent Review, if applicable for members requiring extended inpatient care due to poor response to treatment and/or placement limitations.
- Corrective action expectations for ambulatory providers who do not follow up on members discharged from inpatient settings as per the transitional health care services timeframes defined in Section 14 of the WA Apple Health Integrated Managed Care contract.
- The roles of Tribal governments and other Indian Health Care Providers IHCPs in providing diverse services, including Culturally Appropriate Care, for AI/AN Enrollees and their family members and the Protocols for Coordination with Tribes and Non-Tribal IHCPs applicable to the Contractor's Regional Service Area(s).

Clinical reviewers provide a collaborative approach in coordinating discharge arrangements with the facility staff, care team, member/family, and community resources. Members who have complex discharge needs or for whom it is difficult to identify placement outside of the hospital are referred to Care Management Complex Discharge Program for support. All members discharged from an inpatient facility to a home or community are contacted by the UM clinical staff to support transition needs.

PCP Notification

The assigned PCP is notified of the approval or denial of the hospital stay by a faxed copy of the member's letter.

Definitions

Facility: For purposes of this policy and procedure, facility means, but is not limited to hospital, inpatient rehabilitation center, Long-Term and Acute Care (LTAC) center, skilled nursing facility,

nursing home, psychiatric hospital, Child Study and Treatment Center (CSTC), residential treatment center, or inpatient substance use treatment facility.

Clinical Reviewer: A licensed clinician who reviews physical and behavioral health inpatient cases for medical necessity and availability of benefits using CHPW approved clinical criteria. The Clinical Reviewer may be a registered nurse, licensed practical nurse, licensed social worker, or licensed therapist or counselor.

List of Appendices

A. Detailed Revision History

Citations & References

CFR		
WAC		
RCW		
LOB / Contract Citation	☐ **WAHIMC**	
	☐ **BHSO**	
	☐ **MA**	
	☐ **CS**	
Other Requirements		
NCQA Elements	UM 2 and UM 5	

Revision History

SME Review:	01/12/1999; 08/03/2006; 06/13/2007; 03/19/2008; 01/25/2009; 11/30/2009; 12/03/2009; 07/26/2012; 10/25/2012; 10/06/2013; 08/27/2014; 10/20/2015; 10/23/2015; 11/09/2015; 11/03/2016; 01/13/2018; 06/21/2018; 06/19/2019; 02/07/2020; 05/18/2020; 11/17/2020; 01/29/2021; 03/18/2022; 02/13/2023; 01/02/2024
Approval:	12/09/2009; 10/27/2010; 10/26/2011; 08/08/2012; 11/28/2012; 10/09/2013; 09/24/2014; 11/11/2015; 11/03/2016; 01/25/2018; 06/25/2018; 06/21/2019; 06/25/2020; 11/20/2020; 03/03/2021; 03/21/2022; 03/15/2023; 01/04/2024

Appendix A: Detailed Revision History

Revision Date	Revision Description	Revision Made By
01/12/1999	Original	UM/CM Manager
08/03/2006		Georgette Cortel
06/13/2007	Formatting	Georgette Cortel
03/19/2008	Formatting	Sandra Hewett
01/25/2009	Major changes in content to match current process	Mike Hays
11/30/2009	Minor changes in text. Revised Hospital Notification Form	Mike Hays
12/03/2009	Moved to new template; edited for style & clarity	Jen Carlisle
12/09/2009	Approval	MMLT
10/27/2010	Approval	MMLT
10/26/2011	Approval	MMLT
07/26/2012	Minor editing and wording changes	Lucy Sutphen, MD, FACP
08/08/2012	Approval	MMLT
10/25/2012	Added language to allow for use of other industry- standard clinical criteria for medical necessity determinations	Jane Daughenbaugh
11/28/2012	Approval	MMLT
10/06/2013	Changed "Member benefit" to "Member benefit coverage guidelines" under review criteria section	Jane Daughenbaugh
10/09/2013	Approval	MMLT
08/27/2014	Updated Contract Citation Section	Andrew Boe
09/24/2014	Approval	MMLT
10/20/2015	Minor editing made: under newborn information added mom's information needed; added HTA as criteria used.	Kelly Force
10/23/2015	Modified exception of select contracted facilities from the requirement to notify CHPW of an enrollee's admission. Reviewed and modified edits made by Kelly Force	Jane Daughenbaugh
11/09/2015	Removed statement that a denial would be issued if a facility did not notify	Jane Daughenbaugh

	CHPW prior to discharge of the patient's admission. This was added in error and should not be included. The requirement remains that the facility must notify CHPW within 1 business day of admission.	
11/11/2015	Approval	MMLT
11/03/2016	Minor editing	Cyndi Stilson
11/03/2016	Approval	MMLT
01/13/2018	Added TOC team to discharge planning. Minor editing.	Justin Fowler
01/25/2018	Added definitions and ASAM criteria, updated citations	Patty Jones
01/25/2018	Approval	Patty Jones
06/21/2018	Minor editing	Drew Breuckman
06/25/2018	Approved	Patty Jones, RN, MBA
06/19/2019	Updated facility definition, added LOCUS, CALOCUS and ASAM guidelines. Removed 'Interlink Transplant Criteria' under clinical guidelines	Yves Houghton, RN, BSN
06/21/2019	Approved	MMLT
02/07/2020	Updated citations and regulatory references	Yves Houghton, RN, BSN
05/18/2020	Updated verbiage of criteria used by clinical reviewers. Added UM439 and UM440 TOC processes as dependencies. Minor Editing	Yves Houghton, RN, BSN
06/17/2020	Approved	Ma'ata Hardman, BSN, MBA, CCM
06/25/2020	Approval	CMO Cabinet
11/17/2020	Updated LOB and C&R; minor edits	Yves Houghton, RN, BSN
11/20/2020	Approval	CMO Cabinet
01/29/2021	Updated section under Discharge Planning Coordination to include protocol for discharge planning requests from members determined to be observational level of care and or non-skilled nursing facility care.	Yves Houghton, RN, BSN
03/02/2021	Approval	Ma'ata Hardman

03/04/2021	Approval	CMO Cabinet
03/18/2022	Reviewed, no changes	Yves Houghton, RN, BSN
03/21/2022	Approval	Justin Fowler, RN MSN
03/21/2022	Approval	Ma'ata Hardman
03/21/2022	Approval	CMO Cabinet
02/13/2023	Updated policy dependency from UM439 to CM527 DTD Policy; changed referral from TOC to CM DTD program for complex difficult-to-discharge members; clarified that all members discharging from IP to home/community are contacted by UM clinical staff for transition needs.	Yves Houghton, RN BSN
03/14/2023	Approval	Ma'ata Hardman
03/15/2023	Approval	Clinical Services Leadership Team
01/02/2024	Added CMS NCD/LCD as specific for Medicare criteria. Updated Difficult to Discharge Program to Complex Discharge Program.	Yves Houghton, RN BSN
01/03/2024	Approval	Ma'ata Hardman
01/04/2024	Approval	Clinical Services Leadership Team