CHAPTER 19 CONCURRENT REVIEW

REVISION DATE: 5/26/2017, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: 42 CFR 447.26, AMPM Chapter 1000

The concurrent review process used by the Division of Developmental Disabilities (Division) includes utilization management activities that occur during an inpatient level of care (physical and behavioral health), rehabilitative level of care, or a skilled nursing facility level of care. The Division's subcontracted acute care health plans perform their concurrent review utilization management activities for Division members enrolled with their health plan during an inpatient level of care, skilled nursing level of care, or home health care services.

Concurrent review provides the opportunity to evaluate the ongoing medical necessity of care being provided, and it supports the health care provider in coordinating a member's care across the continuum of health care services. Concurrent review decisions are reviews for the extension of previously approved ongoing care.

The concurrent review process includes:

- Obtaining necessary clinical information from facility staff, practitioners and providers
- Using the clinical information provided by facility staff, practitioners and providers to determine benefits coverage
- Notifying facility staff, practitioners and providers of coverage determinations in the appropriate manner and time frame
- Identifying discharge planning needs at the beginning of the inpatient stay and reassessing these needs throughout the stay
- Identifying and referring potential quality of care concerns and patient safety events for additional review
- Identifying members for referral to specialty programs, including specific case management and disease management, behavioral health, and women's health programs.

Concurrent review may be conducted by phone, fax or, as applicable, on-site at the facility where care is delivered.

The Division utilizes InterQual evidence-based criteria in the concurrent review process. These criteria for concurrent review validate the medical necessity for admission and continued stay, and they evaluate quality of care.

The Division prohibits payment for Provider-Preventable Conditions that meet the definition of a Healthcare-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC) that may be identified during the concurrent review process (refer to 42 CFR 447.26 or the AMPM Chapter 1000). If an HCAC or OPPC is identified, the Division will report the occurrence to AHCCCS and conduct a quality of care investigation.