PerformCare	Policy and Procedure
Name of Policy:	Continued Stay Review Process
Policy Number:	CM-042
Contracts:	☒ All counties ☐ Bedford / Somerset ☐ Capital Area ☐ Franklin / Fulton
Primary Stakeholder:	Clinical Care Management Department
Related Stakeholder(s):	All Departments
Applies to:	Associates
Original Effective Date:	05/14/03
Current Effective Date:	06/14/04
Last Revision Date:	06/14/04
Last Review Date:	07/01/14
Next Review Date:	07/01/15

Policy: Continued stay review of care occurs throughout all levels of care. PerformCare's Clinical Care Management staff work with providers to develop a comprehensive treatment plan to meet the Member's needs. PerformCare Clinical Care Management staff monitors treatment plan progress and determine appropriate level of care as the Member continues through the treatment continuum using Medical Necessity Criteria.

Purpose: To assist the provider in determining a comprehensive treatment plan to meet the Member's needs and to monitor treatment plan progress. To ensure Members meet continued stay Medical Necessity Criteria for the current level of care or to plan discharge or transfer to appropriate level of care. To ensure Members move through the continuum of care appropriately based on Medical Necessity Criteria.

Definitions: None

Procedure:

1. PerformCare reviews the Member's progress with the attending clinician as clinically indicated.
2. The review process focuses on:
   - 2.1. Development of a comprehensive biopsychosocial assessment.
   - 2.2. Defined treatment interventions targeted at specific issues and symptoms.
   - 2.3. Identification of existing natural resources and natural

resources targeted for development.

2.4. Identification of quality of care concerns.

2.5. Differentiation of long and short term goals.

2.6. Measurable objectives associated with reasonable time frames.

2.7. Realistic treatment expectations consistent with the goals of the Member.

2.8. Specific and appropriate discharge planning with scheduled and coordinated aftercare.

2.9. Evidence of Member and family participation in the treatment and aftercare.

2.10. Appropriate treatment of co-morbid substance abuse or mental illness.

2.11. Update on admission symptoms documenting progress or lack of progress made to date and how treatment decisions reflect this.

3. If the Member meets Medical Necessity Criteria for continued stay at the present level of care, the Clinical Care Manager will provide verbal authorization for a specific number of days, document his/her clinical findings in the Member's chart, schedule the next continued stay review and send the authorization to the provider within 24 hours.
4. If the Member does not continue to meet Medical Necessity Criteria for continued stay at the current level of care, the Clinical Care Manager will discuss and refer the case to a Medical Director or Physician Advisor. The Medical Director or Physician Advisor makes the determination for the appropriate level of care and ensures the Member is transferred or discharged to that level of care. *CM-013 Denial Notice Procedure* is followed for all denials.
5. If the Member or provider is not in agreement with the level of care recommended by the Medical Director or Physician Advisor, the Clinical Care Manager will refer the Member or provider to the Complaint and Grievance Unit, and *QI-CG 001 Complaint & Grievance Policy* will be followed.
6. The Medical Director is responsible for all decisions on denial of care.
7. All continued stay reviews are documented in the Member's case in the Continued Stay Review event.
8. PerformCare does not provide incentives to its employees who conduct utilization management activities for denying, limiting or discontinuing medically necessary services.

8.1. UM decision-making is based only on appropriateness of care and service and existence of coverage

8.2. PerformCare does not specifically reward practitioners or other individuals for issuing denials of coverage or

service

8.3. Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization

Related Policies: *CM-011 Clinical Care Management Decision Making*
CM-013 Denial Notice Procedure
QI-027 Monitoring Member Improvement - Quality Control
QI-CG 001 Complaint & Grievance Policy

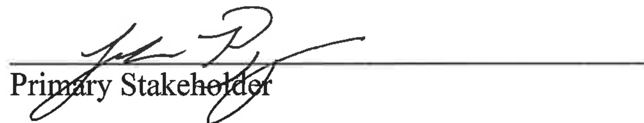
Related Reports: None

Source Documents and References: *DPW HealthChoices Program Standards and Requirements, Appendix T - Medical Necessity Criteria*

Superseded Policies and/or Procedures: None

Attachments: None

Approved by:



Primary Stakeholder