



# Policy and Procedure

**Policy Title:** Concurrent Review – Admission and Continuous Stay  
**Policy No.:** UM-RPP-029  
**Issuing Dept.:** Utilization Management  
**Applicable To:**  M-Cal  Comm  Medicare  
**Effective Date:** 07/01/2020  
**Last Review Date:** 03/09/2026

## Purpose

1. The Risk Bearing Organization (RBO) ensures that any member admitted to a facility is in the least restrictive, but more clinically appropriate, level of care available.
2. To ensure concurrent review process is applied consistently, including cases related to behavioral health, as applicable.

## Policy

1. The Hospitalist or Attending Physician will round on all RBO members daily, seven (7) days a week.
  - 1.1. Admission Review
    - 1.1.1. The RBO’s members admitted to a facility for non-elective diagnostic or therapeutic procedures will be evaluated against medical necessity criteria (e.g., MCG guidelines) within the first 24 hours of admission.
      - 1.1.1.1. Discharge planning documentation can include but is not limited to the member’s living arrangements (e.g., homeless), physical and mental function, community resources (e.g., transportation), social resources (e.g., food banks) durable medical equipment (DME), and other services (e.g., financial).
        - 1.1.1.1.1. As part of the discharge process the member may receive specific Beneficiary Notices (e.g., IM, DND). Refer to Policy UM-RPP-028 Beneficiary Notice Initiative.
      - 1.1.1.2. The RBO will evaluate its members for the appropriate discharge setting based on their medical needs (e.g., Home Health, IV/Oral medication, Skilled Nursing Facility SNF, Board and Care, Shelter) and based on the member’s preference; utilizing the appropriate clinical criteria. Refer to UM-RPP-007 Application of Clinical Criteria policy.
    - 1.1.2. As applicable by contractual or regulatory requirement the RBO will review the admission against medical necessity criteria for Observation level of care.
      - 1.1.2.1. Medicare line of business (e.g., SNP, MAPD, DSNP) will undergo the two-midnight rule review.



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- 1.1.2.1.1. The review of coverage and/or criteria will be based on Medicare regulation (e.g., NDC, LCD, Medicare Manuals, publications). Should coverage or criteria not be applicable, medical necessity review will be based on evidence-based clinical guidelines (e.g. MCG).
- 1.1.2.1.2. Refer to UM-RPP-028 Beneficiary Notice initiative policy for Medicare Outpatient Observation Notice (MOON) notice.
- 1.1.2.2. Should the Medicare beneficiary require continued acute stay beyond the 2 midnight rule the admitting physician is expected to convert the observation status to inpatient based on the complexity medical factors and treatment plan that ascertains medical necessity for the acute setting.
- 1.2. Continuous Stay Review
  - 1.2.1. On each subsequent review, the member will be evaluated for medical necessity for an extended stay
  - 1.3. The RBO's members admitted for approved elective diagnostic or therapeutic procedures will too be evaluated for an extended stay should the length of stay be beyond the approved initial days.

### Procedure

- 1. Admission Review
  - 1.1. The Utilization Management (UM) department receives a face sheet from the facility indicating the need for admission. The UM coordinator will verify member eligibility and benefits with the appropriate health plan. The UM coordinator will assign an authorization number and the facility will receive a letter via fax with the authorization number and initial level of care.
  - 1.2. The Inpatient Case Manager reviews the History and Physical from the Emergency Department, evidenced based criteria from Clinical Criteria (e.g., MCG guidelines) is used to determine medical necessity for admission and / or continued stay. The facility is notified within 24 hours via fax if the admission was approved or denied based on clinical criteria used. The Inpatient Case Manager will contact the Facility Case Manager/Hospitalist/Attending for a concurrent review and medical records to support



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subsequent days.

- 1.3. Discharge planning begins at the time of admission and continues throughout the members inpatient stay in order to plan for a timely and safe discharge.
  - 1.4. Should the Inpatient Case Manager question the medical necessity; the case will be referred to the Physician Reviewer/Medical Director (PR/MD) for review and determination.
  - 1.5. The PR/MD will review complex, catastrophic, trauma level, and/or tertiary care cases.
    - 1.5.1. The PR/MD will refer members to Case Management as appropriate.
    - 1.5.2. The RBO will communicate with the member's health plan for stays greater than 10 days, as applicable.
  - 1.6. Should the Hospitalist/Attending upon transitioning care from the initial attending physician determine the hospitalization is inappropriate; the Hospitalist will review the case with the PR/MD.
  - 1.7. Following review by the PR/MD, in consultation with the Physician Specialist and the Hospitalist, determine the admission does not meet the medical necessity criteria, the Inpatient Case Manager will notify the member, physician, facility and health plan in writing the same day the determination is made. If this is over a weekend, the Full-Service Health Plan will be notified the first working day following the admission.
    - 1.7.1. Only a physician may make an adverse decision (deny/modify).
      - 1.7.1.1. Staff members who are not qualified healthcare professionals may collect data for preauthorization and concurrent review under the supervision of appropriately licensed health care professionals. They may have the authority to approve services for which there are explicit criteria, and no clinical judgement is required.
  - 1.8. The member, member's legal representative, and/or the physician have the right to request an "Expedited Review".
2. Concurrent Review
    - 2.1. Concurrent review is performed daily. Summaries of the reviews are reported to the



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appropriate health plan.

- 2.2. The Inpatient Case Manager or UM Inpatient Coordinator notifies the provider of the admission via telephone, fax, or secure e-mail within 24 hours of the decision.
- 2.3. If the member's medical condition continues to meet medical necessity for acute level of care, the Inpatient Case Manager documents the criteria met and continues the review cycle until discharge.
- 2.4. Should the Hospitalist/Attending determine the member is ready for discharge he/she will document the date, time, and condition upon member's discharge. The Inpatient Case Manager will consult with the Hospitalist or Attending to determine if the member will have any post discharge needs. If discharge is scheduled within twenty-four (24) hours, review again in twenty-four (24) hours to determine if discharge has occurred and services needed have been arranged.
  - 2.4.1. Timely follow-up with the member post-discharge will occur to discuss any issues and ensure timely access to follow-up appointments.
- 2.5. Should the Hospitalist/Attending, determine the member is ready for discharge, and the consulting physician disagrees, the Hospitalist will review the case with the PR/MD.
- 2.6. Following review by the PR/MD, in consultation with the Physician Specialist and Hospitalist, determine the member does not meet the medical necessity criteria and could be safely discharged, the Inpatient Case Manager/Discharge Planner will notify the member, physician, hospital and health plan in writing the same day the determination is made. If this is over a weekend the health plan will be notified the first working day following the discharge. Care shall not be reduced or discontinued until the treating provider has been notified and agrees to a care plan that is appropriate for the member's medical needs and the member has been allowed sufficient time to appeal.
  - 2.6.1. Only a physician may make an adverse decision
- 2.7. The member and/or the physician have the right to request an "Expedited Review."
3. Discharge Review
  - 3.1. Discharge planning begins at the time of admissions and continues through the member's stay. The member's progress is evaluated daily in order to plan for a timely discharge to the appropriate level of care with any scheduled home care or equipment,



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and follow-up visit with the Primary Care Physician (PCP) or Specialist as applicable.

## Forms & Resources

1. Not Applicable

## References and Citations

1. NCCA Standards and Guidelines – “Timeliness of UM Decisions”

## Definitions

Term	Definition
Concurrent Review	A methodology of screening members admitted to a facility to determine that services delivered are medically necessary and are at the least restrictive and clinically appropriate level of care.

## Company/Client Approval(s)

Date	Company/Client	Approve By (Full Name – Title)
07/01/2020	Altura MSO	Bonnie Orellana, VP Medical Management
02/11/2021	AltaMed Health Services	Dr. Ursula Baffigo, Senior Medical Director
02/11/2021	Omnicare Medical Group	Dr. Ursula Baffigo, Senior Medical Director
02/10/2022	AltaMed Health Services	Dr. Ursula Baffigo, Senior Medical Director
02/10/2022	Omnicare Medical Group	Dr. Ursula Baffigo, Senior Medical Director
08/11/2022	AltaMed Health Services	Dr. Thomas Kim, Senior Medical Director
08/11/2022	Omnicare Medical Group	Dr. Thomas Kim, Senior Medical Director
02/09/2023	AltaMed Health Services	Dr. Thomas Kim, Vice President, Associate Chief Value Officer
02/09/2023	Omnicare Medical Group	Dr. Thomas Kim, Vice President, Associate Chief Value Officer
08/24/2023	LaSalle Medical Associates	Dr. Albert Arteaga, President
02/08/2024	LaSalle Medical Associates	Dr. Felix Lin, Medical Director
02/15/2024	AltaMed Health Services	Dr. Thomas Kim, Vice President, Associate Chief Value Officer
02/15/2024	Omnicare Medical Group	Dr. Thomas Kim, Vice President, Associate Chief Value Officer
05/07/2024	AltaMed Health Services	Dr. Thomas Kim, Vice President, Associate Chief Value Officer
05/07/2024	Omnicare Medical Group	Dr. Thomas Kim, Vice President, Associate Chief Value Officer
05/09/2024	LaSalle Medical Associates	Dr. Felix Lin, Medical Director
08/06/2024	LaSalle Medical Associates	Dr. Felix Lin, Medical Director
08/06/2024	AltaMed Health Services	Dr. Thomas Kim, Vice President, Associate Chief Value Officer
08/08/2024	Omnicare Medical Group	Dr. Thomas Kim, Vice President, Associate Chief Value Officer
02/13/2025	LaSalle Medical Associates	Dr. Felix Lin, Medical Director
02/18/2025	AltaMed Health Services	Dr. Thomas Kim, Vice President, Associate Chief Value Officer
02/18/2025	Omnicare Medical Group	Dr. Thomas Kim, Vice President, Associate Chief Value Officer
02/10/2026	AltaMed Health Services	Dr. Thomas Kim, Vice President, Associate Chief Value Officer
02/11/2026	Family Choice Medical Group	Dr. Alan Adler, Medical Director



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02/12/2026	LaSalle Medical Associates	Dr. Jasmine Sharma, Medical Director
02/25/2026	Golden Physicians Medical Group	Dr. Dat Nguyen, Medical Director
03/09/2026	Omnicare Medical Group	Dr. Thomas Kim, Vice President, Associate Chief Value Officer

## Version History

Date	Company/Client	Action Description
11/06/2020	Omnicare Medical Group	Annual Approval
08/24/2023	LaSalle Medical Associates	Initial Adoption and Approval
03/01/2025	Family Choice Medical Group	Initial Adoption and Approval
05/01/2025	Golden Physicians Medical Group	Initial Adoption and Approval