Section 5A – Inpatient Admission Services:

Overview

Chinese Community Health Care Association's (CCHCA) Inpatient Case Management program includes monitoring inpatient acute hospitalizations and patients in a Skilled Nursing Facility (SNF) as well as working with physicians caring for the patient. The program includes:

- Concurrent review of the hospital admit course to evaluate and ensure the appropriate level of care
- Discharge planning to assist the member with a transition of care to the next level of care or to home

Admission Protocols

Admission for non-surgical and elective surgeries require prior authorization. In these cases the PCP or in the case of an elective surgical admission, the in-network contracted specialist submits the Authorization Request Form (ARF) with supporting medical records.

Prior authorization is required to refer members to an out-of-network hospital.

If a patient is hospitalized at a non-contracted hospital, the Inpatient Case Manager may work with the hospital staff to transfer the patient to an in-network contracted hospital when appropriate.

For members admitted via the Emergency Department (ED), the hospital is required to notify the CCHCA UM Department within 24 hours of the admission. Failure to provide inpatient notification and/or timely clinical information may result in a denial for the admission. Acute inpatient face sheets can be faxed to (833) 964-0922.

Criteria

MCG criteria is used to determine inpatient medical necessity. MCG identifies patient care benchmarking and recovery stages to enhance health care delivery, resource management and patient outcomes. This approach can reduce unnecessary variations in health care delivery and health care disparities in our community. MCG provides health care professionals with evidence-based clinical guidelines at the point of care. MCG criteria also supports prospective, concurrent and retrospective review, provides proactive care management, discharge planning, patient education and quality initiatives.

Discharge Planning

Discharge planning to an appropriate setting begins on day one/date of admit of a patient's hospital admission.

Lower levels of care includes but is not limited to:

Skilled Nursing Facility (SNF) – Placing patients in an SNF requires prior authorization from the UM Department to determine whether the patient meets criteria for skilled nursing. The UM Department will also confirm that the SNF is a contracted in-network facility and verify the patient's SNF benefit.

Skilled nursing benefits shall be provided to a patient requiring skilled nursing services on a daily basis and/or skilled rehabilitation services at least 5 days per week. Skilled nursing or skilled rehabilitation services must be ordered by a physician and performed by or under the supervision of a licensed nurse, physical therapist, occupational therapist, or speech therapist. Examples of skilled nursing services on a daily basis include:

- Administration of enteral feedings, intravenous medications, extensive pressure ulcer care, nasopharyngeal and tracheostomy suctioning.
- Teaching and training by skilled personnel with the goal of promoting independence (For example, teaching self-administration of injectable medications or colostomy care).

Long Term Care Facility (LTCF)/Custodial Care – Patients who do not meet criteria for a SNF admission but who need 24 hour assistance may be placed in a Long Term Care Facility. However, Long Term Care is not a benefit of CCHCA or most contracted Health Plans, however may be covered under Medi-Cal FFS. LTCF/Custodial care does not require prior authorization.

Custodial care services involve the assistance of an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Determining whether a person is receiving custodial care considers the level of care and medical supervision required.

Acute Rehabilitation Facility – Placing patients in an Acute Rehab Facility requires prior authorization and must meet MCG criteria. Acute rehab is for

patients who have experienced a major injury, disorder or illness who are in need of an intensive inpatient program to regain the skills needed to retrain a person on the basics of activities of daily living or achieve baseline level of functioning. Acute rehabilitation services include providing therapy for a patient with the goal of measurable functional improvement in a reasonable period of time.

Hospice Care – Hospice benefits are limited and therefore, require prior authorization so that the patient receives the care provided as per their evidence of coverage.

Inpatient Case Manager's Support Physicians in Discharge Planning

The Inpatient Case Manager is available to assist physicians in discharge planning and the post-acute hospital phase. During the treatment planning phase, options for post-acute services are identified early in the patient's hospitalization. If the patient discharge is from another facility, the Inpatient Case Manager coordinates with the hospital staff to assure a smooth transition out of the acute care facility.

The Inpatient Case Manager can assist by:

- Identifying services that can benefit the patient after acute hospitalization.
- Working with the hospital Discharge Planner to arrange for Skilled Nursing Facility placement or home health care at home.