



Policy and Procedure No: UM 58.4		Revision No: 4
Division: Care Management		
Department: Utilization Management		
Title: PHC-CA Inpatient Concurrent Review		
Effective Date: 3/27/2017		
Supersedes Policy No: 93101, UM 58.0, UM 58.1, UM 58.2, UM 58.3		
Reviewed/Revised by: Tiffany Jarrett		Review/Revision Date: 11/3/2025
Approving Committee: Utilization Management Committee		Date: 12/15/2025
Executive Oversight Committee Date: 12/16/2025		

Purpose:

The purpose of this policy is to provide PHC California’s (the Health Plan) guidelines for concurrent review of inpatient acute care hospital admissions and to assess the appropriateness and medical necessity of the admission and continued hospital stay under the requirements of the contract.

Policy:

It is the policy of PHC California (the Health Plan) to review the medical necessity, appropriateness of admission, level of care and service location for all acute hospital admissions and on a regular basis to establish the need for continued stay and appropriateness.

Procedure:

1. The Utilization Management (UM) Department receives notification of in-patient admission via telephone or fax.
2. Upon notification of an admission Concurrent Review is initiated within twenty-four (24) hours or the next business day following a weekend or holiday.
3. The Utilization Management Department contacts the requesting facility and requests supporting clinical documentation for the admission.
4. During the course of an inpatient admission, upon receipt of an urgent concurrent request a decision is made within twenty-four (24) hours or the next business day and communicated to the facility.
5. A Concurrent Review decision is communicated to the facility no later than seventy-two (72) hours of notification of admission.
6. Review and assessment for medical necessity and appropriateness of care includes, but is not limited to the following:
 - i. Plan of Treatment
 - ii. Place of Service
 - iii. Level of Care
 - iv. Length of Stay

- v. Standards of Care
 - vi. Severity of Illness
 - vii. Intensity of Service
 - viii. Discharge Plan
 - ix. Potential Quality of Care Issues
7. Discharge planning is conducted to facilitate effective and timely discharge. Discharge planning is initiated upon notification of the admission and modified, as necessary throughout the stay.
 8. If the clinical status meets admission criteria, the admission is authorized.
 9. Hospital days that do not appear to meet criteria may be identified at any time during the concurrent review process (i.e. prospective or concurrent review).
 10. The Health Plan does not require prior or concurrent authorization from the hospital when the provider orders an Initial Mental Health Assessment.
 11. The Medical Director is consulted whenever the admission or continued stay is in question or unclear.
 12. Concurrent Review decisions resulting in a denial, deferral or a modification, which includes termination, reduction or suspension of an existing service (i.e. acute care hospitalization), as well as the denial, in whole or in part, of an initial request for service, is determined by the Medical Director based on medical necessity. Adverse decisions pertaining to care that is underway shall be communicated to the enrollee's treating provider within twenty-four (24) hours. Care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the enrollee.
 13. All documentation and communication are entered into the health plans authorization management system.

Definitions:

1. Concurrent Review: The review process used to evaluate the medical necessity, appropriateness, and timeliness of admissions, continued stays and discharge of patients hospitalized in acute hospitals and skilled nursing facilities.
2. InterQual: Utilization management criteria, used to establish the required intensity of service and severity of illness of the patient to ensure the appropriate care for a particular condition and set of clinical circumstances.
3. PQI: Potential Quality Issue is an issue identified by any internal or external source that has the potential to be considered a quality of care or quality of service issue. It is not a Quality of Care grievance, which is a complaint about care provided by a member. A PQI requires investigation,



clinical review of medical records to determine validity. PQI cases are referred to Risk Management for investigation. QOC PQI's are reviewed by Quality Management.

4. Retrospective Review: A Utilization Management or Clinical review undertaken by review of medical records for services requiring prior authorization for which prior authorization was not obtained prior to receiving the service.
5. RN CTM: RN Care Team Manager who is responsible for member assessments, re assessments, care planning and member interaction to promote quality of care and implementation of the care plan. Also responsible for pre-admission teaching.
6. Transition of Care: Process employed to ensure effective transition of member's care from one level of care to another care setting to ensure continuity of care and to minimize risk to the patient and to minimize risk of re-admission.
7. Utilization Management (UM) Nurse: A nurse who is responsible to perform pre-admission review, telephonic and on-site concurrent review, discharge planning and transition of care documentation.

Monitoring:

This policy is reviewed and updated, as necessary and approved annually by the Utilization Management Committee.

Reference(s):

1. <https://www.dhcs.ca.gov/provgovpart/Pages/TAROverview.aspx>
2. DHCS Managed Care Contract
3. DHCS Approved MOT December 9, 2021

