Acentra HEALTH

Inpatient Hospital: Emergency & Elective

Provider Education 2023

Inpatient Hospital

- Inpatient services are defined as those items and services which are medically appropriate to the inpatient hospital setting and meet the medical necessity requirements outlined in the criteria and policies of the Quality Improvement Organization (QIO), Acentra Health. These items and services must be directed and documented by a licensed Physician in accordance with hospital bylaws in a facility meeting hospital criteria.

- All acute care hospital admissions, except deliveries and births, must be authorized by Acentra Health.
  - Emergency admission authorization requests must be submitted within 5 business days of the admission.
  - Elective admissions must be prior authorize.
    - Elective admission occurs when a patient's condition requires non-urgent treatment that can be anticipated or scheduled in advance.

Prior Authorization Requests

For elective admissions, authorization requests must be submitted **on or before** the service date.

For emergency admission, authorizations may be submitted within 5 business days of admission.

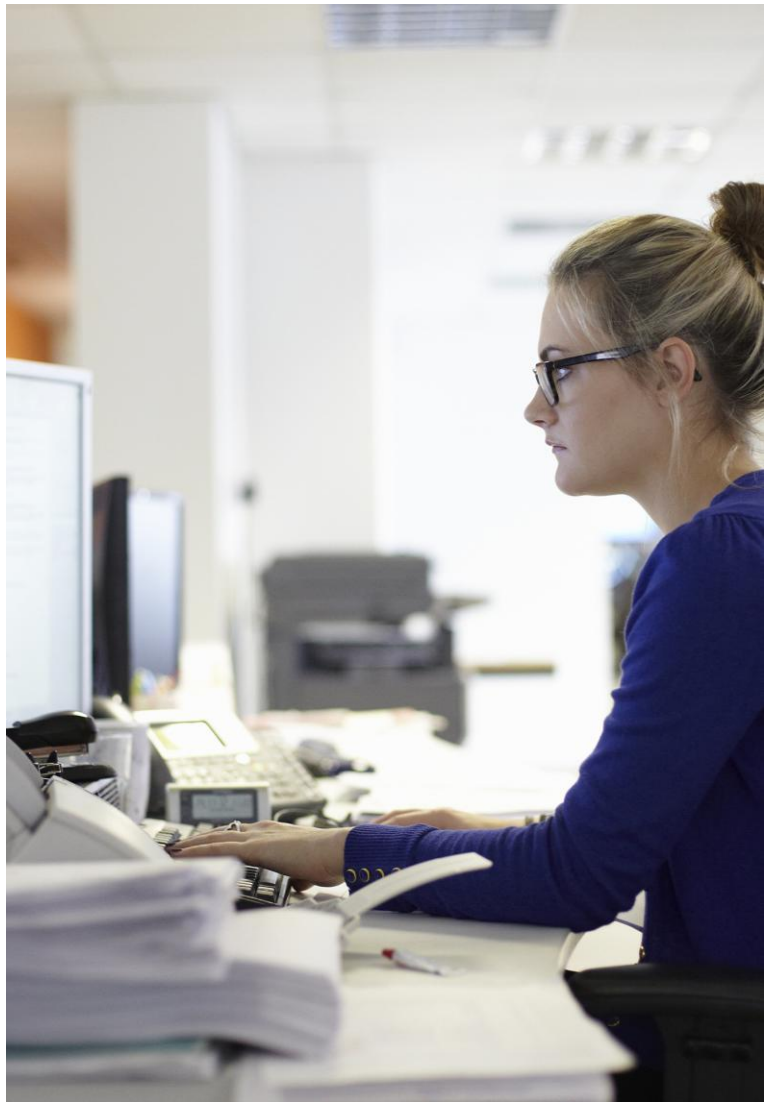
Authorization requests may be submitted online at https://portal.kepro.com or by fax using the Inpatient Prior Authorization Request form.

Prior Authorization Requests

Dual Eligible members

- Only required to obtain a prior authorization if Medicare does not make a payment, or the service is not covered.
- Provider must submit a copy of the Medicare denial with authorization request.

Inpatient Notes



- Acentra Health does not review/authorize observation stays. Transfers from observation to acute care will use the date the member switched from observation to inpatient as the first day of inpatient admission.
- Acentra Health reviews for Day 1 only of acute inpatient admission, not the length of stay; Medicaid determines payment for the hospital length of stay based on claims data.
- Acentra Health reviews inpatient stays for Fee For Service only. Please contact the appropriate MCO if member is enrolled in MCO on date of admission.
- Out-of-state hospital services are limited to true emergencies or those services for which prior approval from **SCDHHS** has been obtained. A true emergency is described as an accident or disease in which the health of the beneficiary would be endangered if care and services were postponed until return travel to South Carolina.

Authorization Types

❑ Prior Authorization

Should always be submitted on or before the service begins.
**Make sure to select the correct service type: elective or emergency.
**Emergency admissions may be submitted with in 5 business days of acute inpatient admission.

❑ Retrospective Authorization “Retro”

Needed when services were performed before the member was eligible for Medicaid and the member has since been granted retrospective eligibility covering the date of service.

- A Retro case is NOT one that is submitted late for any reason other than eligibility.
- Untimely requests will be administratively denied.
- Providers must identify a request as RETRO on the fax request form or by request type in Atrezzo.

Processing Timelines

Acentra Health completes requests for services expeditiously and within contractual timeframes. The review completion timeframe is measured from the date Acentra Health receives a request.

- New Request/Admission review – 5 business days
- Retrospective Reviews – 5 business days

Review Process

Administrative Requirements

- Member eligibility verified
- Provider eligibility verified
- Medicaid Guidelines applied

Nurse Review

- InterQual® or State defined criteria applied
- May pend for additional clinical information
- Approve if criteria met
- Refer to physician reviewer if documentation does not support medical necessity.

Physician Review

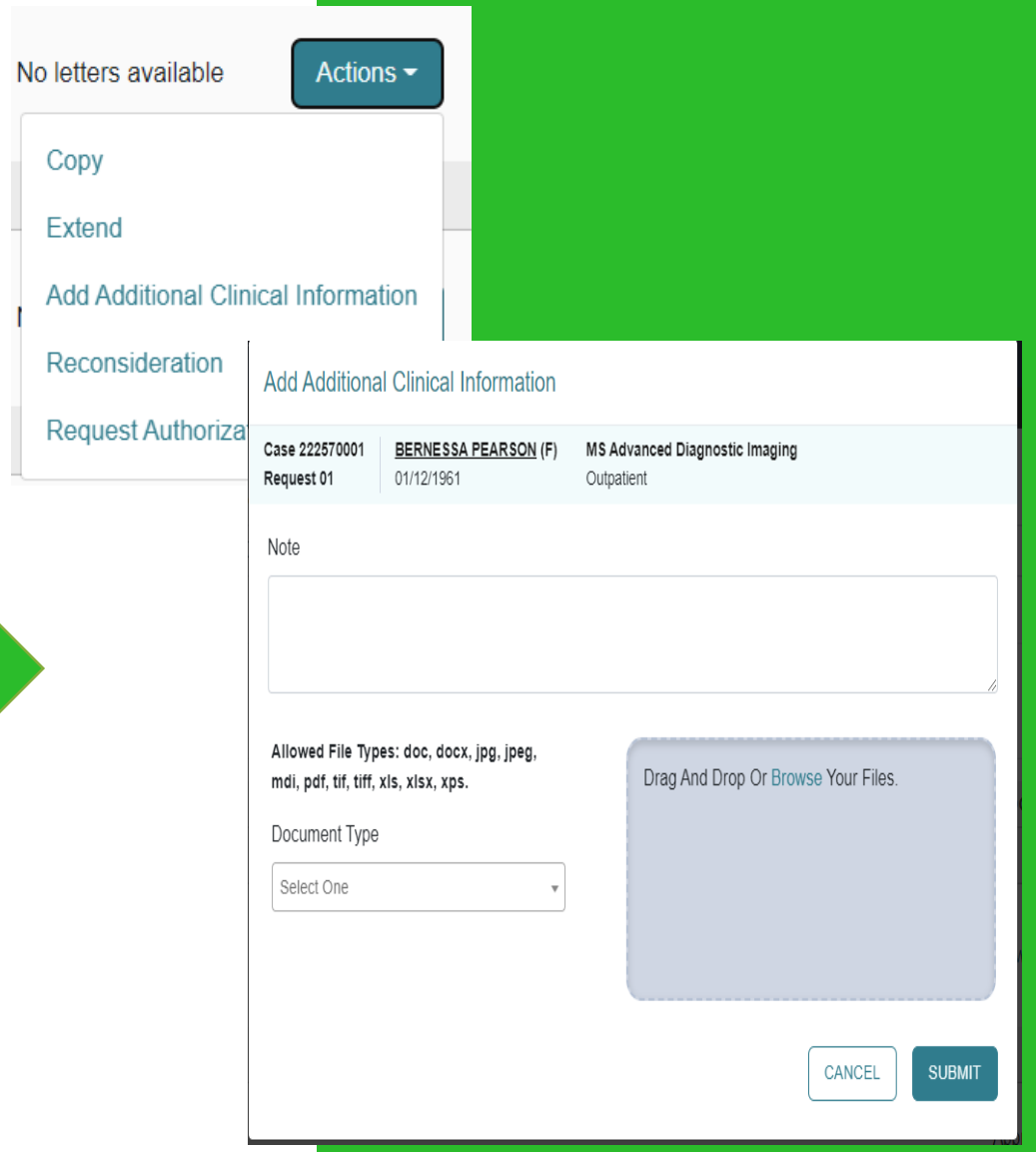
- The medical director, or another qualified physician reviewer will review the case. against InterQual® or State defined criteria and national standards to provide a decision.
- The physician or qualified practitioner may approve or deny the review.

Pended Reviews

- A review may be pended for one of the following reasons:
  - Missing required information such as plan of care or provider number
  - Additional information or clarification is needed before a decision can be made
- Notifications are sent via fax or web portal
- A provider has 2 business days to respond to the additional information request
  - If the case contains no clinical information, the case will be administratively denied.
  - If the case has insufficient clinical information and there is no response to the pended, the case will move to the physician reviewer for a determination.
- If a review is administratively denied, the provider may submit a new request once they have all the necessary information.

Responding to Pended Reviews

- If you submitted the request online thru the Portal:
  - Log into the Portal and open the pended case.
  - ACTION TAB – additional Clinical Information.
  - Upload the requested documents or type the information in the note section.



Denials and Reconsiderations

Administrative Denial

- When any portion of the review is denied because it does not comply with Medicaid regulations
- Example: untimely, insufficient information
- Provider may submit a new case for the service if an administrative denial is received. This does not apply to those cases that were denied for untimely submission.

Clinical Denial

- Occurs when any portion of the requested service is denied by a physician reviewer due to medical necessity
- Does not meet state Medicaid criteria with information submitted or does not meet other national evidence-based criteria

Reconsideration

- May only be requested for clinically denied cases
- Not used for Administrative Denials

Reconsiderations

- May be submitted within 30 days of the **clinical** denial date
  - This is your opportunity to provide more detailed clinicals
- May be submitted
  - Via phone (will still require additional information to be faxed)
  - Fax
  - Web portal *preferred
- A clinical reviewer will review any additional information submitted. If unable to meet InterQual® or State approved criteria, it will be referred to the physician reviewer.
- A physician reviewer – a different physician from the one who originally reviewed the case - will look at the case and any new information submitted to support the reconsideration.
- The physician reviewer may
  - Uphold original decision (no change made).
  - Overturn the original decision (approve the case).
- If original decision is upheld, provider may appeal the decision to SCDHHS.

Appeals

- If a reconsideration is upheld, an appeal may be requested. Specific instructions will be included in the reconsideration determination letter.
- SCDHHS will review the provider's request and conduct a Fair hearing.
- Members may request an appeal within 30 calendar days from the reconsideration determination notice:
  - online at www.scdhhs.gov/appeals,
  - Fax 803 255 8206
  - Email appeals@scdhhs.gov
  - Mail Office of Appeals and Hearings

    PO BOX 8206

    Columbia, SC 29202

Resources and Education

- Hospital Services Provider Manual
- Provider Training Resources | SCDHHS
- SC Acentra Health website
- Acentra Health Customer Service
  - 1-855-326-5219
  - scproviderissues@kepro.com generic questions please, do not include PHI