HOSPITALIZATION

Admission or Observation Status:

Scott and White Health Plan (SWHP) members are covered for life-threatening urgent/emergent care at any time in any facility. If a SWHP member requires observation and/or admission to a hospital, SWHP must be notified within 24-48 hours of admission in order to receive consideration of SWHP coverage for the stay. Health Services Division (HSD) of SWHP should be contacted at **254-298-3088 or 1-888-316-7947** Monday-Friday, 8:00 a.m. to 5:00 p.m. After-hours, weekends, holidays, please call Scott & White's main facility in Temple at **254-724-2111**. You may request that a SWHP nurse Continuing Care Coordinator is contacted to speak with you. The following information is needed:

- Member Name and/or Membership Number from SWHP card
- Day & Time of Admission or Observation
- Route of Admission (i.e., ER, Urgent, Scheduled Clinic Admit, etc.)
- Facility Name and Telephone Number(s)
- Admitting/Attending Physician or Provider
- Telephone Number for Physician(s), Provider(s), and/or the Utilization Review (U.R.) Dept.
- Admitting Diagnosis
- Procedure(s) Performed/Scheduled

HSD staff will provide a confirmation number to facility. This is used on billing and indicates that admission (observation) has been called in within the authorized time frame. **This is not an authorization for payment**. A SWHP Nurse Continuing Care Coordinator (CCC) provides member benefits and approved length-of-stay (LOS). The CCC may need to obtain a report from the Physician and/or Utilization Review/Case Management Department of the facility prior to determining SWHP coverage.

Pre-Admission Certification:

All elective/scheduled admissions for selected procedures must be prior approved by SWHP Medical Director(s) through use of the appropriate SWHP Authorization Form.

Concurrent and Continued Stay Review:

HSD reviews each hospitalization from the time of patient admission or observation through discharge and follow-up care. Each hospitalization day must meet InterQual® and/or SWHP internally-developed justification criteria of medical necessity, as determined by Plan Medical Director(s). Surgical patient must be admitted on the day of surgery unless specific medical justification for earlier admission is provided and approved by the Plan Medical Director(s). If SWHP HSD does not authorize an extension of hospital days based on submitted medical justification, those days **will not be paid**.

Retrospective (Post-Service) Review:

It is noted that the majority of determinations made by SWHP are related to benefit coverage interpretations according to the Evidence of Coverage (EOC) and/or Standard Plan Document (SPD) and do not involve issues of medical necessity or appropriateness. Other decisions about medical necessity or appropriateness are made by the SWHP Medical Director(s) with input from the treating clinical Practitioners as appropriate. SWHP benefit determinations are related to payment for care or services based upon input from the Practitioner/Provider and according to the terms of the benefit contract.

Retrospective (Post-Service) review is conducted by the Continuing Care Coordinators (CCCs) / delegated reviewers or the SWHP Claims RN as needed on cases that have been "missed" during the inpatient or concurrent review process due to the types/frequencies of tests/procedures in which the medical records were unavailable or the patient was admitted and discharged from a facility or provider's care before a report could be obtained or records reviewed (i.e., situations in which the case and/or medical records have never been reviewed by SWHP due to circumstances beyond our control. This does not include subsequent review of services for which prospective or concurrent reviews were previously conducted). When retrospective (Post-Service) review is performed, the review will be based upon written screening criteria (e.g., InterQual® or internally-developed SWHP Screening Criteria) established and annually updated with appropriate involvement from physicians (practicing physicians) and other health care providers. The CCC/delegated reviewer or Claims RN will review any potential issues with regard to medical necessity or appropriateness with the Plan Medical Directors(s). No denials are ever issued without Medical Director review and approval. If any denial is issued, appeal rights are provided to both the Member and the Practitioner or Provider per the requirements of the Texas Department of Insurance (TDI).

Additionally, some retrospective review(s) may be conducted to collect data for health/medical care evaluation studies and are not related to the payment of claims.

For information or clarification on any above noted items, please contact Health Services Division at 254-298-3088 or 1-888-316-7947.