CLINICAL MEDICAL POLICY	
Policy Name:	Concurrent Care
Policy Number:	MP-115-MD-PA
Responsible Department(s):	Medical Management
Provider Notice/Issue Date:	11/01/2023
Effective Date:	12/01/2023
Next Annual Review:	06/2024
Implementation Date:	06/21/2023
Products:	Highmark Wholecare℠ Medicaid
Application:	All participating hospitals and providers
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Policy History

Date	Action
12/01/2023	Provider Effective date
09/22/2023	PARP Approval
06/21/2023	QI/UM Committee review
06/21/2023	Policy initially developed

Disclaimer

Highmark Wholecare℠ medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

Policy Statement

Highmark Wholecare℠ may provide coverage under the medical benefits of the Company's Medicaid products for medically necessary long-term acute care.

(Current applicable Pennsylvania HealthChoices Agreement Section V. Program Requirements, B. Prior Authorization of Services, 1. General Prior Authorization Requirements.)

Definitions

Prior Authorization Review Panel (PARP) – A panel of representatives from within the PA Department of Human Services who have been assigned organizational responsibility for the review, approval and denial of all PH-MCO Prior Authorization policies and procedures.

Long-Term Acute Care (LTAC) facility – certified facilities focus on patients who, on average, stay more than 25 days. Many of the patients in LTACs are transferred there from an intensive or critical care unit. LTACs specialize in treating patients who may have more than one serious condition, but who may improve with time and care, and return home. LTACs generally give services like respiratory therapy, head trauma treatment, and pain management.

Concurrent care - care provided to an inpatient in a hospital, long-term acute care hospital, rehabilitation hospital or skilled nursing facility, simultaneously by more than one (1) doctor during a specified period of time.

Procedures

1. Concurrent care may be considered medically necessary when ANY ONE of the following indications is met:
    A. Two (2) or more separate conditions require the services of two (2) or more doctors; OR
    B. The severity of a single condition requires the services of two (2) or more doctors for proper management of the individual.

Note: The necessity of each doctor's particular skills will be determined by considering the respective specialties and the diagnosis for which services were provided. If additional information is required to establish medical necessity, hospital records may be requested for review. These records should:

- Document the attending/ordering professional provider's request for the consultant to see the patient; AND
- Include sufficient documentation to indicate the medical necessity for each doctor's professional services.

2. When concurrent care services are not considered medically necessary
    - Services that do not meet the above criteria will be considered not medically necessary
    - Services that exceed normal frequency or duration for a given condition without documented circumstances requiring additional care
    - Services by one (1) physician duplicating or overlapping those of another provider without recognizable distinction.

3. Post-payment Audit Statement
    The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Highmark Wholecare℠ at any time pursuant to the terms of your provider agreement.

4. Place of Service
    The proper place of service for concurrent care services is inpatient.

5. Length of Coverage
   Significant practical improvement towards achieving a maximum level of functioning or pain management must be expected to occur within a reasonable time period. Significant practical improvement towards achieving a maximum level of functioning or pain management must be expected to occur within a reasonable time period commensurate with the patient's diagnosis. As a benchmark, progress meeting short-term goals is expected on a weekly basis.

Governing Bodies Approval

CMS
The Centers for Medicare and Medicaid Services (CMS) has published the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, §30. Rev. 147.

Reimbursement

Participating facilities will be reimbursed per their Highmark Wholecare℠ contract.

Reference Sources

The Centers for Medicare and Medicaid Services (CMS). Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, §30. Rev. 147, Issued August 26, 2011. Accessed on June 1, 2023.