

CONCURRENT REVIEW

Authored by
mohammad looti

November 7, 2025

RECOMMENDED CITATION

mohammad looti (2025). *CONCURRENT REVIEW*. PSYCHOLOGICAL SCALES. Retrieved from <https://scales.arabpsychology.com/?p=66434>

CONCURRENT REVIEW

Primary Disciplinary Field(s): Healthcare Administration, Managed Care, Utilization Review, Psychiatry

1. Core Definition

Concurrent Review is a specialized type of utilization management (UM) practice employed by healthcare payors, such as insurance companies or government programs, to assess the appropriateness and medical necessity of ongoing medical treatments, particularly those requiring inpatient hospitalization or extended facility stays. Unlike pre-admission review, which occurs before care begins, or retrospective review, which occurs after discharge, concurrent review is conducted in real-time while the patient is actively receiving care. The primary objective is to certify the continued requirement for the specific level of care being provided, ensuring that resources are utilized effectively, efficiently, and according to established clinical guidelines.

In practice, concurrent review involves a detailed, systematic examination of the patient's clinical record by a utilization reviewer--often a registered nurse or a physician advisor--who compares the treating physician's documentation (diagnosis, treatment plan, progress notes, and anticipated discharge date) against pre-defined, evidence-based criteria sets (e.g., InterQual or Milliman Care Guidelines). This process is crucial in high-cost settings like psychiatric facilities, long-term acute care hospitals, or intensive care units. The review does not focus on the quality of the care itself, but rather on the necessity of the setting and the intensity of the services provided. If the reviewer determines that the criteria for continued stay at that specific level are no longer met, the payor may issue a denial or recommend a transition to a lower, more appropriate level of care, such as step-down units or skilled nursing facilities, leading to a crucial administrative dialogue between the payor and the provider.

2. Etymology and Historical Development

The concept of utilization review, of which concurrent review is a central mechanism, gained significant traction in the United States healthcare system following the implementation of federal legislation aimed at curbing escalating medical expenditures. Historically, the shift from indemnity insurance models, where providers were paid for every service rendered (fee-for-service), to structured managed care organizations (MCOs) necessitated stronger oversight mechanisms. Prior to the widespread adoption of concurrent review, hospitals often operated with little external pressure regarding length of stay, which frequently led to inefficiencies and unnecessary utilization, particularly in psychiatric and complex medical cases where definitive endpoints were less clear.

Formal concurrent review processes became codified in the 1980s and 1990s as insurance companies and governmental programs, notably Medicare and Medicaid, sought to standardize

patient care trajectories and enforce medical necessity documentation. The development of standardized criteria sets by third-party vendors allowed utilization reviewers to apply objective metrics across diverse patient populations. This standardization was critical for moving utilization decisions away from purely subjective clinical judgment and into a framework that integrated cost efficiency with clinical efficacy. The modern utilization review department within any hospital or health plan relies heavily on timely and frequent concurrent reviews to manage the financial risk associated with prolonged inpatient episodes, particularly as payment models transition toward global budgets or bundled payments that place financial accountability directly onto providers.

3. Key Characteristics

Real-Time Assessment: Concurrent review is performed while the patient is actively receiving treatment. This immediacy distinguishes it from retrospective or pre-admission reviews, allowing for mid-course corrections in the treatment or administrative setting regarding the appropriateness of the current level of care.

Focus on Medical Necessity: The fundamental inquiry is whether the patient continues to meet the necessary intensity of service requirements and severity of illness criteria to justify the current, often costly, level of care, such as **inpatient hospitalization**. The review ensures that the services provided cannot be safely and effectively administered in a less intensive environment.

Utilization of Standardized Criteria: Reviewers rely on nationally recognized, evidence-based clinical guidelines (e.g., InterQual, Milliman Care Guidelines) to ensure objective and consistent decision-making across various facilities and diagnoses, ensuring fairness in defining the duration of authorized care and reducing variability in clinical practice.

Certification and Denial Process: The process results in either the certification of continued stay authorization for a specific period (e.g., three to seven days) or a determination that the criteria are no longer met. A denial triggers a formal notice of non-coverage and initiates a formal **appeals process** available to both the patient and the provider.

Continuous Documentation Requirement: Concurrent review places a continuous administrative burden on healthcare providers to maintain meticulous and timely clinical documentation that explicitly justifies the patient's ongoing need for the specific level of care being billed. Failure to document adequately can result in immediate loss of payment authorization.

4. Significance and Impact

The significance of concurrent review lies primarily in its powerful role as a mechanism for **cost containment** within the complex healthcare economy. By systematically challenging and verifying the necessity of extended inpatient stays, payors are able to reduce unnecessary service utilization, leading to lower overall costs for insurance beneficiaries and health plans. This system incentivizes hospitals to manage lengths of stay actively and to prioritize effective discharge planning, ensuring that patients transition to post-acute care settings as soon as clinically

appropriate and medically stable.

Furthermore, concurrent review subtly influences the quality and efficiency of clinical documentation. Since authorization for payment hinges on the documentation supporting the medical necessity criteria, providers are compelled to improve the precision and clarity of their records. This focus on documentation can indirectly improve patient safety and care coordination by requiring all members of the treatment team to articulate the patient's status and goals clearly. In the context of **psychiatric healthcare**, specifically mentioned in the source material, concurrent review is particularly critical because determinations of stability and readiness for discharge often involve subjective assessments of behavioral and psychological factors, making the objective application of standardized review criteria essential for financial authorization and resource allocation.

The impact of concurrent review extends beyond immediate financial savings; it drives structural changes in hospital operations. It fosters the development of dedicated utilization review teams within facilities and encourages closer collaboration between clinical staff, finance departments, and external payors. This collaborative yet often adversarial relationship ensures that resource allocation is optimized, preventing the stagnation of care and facilitating quicker throughput, which is vital in managing hospital capacity, especially during periods of high demand and limited bed availability.

5. Debates and Criticisms

Despite its stated goals of efficiency and cost control, concurrent review is frequently the subject of intense debate and criticism, particularly from clinical practitioners and patient advocates. A primary criticism revolves around the perception that utilization reviewers--who may not be specialists in the patient's specific condition--interfere with the physician-patient relationship by imposing rigid administrative guidelines over professional clinical judgment. Clinicians often argue that the strict application of generalized criteria fails to account for the unique complexities and comorbidities of individual patients, potentially leading to decisions that compromise optimal patient outcomes or interrupt necessary continuity of care.

Another significant point of contention is the substantial administrative burden imposed on healthcare providers. The necessity of continuous, detailed reporting and the frequent involvement in back-and-forth appeals and documentation submissions divert valuable clinical time away from direct patient care. When a concurrent review results in a denial of continued stay, the hospital must either absorb the cost of the subsequent care or engage in a time-consuming administrative battle, creating financial instability and administrative friction between the payor and the provider. Critics also voice concern that the financial incentive to reduce length of stay may inadvertently lead to premature discharges, especially in sensitive areas like mental health, where achieving

durable clinical stability often requires flexibility in the duration of inpatient treatment that standard criteria may not accommodate.

Further Reading

[Psychiatry \(Wikipedia\)](#)

[Medicare \(Wikipedia\)](#)

[Pre-certification \(Wikipedia\)](#)

[Appeals \(Wikipedia\)](#)

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