Utilization Review: Much More Than Just Inpatient/Observation

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Objectives

1. Understand why utilization review/management must be completed?
2. Be aware of the expanding role of QIOs
3. Increase knowledge of utilization review and how it can be taken to the next level
What Is Utilization Management

• Utilization management (UM) is the evaluation of the appropriateness, medical need and efficiency of health care services procedures and facilities according to established criteria or guidelines

• The Institute of Medicine defines UM as “a set of techniques used by or on behalf of purchasers of health care benefits to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision”

• Standard UM services include:
  • Prospective, concurrent and retrospective reviews
  • Precertification of hospital stays
  • Discharge planning

Regulations and Mandates for UR

• Social Security Act
  • Section 186 provides the regulation for hospital-based UR

• Centers for Medicare & Medicaid Services(CMS) Conditions of Participation(CoP)
  • Title 42 of the Code of Federal Regulations
  • 42 CFR interpretive guidelines, exceptions to the UR committee

• Hospitals are required to have a UR Plan (“Plan”) to show how they will manage situations in which there are conflicting conditions/issues
Conditions of Participation

- CMS Section 42CFR482.30
  - To be a Medicare and Medicaid provider, the COP must be met
  - The Plan must have a process for reviewing the medical necessity of admissions, the appropriateness of the setting, the medical necessity of extended stays, and the medical necessity of professional services
  - The Plan must address the steps to take if the review determines the admission or procedures completed were not appropriate or indicated, and must specifically address who makes that determination and patient notification
  - The Plan must meet federal and state requirements - specifics of the Plan are identified in Federal Registry, 42CFR

Components of Utilization Review

- Precertification
  - Obtain permission from the payer to have a specific test or procedure, generally associated with elective or urgent cases

- Verification
  - Determine that the patient has coverage for the services that he/she is seeking

- Authorization
  - Receive payer approval of services provided based upon the clinical review information submitted. Usually includes an approval number and the number of days approved.

- Initial & Concurrent Review
  - Applies nationally recognized criteria tool
  - Determines the appropriate status and level of care
  - Medical necessity to support continued stay
  - Facilitate discharge plan
**Medical Necessity**

- Service or supplies provided by a hospital, skilled nursing facility, physician, or other provider, which are required to identify or treat patient illness or injury
- Determined by the payer to be consistent with symptoms, diagnosis, and treatment of patient condition, disease, ailment, or injury
- Appropriate with regard to standards of good medical practice
- Most appropriate supply, level, or location of service, which can be safely provided to the patient
- *Not for the convenience of the patient or family*
- *Not considered to be experimental as defined by the plan*
- *“Physician ordered” does not necessarily mean medically necessary*

**Utilization Management and Quality Improvement Organizations (QIO)**

- We are continuing to see seeing CMS attach financial reimbursement initiatives to outcomes, and the proposed CY 2016 OPPS rule reinforces this strategy:
  - QIOs will oversee the majority of patient status audits, with the Recovery Audit program focusing only on those hospitals with consistently high denial rates
Advanced Utilization Review Programs

• A successful program is much more than determining inpatient, observation or outpatient, and length-of-stay (LOS) management
  • Utilize data to drilldown for opportunity areas based on utilization
    o ICU level of care
    o Pharmacy cost
    o Lab cost
    o Radiology cost/orders
  • Understand the variances by:
    o Physician or physician practice
    o Service line or specialty

Leadership and Structure

• Ensure leadership understands and is supportive of all areas on which the UR committee is focused and which it’s measuring
• Identify a physician leader to provide peer review/feedback
  • Medical director of a service line
  • Physician advisor
  • Chief medical officer (CMO)
• Outline acceptable clinical parameters and pathways based off national best practice
Outcomes of Utilization Management

- Possible enhancement of quality and effectiveness of patient care
- Possible reduction in ALOS leading to increased profitability
- Improved healthcare outcomes for the patients providing positive brand value to the provider
- Predictability in care pathways and treatment measures instituted
- Reduction in revenue leakages and aligning investment decisions more towards future costs and business efficiency
- Enhancing competitiveness of the provider
Utilization Review Committee Charter

Purpose
The Utilization Review Committee assists the Board and Medical Staff in providing utilization review for patients, including Medicare and Medicaid patients, with respect to medical necessity of admissions to the institution, duration of stay, and professional services furnished including drugs and biologicals.

Authority, Reporting, Meetings
The Utilization Review Committee is permanently commissioned by the Hospital and Board to implement policies for reviewing stages of hospital admissions, including but not limited to, medical necessity for admission, over/under utilization of ancillary services, delays in services, quality of care indicators, adequacy of medical record documentation, blood reviews, lengths of stay and timeliness of discharge. The Utilization Review Committee is directly accountable to the Quality Improvement Committee.

Membership and Meetings
Membership includes representation from the Medical Staff as well Case Management, hospital management, Pharmacy, Quality, Infection Control and HIM/medical records. The Utilization Review Committee will meet monthly. The quorum for meetings and decisions making is two Medical Staff Members and at least 2 other members. A record will be kept of actions taken at the meetings.

The Utilization Review Committee is chaired by: [Name]

On a Quarterly basis, the Utilization Review Committee reports findings, trends, and recommendations for action as well as the status of performance improvement projects to the Quality Improvement Committee. Key findings related to individual Medical Staff performance and plans of action for consideration of action referred by the Medical Staff are reported to the Medical Executive Committee.

Responsibilities:

1. Review of admissions before, at, or after hospital admission
   a. Review may be conducted on a sample basis
   b. Review cases reasonably assumed to be outliers as determined by high costs and utilization of institutional resources
   c. Review cases reasonably assumed to be outliers as determined by extended length of stay
   d. Review cases deemed to be an outlier based on extraordinary length of stay
   e. Review cases for medical necessity
   f. Review readmissions
2. Improvement of Patient Flow
3. Review of RAC/PEPPER reports
4. Review of palliative care services
5. Medical Record Review
6. Blood Utilization Review
7. Infection Control Review
8. Pharmacy & Therapeutics Review
9. Develop, and review annually, a Utilization Management Plan

Quality Strategy and Guiding Structures

- Review required information in Utilization Review Committee to create a more comprehensive picture of care quality and financial stewardship

  Sample Agenda
  Utilization Review Committee

  1. Reports:
     a. Blood Utilization
     b. R/T Medication Utilization
     c. Infection Control
     d. Medical Records
     e. Denials/Adjustments
     f. UR Performance Indicators (examples include – CMS, avoidable days, case management interventions, readmissions, PEFFER Indicators, Cost of Care, LOS, Documentation Indicators)
     g. RAC
     h. PEFFER
  2. Case Reviews:
     a. Results of cases review done outside of committee
     b. Case presentation
  3. Committee Performance Improvement:
     a. Concurrent review and education program
     b. Readmission Reduction

- UR members include:
  - Physician chair
  - Additional provider
  - Case management
  - Infection control
  - Pharmacy
  - Health information management
  - Hospital administration representative
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THANK YOU

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