CENTRAL IOWA HEALTHCARE
UTILIZATION MANAGEMENT PLAN
November 2016

I. AUTHORITY

The Utilization Review Plan, as approved by the Governing Body, is a part of the CIH Performance Improvement Program in accordance with applicable statutes and regulations. The Bylaws of the Medical Staff provide for the Patient Care Evaluation Committee to serve this purpose.

II. PURPOSE

The Patient Care Evaluation Committee shall review patients regardless of pay source to assure all patients high quality, cost effective health care. The program addresses over utilization, under utilization, and inefficient scheduling of resources to patients at Central Iowa Healthcare. The objectives are:

1. Assure care at a level Appropriate to patient needs.
2. Provide professional accountability for utilization of health care resources to the patient and those paying for the care.
3. Educate the Medical Staff and other Health Care professionals by identification of problem areas for continued education or quality of care and utilization issues.
4. Provides for a review of services furnished by CIH to patients.

III. ORGANIZATION OF THE COMMITTEE

This committee will consist of members of the Medical Staff, including Surgery, Medicine, and OB-Nursery section heads. Physician members will be appointed by the Chief of Staff for a period of one year. A physician is the chairperson of this committee. Non-physician, non-voting members of this committee will represent Administration, Health Information Management, Nursing Service, Utilization Review, Patient and Family Services, and other departments as deemed appropriate. This committee shall meet every other month and as called by chairperson.

IV. FUNCTIONS

1. The Patient Care Evaluation Committee shall develop a Utilization Review Plan that is acceptable to the Medical Staff, Administration, the Governing Board, and external regulatory agencies.
2. The Utilization Review Plan, criteria, and activities are to be reviewed and evaluated to determine current relevance and resolution of problems identified. Revisions are made as appropriate.
3. The Committee and/or the Utilization Director will review indicators which include under utilization, over utilization, and inefficient scheduling of resources.
4. The support services of Respiratory Care, Physical Therapy, Occupational Therapy, Diagnostic Imaging, Ultrasound and Laboratory will review their specific departmental indicators for the appropriateness of the therapy/diagnostic tests provided. They will refer any problems identified in the utilization of services provided to the Patient Care Evaluation Committee and/or Quality Improvement Council.
5. The UR physician advisor, or designee, provides time to UR Director/Nurse Reviewer for admission, continued stay and readmission review and compliance, for problem referrals, medical record review and consultation on UR issues.

V. PEER REVIEW:

1. **Physician Reviewer:** A physician reviewer is a member of the Medical Staff or physician advisor designee who is assigned responsibility for performing peer review functions in accordance with the Medical Staff Peer Review Process. Active staff members and Courtesy staff members may be peer reviewers. Active staff members include members of the Patient Care Evaluation Committee.
2. **Types of Review**

Problems identified through the different types of review are addressed through the utilization peer review process.

a. **Concurrent Review:**
   Concurrent review includes admission review and continued staff review and focuses on the medical necessity for admission and continued stay for all patients.

b. **Admission Review:**
   Admission review is an assessment of the medical necessity for a patient’s admission to the hospital as an inpatient and proper documentation of the admission order.

c. **Continued Stay Review**
   A continued stay review is the assessment of the medical necessity of a patient’s need for continued stay at the acute level of hospital care. Justification for continued stay is based on the attending physician’s documentation in the medical record.

d. **Retrospective Review**
   Retrospective review will be performed in the following circumstances:
   - Problem cases not identified by concurrent review.
   - Random sampling of cases to pick up situations that are new or to verify that the system is working properly.
   - Cases of under-utilization and over-utilization.
   - Post discharge cases for which third party payers question or deny care.

e. **Focused Review**
   A focused review is a review of known or suspected specific problems. This type of review would be done when a concerning trend is identified or to compare to national norm/comparative data bases. The Patient Care Evaluation (PCE) Committee shall initiate focused review of records and approve the sampling methods. Focused review will apply to all patients regardless of payment source. Focused review may be based on diagnosis, procedure, admission, duration of stay, physician, ancillary services provided, delay of services and all professional services performed on the hospital premises with respect to the medical necessity for these services.

f. **Medical Care Evaluation Studies**
   For Utilization Review, the goal of evaluating medical care is to promote the most effective and efficient use of available healthcare resources and services provided. Patterns of resource utilization should be evaluated on a retrospective basis as a part of the overall evaluation of the quality of care provided with the hospital. Methodology used by the Patient Care Evaluation Committee for selection of types of evaluation may include:
   - Data used to perform studies may be medical records, hospital data, external benchmarks, that produce other comparative data, cooperative endeavors with Kepro, the Iowa Healthcare Collaborative (IHC), Optum (EHR), or other appropriate agencies.
   - Analysis of patterns of care for admissions, length of stay, ancillary services, use of consultants, or classes of admissions wherein patterns of care are found to be questionable.
   - If analysis indicates inappropriate use of hospital resources, corrective action should be specific to the problem and may include concurrent review, educational or training programs, amended staff patterns, provision of new equipment or facilities, or improved scheduling of resources or adjustments in staff privileges.
   - Problems with the review process for either admission or continued stay may recommend more effective and efficient hospital procedures.
   - Questions that deal with appropriateness and quality of the professional services rendered will be referred to the medical staff or medical staff committee(s) responsible for that service. The medical staff/committee will in turn study, analyze and act upon its findings and will also report back the results of such studies to the PCE Committee.
• Analysis of findings are be reported at Patient Care Evaluation, Quality Improvement Council, and Medical Executive Committee.
• Necessary actions will be communicated to Physician/Department Director by Chairperson or an Executive.

At least one study must be in progress at any time, with no less than one completed study per year.

3. **Utilization Review Director and Utilization Nurse Reviewers**:
   The Utilization Review Director/Nurse Reviewers, under the direction of the Patient Care Evaluation Committee, has responsibility for the following activities:
   a. **Utilization Review/Performance Improvement (using Milliman Guidelines)**
      The process of measuring and assessing the use of professional care, services, procedures, and facilities, including the medical necessity and appropriateness of:
      • Necessity of admission
      • Inpatient/Observation appropriateness of initial placement, Level of Care, and Department
      • Appropriate documentation to clearly delineate inpatient or outpatient status
      • Appropriate utilization of resources
      • Continued stay/multiple encounters
      • Discharge/post hospital care referrals
      • Readmissions/revisits
      • Evaluation of specific cases, patterns and trends indicating over-utilization
      • Excessive resource use
      • Intervention to prevent or resolve utilization problems adversely affecting the balance between quality and minimized risk in care delivery
      • Performance improvement team activities to improve systems and processes associated with inefficient or inappropriate delivery of care and services.

   b. **Medical Record Requirements**
      Utilization reviews and determinations are documented in the UR section of the current Paragon electronic health record program which shall include the following elements:
      • Patient name
      • Name of physician
      • Date of admission
      • Plan of care can include any of the following:
        o Diagnoses, symptoms, complaints, and complications indicating need for admission
        o Functional level of care
        o Medications
        o Treatments
        o Restorative and rehabilitative services
        o Activities
        o Diet
        o Social services
        o Continuing care plans
        o Discharge plans
      • Initial and subsequent continued stay review dates
      • Date of surgery if applicable
      • Reasons and plan for continued stay

4. **Conflict of Interest:**
   Physicians may not participate in the review of any case in which he/she has been or anticipates being professionally involved. Physicians having a direct or indirect financial interest in the case(s) being reviewed may not participate in the utilization review activities pertaining thereto.
5. **Extended Stay Review:**

   Hospitals that are paid for inpatient hospital services under the prospective payment system must conduct review of duration of stays and review of professional services as follows:
   
   a. For duration of stays, these hospitals need review only cases that they reasonably assume to be outlier cases based on extended length of stay, as described in CFR §412.80(a)(1)(i) (Appendix A).
   
   b. For professional services, these hospitals need review only cases that they reasonably assume to be outlier cases based on extraordinarily high costs, as described in CFR §412.80(a)(1)(ii).
   
   c. The PCE Committee must make the periodic review within two (2) months after discharge.

6. **Denial Process**

   Denial procedures in other cases are governed by individual insurance carriers. When a payer issued Denial is issued, the chart is reviewed to determine if the denial is appropriate and will contact the denial issuing company/service to find out what appeal avenues exist.

   All denial decisions, whether issued by the hospital, individual carriers or HHS contractors may be appealed by the beneficiary, the physician, or the provider.

   If the denial is upheld, the Utilization Review Director/Staff and PFS will focus on the safety of the patient, that is, an alternative level of care for the patient if continued care is not covered.

   The determination that an admission or continued stay is not medically necessary:
   
   a. May be made by Physician Advisor Designee, or one physician member of the PCE Committee if the practitioner or practitioners responsible for the care of the patient, as specified of §482.12(c), concur with the determination or fail to present their views when afforded the opportunity; and
   
   b. Must be made by Physician Advisor Designee and 1 member of PCE Committee, or at least two physician members of the PCE Committee in all other cases.
   
   c. Before making a determination that an admission or continued stay is not medically necessary, the PCE Committee or Physician Advisor Designee must consult the practitioner or practitioners responsible for the care of the patient, as specified in §482.12(c), and afford the practitioner or practitioners the opportunity to present their views.
   
   d. If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than 2 days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient, as specified in §482.12(c)

7. **Review Reporting**

   Review activities are summarized in reports that are reviewed and evaluated at Patient Care Evaluation Committee monthly.
VI. CONFIDENTIALITY

Confidentiality of all utilization review activities will be the highest degree possible. Patients, physician and employees are not identified in minutes or reports. Copies of Utilization Review records are made available to only the committee involved, the Medical Staff, Administration and the Governing Board. Utilization Review records are never a permanent part of the medical record, and are not discoverable. Reviewing organizations such as accrediting bodies, the State Department of Health, and the hospital’s insurance company may review summaries of reports.

VII. QUALITY OF CARE

Quality of care is monitored concurrently and retrospectively in accordance with the overall Performance Improvement Program. The PCE Committee will review reports of the QI criteria-based reviews and patient care reviews. Monitoring performed as a UR review activity and results are reported to the Quality Improvement Council. Quality improvement activities are described in the Performance Improvement/Patient Safety Plan.

VIII. DISCHARGE PLANNING

The UR Staff/Nursing will work proactively to coordinate patient transfers and discharges with clinical staff, physicians, medical social workers, clinical resources and community resources for a smooth transition along the continuum. Discharge Planning is a collaborative effort of a multi-disciplinary team of individuals performed as an integral part of the direct patient care process. The concurrent utilization review process is one of several mechanisms designed to identify patients needing further intervention to plan coordination.

IX. RESPONSIBILITY

The hospital shall provide orientation and continuing education for Utilization Staff/Performance Improvement Staff and other personnel who screen for monitor and evaluation indicators. The hospital will support the purposes of the Utilization Review Program, assist Patient Care Evaluation Committee activities and will provide adequate personnel to assure continued utilization review activities. The hospital administration will provide the Patient Care Evaluation Committee information essential to its effective performance.

Kepro, the Quality Improvement Organization for the State of Iowa, has specific review requirements for Medicare and Medicaid patients. All physicians admitting patients to Central Iowa Healthcare and the UR Director will follow the review requirements so as to be in compliance with federal law.

Tricare has specific review requirements for Champus patients. All physician admitting patients to Central Iowa Healthcare and the UR Nurse Reviewer will follow the review requirements so as to be in compliance with federal law.

X. DISCIPLINE

The PCE Committee is not a disciplinary committee. Any perceived problems with medical staff members will be forwarded the Medical Staff Executive Committee for consideration. Medical staff members who frequently experience utilization management denials may be subject to a focused review or other restrictions, which the Medical Staff Executive Committee deems necessary to correct the utilization related problems.

XI. EVALUATION OF THE UTILIZATION REVIEW PROGRAM

The hospital Utilization Review Plan must be reviewed and updated or modified as necessary, based upon the ongoing evaluation of the utilization review activities and their relationship to the quality of patient care.
PROCEDURE:

I. ADMISSION REVIEW

1. Check daily census sheet for new observation and patient admissions. Perform a review of the electronic documentation as well as the hard copy record for orders and written notes. Check discharge census for one day stays.

2. Check each admission for specific assessment and service criteria as outlined in Milliman Care Guidelines. Those records that fail first level nurse review for inpatient care are referred for a second level review. CIH business associate, Optum (EHR) performs secondary physician review on cases that the UR Physician Advisor cannot render a determination on.

3. Check each one-day stay discharge to assure accuracy of patient status and medical necessity.

II. ACUTE CARE CHART REVIEW

1. Utilization review staff participates in multidisciplinary care planning meetings with chart monitoring daily.

2. The UR nurse communicates to members of the multidisciplinary care team when a patient no longer has medical necessity for acute hospital care so appropriate discharge planning can be made.

III. DENIAL OF PAYMENT PROCEDURE FOR MEDICARE/MEDICAID BENEFICIARIES

Only a physician can deny payment benefits to a patient. If a denial is appropriate, the reviewing physician shall contact the attending physician. If the attending physician disagrees with the denial and is able to document medical necessity for hospitalization, the reviewing physician may approve additional length of stay. If an agreement cannot be reached, a second member of the committee will review the chart. If the attending physician does not contest the determination, a Hospital Issues of Notice of Non-Coverage (HINN) shall be delivered to the patient or his/her representative within 24 hours of the determination. A Copy will be given to business office, UR files, patient, and chart.

INSTRUCTIONS IN THE APPROPRIATE MEDICARE OR MEDICAID HOSPITAL ISSUES NOTICE OF NONCOVERAGE PROCEDURE MANUAL FOR HOSPITAL LIAISONS SHALL BE FOLLOWED WHENEVER ISSUING ONE OF THESE NOTICES.

If a physician feels that benefits should be denied to his patient, the Utilization Review Nurse should be contacted and he/she will issue the HINN at his/her request. Copies of all HINN go to hospital business office, UR files, patient, and chart.

A patient who has been denied benefits but chooses to remain in the hospital may require reinstatement if their condition reaches an acute level of care. (Kepro and WPS)

IV. PRIVATE INSURANCE COMPANY REVIEW

The insurance nurse reviewer will call and give a list of patients to review. Charts are reviewed, pertinent information is then provided. If the Insurance nurse has questions that cannot be answered by reading the chart, she will call the attending physician. Encourage the physician to
appeal all denial if there is any question of medical necessity. OPTUM (EHR) will appeal the denial if they make the determination for inpatient services.

PREFERRED CARE NETWORK
When nurse reviewer calls, answer questions about admission. They do not do continued stay review as they are DRG payers.

OTHER COMPANIES
When informed of an insurance company denial, speak to physician and encourage a Peer to Peer review with the Medical Director of the Insurance Company. Utilize OPTUM (EHR) in appeals management as appropriate.

V. If any unusual circumstances are noticed during chart review, notify the appropriate department director, Q.I. Director, Social Worker, etc., or refers to PCE for physician review.