Clinical Resource Management Series — Part 3 of 10

Utilization Review and Denial Management

Part 3 in our Clinical Resource Management (CRM) series is focused on utilization review and denial management.

Although we are writing this newsletter specifically for the utilization review function—as illustrated in the diagram to the right—all of the CRM functions must work together to have a successful program.

We hope you will find the information helpful as you develop and/or strengthen your program.

Utilization Review

In the hospital setting, Utilization Review provides both a review function as well as a support function for the provider and other staff related to the admission decision, continued stay and resource utilization.

Utilization Review is responsible for delivering Advance Beneficiary Notices (ABNs), interfacing with third party payors regarding authorizations and delivering the Important Message from Medicare (IM) regarding discharge rights to Medicare patients.

The goal is to achieve appropriate reimbursement & prevent denials from Medicare and other third party payors.

Denial Management

Denial management is another important component of Utilization Review.

Although denials may be received by the business office, utilization review staff should always be involved with reviewing the denial. A potential exception is for denials that occur because incorrect codes or information was transmitted. UR staff provide critical input in writing appeals as well as helping to identify strategies to prevent future denials.
Regulatory requirements for review of medical necessity and utilization can be found in both Appendix A (PPS Hospitals) and Appendix W (Critical Access Hospitals).

**PPS Hospitals**

Let’s talk about PPS Hospitals first. The State Operations Manual Appendix A, published 03-21-14, includes requirements for the utilization review functions in §482.30 as summarized below.

- **Utilization Review Plan:** The Hospital must have a UR plan that provides for the review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. The interpretative guidelines require that the UR plan include delineation of the responsibilities and authority for those involved, establishment of procedures for the review of the medical necessity of admissions, the appropriateness of the setting, the medical necessity of extended stays, and the medical necessity of professional services.

- **Utilization Review Committee:** The Committee must include two or more practitioners. At least two of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in §482.12(c)(1).

- **Concurrent Medical Necessity Review:** Reviews must occur for Medicare and Medicaid patients with respect to the medical necessity of—
  - i) Admissions to the institution;
  - ii) The duration of stays;
  - iii) Professional services furnished including drugs and biologicals.

Although the regulations state that reviews may be performed before, at, or after hospital admission—organizations almost always perform the reviews during the admission as a strategy to prevent denials.

- **Physician Review:** One or two physician members of the UR Committee are responsible for determining if an admission or continued stay is not medically necessary. This includes any change from inpatient to observation (Code 44).

- **Outlier Review:** Hospitals are required to conduct reviews of any cases that they reasonably assume to be outlier cases based on length of stay or high costs. You may choose to use the Medicare definition of an outlier—but most facilities set the threshold lower to ensure more timely review.
Regulatory Requirements

Critical Access Hospital (CAH)

State Operations Manual Appendix W, published 04-11-14, are not overly specific in relationship to utilization review functions. However, they do require that CAHs have an, “Effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes”. §485.641(b)

Utilization of the PPS Hospital requirements as outlined on the previous page will help the CAH to develop and sustain a viable UR program. Components should include:
- Utilization Review Plan
- Active Utilization Review Committee with two physician members (You may designate one or both as UR Physician Advisors)
- Concurrent Medical Necessity Reviews
- Medical Necessity Physician Review
- Outlier Review

Other Regulatory Requirements

Both CAHs and PPS hospitals are subject to the same rules for determining patient status and billing for Medicare and Medicaid, although the reimbursement mechanisms may be different. The Medicare Claims Processing Manual and the Medicare Benefit Policy Manual both provide important information. There are also periodic updates from CMS that are published in MLN Matters or as CMS transmittals. And of course—the Federal Register is the first source for changes. It is extremely important that UR staff are knowledgeable and current with all of the requirements. If you haven’t done so — sign up to receive updates on the CMS web site. At a minimum, UR staff should be aware of the most current rules and regulations related to:
- 2-Midnight Inpatient Presumption
- 96 hour LOS (CAH only)
- Observation including Observation after outpatient surgery
- Swing Bed including 3-day qualifying stay and criteria for swing bed admission
- Important Message from Medicare
- Advance Beneficiary Notices

Medical Necessity Guidelines

A word about medical necessity guidelines. As you know the two most common are Interqual and Milliman Care Guidelines (mcg). Most organizations today, use one or the other to help review cases for medical necessity, utilization of resources and length of stay.

Although the use of guidelines can be very helpful, it is extremely important to remember that CMS has made it very clear that only the provider can determine status based on the severity of the patient’s signs and symptoms and the medical predictability of something adverse happening to the patient. If you question the provider’s decision making—that’s the time to call your UR physician advisor.

Medicare Benefit Policy Manual  Chapter 1—06-27-14

“However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.”
**Point of Entry**

Utilization Review staff play a very important role in reviewing and discussing admission decisions with providers. This includes ensuring that there is a clear order for the type of admission (inpatient, outpatient, observation), that documentation clearly supports the admission decision and orders for treatment support both the type of admission and medical necessity.

Review at the point of entry is even more critical than in the past with the advent of the recent CMS rules requiring physician certification for inpatients and that patients will be discharged or transferred within 96 hours in Critical Access Hospitals.

Of course, saying that support at the point of entry is critical—is fine—but in a rural facility with limited resources, how does that occur? Some common strategies you may want to consider are outlined below.

1. **Order Sets:** Develop order sets that include certification requirements—and definitions. Most facilities that I have visited recently already have this in place! This helps queue providers as well as other staff as to what is needed regarding documentation.

2. **Resources:** Provide tip sheets or other simple to read information for Emergency Department providers and Hospitalist. Include information about your most common types of admissions.

3. **Planned or Elective Admissions:** Develop a process for review by UR staff, if possible, before the admitting order is written. Although this may not be possible for all admissions, try to catch those that may have been problematic in the past relative to lack of documentation and/or denials.

4. **Hours:** Stagger UR staff to cover more hours, including evenings. This may seem to be a costly solution—but—depending on your history of denials and the cost of denials, it may be money well spent.

4. **On-Call:** As an alternative to extending hours, consider placing UR staff on-call with the expectation that they are notified for all non-emergency admissions. Some facilities are using technology solutions, such as smart-phones, to facilitate this process.

6. **Cross-Training:** Cross-train a limited number of other staff, such as house-supervisors, to support physicians when UR staff is not present. If the house-supervisor is the individual in your organization that receives requests for bed placement—they are the ideal individual to also review the documentation and admission status with the provider.

7. **ED Case Manager:** Develop an ED Case Manager role that can also help with UR functions. Although great in concept—unless you are large enough to have 24-hour coverage in the ED, the UR functions may still not be well covered.
Daily Reviews

Daily reviews are critical to ensure that the patient and the documentation, including orders for treatment, continue to support medical necessity. Remember—this is not just provider documentation—but documentation of other disciplines as well. Here are a few tips:

♦ **Go see the patient.** The most important tip is, “Go See The Patient”. The medical record may paint a different picture than the actual patient condition—and you won’t know that unless you actually go to the bedside.

♦ **Talk to the Provider:** It is very important to ask questions when discussing a specific case with a provider—and not to challenge medical decision making. Ask the provider to document their rationale for admission or for keeping the patient in the hospital. “The patient does not meet criteria” - should never be in your lexicon. And if you need support, talk to the physician advisor and ask for their help.

♦ **Observation:** The UR staff serve a very important function relative to monitoring patients that are placed in Observation including:
  - Ensuring that orders are time-limited.
  - Ensuring that orders and documentation include a clear cycle of assessment and reassessment.
  - Advising the provider if an observation patient may be appropriate for inpatient admission if it appears that they will meet the 2-midnight inpatient requirement. Remember hours in the ED and Observation count.

Ideally observation patients are reviewed at least twice per day and/or whenever a cycle of assessment/reassessment has been completed. In many facilities, the UR staff is also responsible for determining the number of hours that are billed.

Multi-Disciplinary Planning

Provider Multi-disciplinary Rounds

Multi-disciplinary rounds that include the provider are an ideal method of collaboration—and ensuring that everyone is on the same page. If you have a hospitalist program, it should be relatively easy to find a time that works for the provider and other disciplines.

Disciplines typically include, in addition to the provider:

- Utilization Review and Discharge Planning
- Clinical Documentation Improvement (CDI) and/or HIM
- Social Services
- RN responsible for patient
- Pharmacist
- Rehabilitation (PT/OT/Speech)
- Dietitian

I was at one facility a couple of years ago that had unlimited visiting hours including the ICU — except 30 minutes in the morning and 30 minutes in the afternoon when they restricted visitors for multi-disciplinary rounds. **Good Idea!**

Each patient should be discussed, with a focus on the treatment plan, goals of treatment, adherence to evidence-based care/guidelines, expected length of stay and the discharge plan. AND — because these are rounds that occur in the patient room, the patient is an important contributor to the discussion. If you use white boards that shows key milestones—it’s an ideal time to update the board.
**Multi-Disciplinary Planning cont.**

**Multi-Disciplinary Meetings:** Many organizations have a sit-down meeting on a daily basis to discuss each patient. We much prefer the option of multi-disciplinary rounding. However, if you choose to have a meeting, they must be well structured or they become nothing more than a nursing report—or a repeat of information that everyone in the room already knows—and therefore provides little value.

Just like multi-disciplinary rounding focus on the treatment plan, goals of treatment, adherence to evidence-based care/guidelines, expected length of stay and the discharge plan. Ensure that someone has spoken to the patient prior to the meeting and that you incorporate their input!

If you use white boards, be sure to assign someone to update after the meeting. And don’t forget to document the meeting, including attendees, in the patient record.

**Outliers or Complex Patients:** Just a word of caution. DON’T try to discuss extremely complex patients as part of your regularly scheduled meeting. Meetings to discuss complex patients should be scheduled at a separate time and may include additional individuals such as the patient’s primary care provider, physician specialists, Infection Preventionist, Home Health, Long Term Care, CEO or CFO. Attendees will depend on the patient needs. You may also want to consider including the patient and/or family.

**Third Party Payors**

UR staff is responsible for third party payor authorizations. And **no authorization means no reimbursement.**

Medicare, at least currently, does not require pre-authorization for services (although this is in the discussion stages). Many third party payors require both initial authorization as well as continued stay authorizations. This can take a significant amount of time—as I’m sure you are aware.

Here’s some strategies to consider:

1. Negotiate with the payor to allow you to complete admission and continued stay reviews internally based on pre-approved guidelines.

2. Send information and receive approvals electronically, again based on pre-approved guidelines, so that you are spending less time on the phone.

3. Negotiate the need for approval only if a patient exceeds pre-determined length of stay or charge thresh-holds.

The ideal time to discuss these strategies are during contract negotiation. Talk to the CFO or individual responsible for negotiating contracts about including some or all of these options in the next contract negotiation.

**Important Message from Medicare**

Utilization Review is often responsible for either delivering—or ensuring delivery of the Important Message from Medicare (IM) for Medicare and Medicare-eligible patients. Some organizations have the admitting department provide the first notice and UR is responsible for delivering the second notice. Regardless of your process, it is imperative that these notices are delivered within the timelines defined by Medicare.

Some hospitals have adopted a strategy of delivering the IM on Friday to all Medicare patients regardless of whether they are expected to be discharged or not rather than relying on nursing. This seems a little over-zealous, but each facility will need to develop their own strategy to ensure the IM is delivered. Pay special attention to your process if the individual(s) usually responsible are off sick and/or on vacation.

At a minimum, UR should track the timeliness of delivery. Also make sure you have the most recent IM which includes both the date and a time the notice was signed. I am still finding IM’s that do not include the time of delivery. Requirements and the most current form may be found at CMS.gov.
**Physician Advisor(s)**

Every UR Program should have an identified physician advisor. This is usually one (or both) of the physicians on the UR Committee. In some organizations, the Chief-Of-Staff elect or other medical staff officer is designated as the UR Advisor. Although this can work well—there is a learning curve for each physician who assumes the role.

The following is a list of functions usually assigned to the physician advisor(s):

- Chair or Co-Chair of UR Committee.
- Conduct clinical reviews on cases referred by UR staff and/or other healthcare professionals.
- Hold regular meetings with UR staff to discuss selected cases and make recommendations.
- Interact with medical staff and medical directors of third party payors to discuss the needs of patients and alternative levels of care.
- Act as consultant and resource to the attending physician regarding appropriateness of hospitalization, continued stay, documentation and utilization of resources.
- Function as an expert resource to medical staff regarding federal and state regulations.

A job description should be developed with specific accountabilities. This is especially critical if the UR Physician Advisor is a paid position.

**Utilization Review Committee**

The UR Committee serves an important purpose in guiding the UR functions and performing record reviews.

The UR Committee is typically responsible for:

- Ensuring that regulatory guidelines related to UR have been implemented and that monitors are developed to ensure compliance, if appropriate.
- Educating staff and providers regarding the UR function and regulatory requirements.
- Reviewing records when there is a question about medical necessity or other utilization issues.
- Reviewing denials and appeals.
- Reviewing data compiled by the UR staff.

(The next page includes a list of metrics commonly collected and reviewed.)

Typical the UR Committee includes the following—although membership can vary:

- 2 physicians
- 1—2 mid-level provider (especially important if mid-level providers admit patients)
- Utilization Review
- Discharge Planning
- Clinical Documentation Improvement Specialist and/or HIM
- Quality Director
- CNO
- CFO
**Metrics**

Metrics measure the effectiveness of your UR program and show that you have a data-driven program. The following are recommended metrics. Please note that these metrics are also applicable to other aspects of your CRM program—not just UR.

### Metrics—Provider Attestation

| CAH only | Number and % of patients without provider certification in medical record that expected LOS is 96 hours or less |
| CAH only | Number and % of patients without provider certification in medical record that expected LOS is 96 hours or less |
| CAH only | Number and % of patients that exceeded 96 Hour Length of Stay |

Provider documentation (attestation) at admission that LOS is expected to be at least 2-midnights for inpatients.

### Metrics—Length of Stay

| Average LOS inpatients (excluding swing) |
| Average LOS Medicare (excluding swing) |
| Average LOS by specific diagnosis compared to GMLOS for most common diagnosis |
| Average LOS Swing bed |

Swing Bed patients with exactly a 3-day qualifying stay.

### Metrics—Medical Necessity / Documentation

Number of Medicare and Medicaid inpatients that do not appear to meet medical necessity as determined by UR staff. Include number referred to UR Physician or UR Committee for review.

Number of Medicare and Medicaid observation patients that do not appear to meet medical necessity. Include number referred to UR Physician or UR Committee for review.

Number of observation patients that do not show specific time limited orders or documentation of assessment and reassessment.

Number of outpatient surgery or outpatient procedure patients placed in observation post-procedure.

### Metrics Outliers

| Number of Length of Stay outliers (as defined by your organization) |
| Number of Cost outliers (as defined by your organization) |

### Metrics—Discharge Delays

Avoidable (Discharge) Delays—Internal

- Internal Examples
  - Therapy not available on weekends
  - Medical Imaging equipment not working
  - Lab delays
  - Consult delayed

Avoidable (Discharge) Delays External

- External Examples
  - LTC bed not available
  - Transferring organization delayed transfer
  - Lack of Home Health
  - Late arrival of medical equipment
  - Family unable to pick up patient

### Metrics—Denials

Denials by payor including MAC and RAC

Denied Days

Denied Charges

Reasons for denials

### Metrics—Process Measures

Medical Necessity reviews completed for each inpatient and observation patient daily

Number of referrals to UR Physician Advisor

### Metrics—Patient Required Notices

Important Message from Medicare delivered within timeframes required and signed, dated, timed

Number of ABNs delivered (including reason)
So… What does an Excellent Utilization Review Program look like?

Experience has shown that there are a number of elements that must be in place, regardless of the size of the organization, to establish a solid foundation for a successful Utilization Review Program. Use the table below to evaluate your program!

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<th>Criteria for Success</th>
<th>Yes</th>
<th>No</th>
<th>Maybe—We’re Getting There</th>
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<td>1. Active, demonstrated support from hospital and medical staff leadership.</td>
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<td>2. Physicians respect and interact in a collegial manner.</td>
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<td>3. Expectations are clearly defined for Individuals assigned to UR functions, including UR Physician Advisor(s)</td>
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<td>4. UR Physician Advisor is actively involved in UR processes.</td>
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<td>5. Initial and ongoing orientation and education is in place for Utilization Review staff, Physician Advisor(s) and UR Committee.</td>
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<td>6. UR staff are knowledgeable regarding most recent regulations applicable to UR—and have a process to stay current.</td>
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<td>7. Utilization Review Plan is current (updated within 12 months).</td>
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<td>8. Active Utilization Review Committee with at least 2 physicians.</td>
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<td>9. Multi-disciplinary rounds and/or meetings are well-organized and effective with clearly defined roles and responsibilities.</td>
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<td>10. Multi-disciplinary rounds occur at least 3 times per week and include the UR Physician advisor and/or Hospitalist.</td>
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<td>11. UR staff are available 24-hours per day to review admissions and provide support.</td>
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<td>12. Order sets or other information has been developed to assist with admitting status decisions and documentation — and are available to physicians including ED physicians &amp; Hospitalists.</td>
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<td>13. UR staff participate actively in reviewing denials.</td>
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<td>14. Metrics (data) is collected and reported at each UR Committee. Data is used to drive improvement.</td>
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Stay tuned for the next newsletter in our CRM series. And if you missed one—just let us know and we will be glad to send to you by E-Mail.

Happy Reading

If you have questions or comments - or would like an on-site review of your Clinical Resource Management program, please contact HTMS Regional Chief Clinical Officers:

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