HARDIN COUNTY GENERAL HOSPITAL
HOSPITAL-WIDE POLICY

Title: UTILIZATION REVIEW PLAN **Effective Date: 2/14/06**
Policy Number: 114 **Med Staff:**
Regulation: **Admin:**

I. POLICY

AUTHORITY

The Utilization Review Department has been established to assure high quality patient care and to assist in the promotion and maintenance of high quality care through the effective utilization of available health resources from pre-admission through discharge. The department is managed by the UR Coordinator and governed by the Medical Staff and Board of Directors. Health Systems of Illinois for (Medicaid) and Livanta (for Medicare and the Illinois QIO) have the authority and responsibility for assuring an effective review.

OBJECTIVES

To provide for cooperation between hospital administration and the medical staff to assure effective and efficient utilization of available hospital facilities and services and the provision for continuity of patient care.

COMMITTEE

The Utilization Review Committee is a subgroup of the Medical Staff Committee and meets monthly. It is composed of all active staff physicians as a committee of the whole plus three non-physician members representing nursing services, medical records, and administration. Other non-physician members may be appointed at the discretion of the committee or administration. A minimum of two members must be physicians.

CONFLICT OF INTEREST

No physician will make review decisions on patients with whom he/she was professionally involved in the care of the patient whose case is being reviewed. No physician or committee member who holds a significant financial interest in the hospital or a direct or indirect financial interest in the case being reviewed will be permitted to make review decisions. If there is a conflict of interest for a physician, an alternate staff physician will review that particular case.

SCOPE

1. UR provides services to:
   a. Assure appropriateness and necessity of admission at the most efficient level of care, regardless of payment source.
   b. Assure that the level of continued care is appropriate to the patient needs.
   c. Provide for timely review of the medical necessity for admission, continued stays and services rendered.
   d. Address over-utilization, inefficient scheduling of resources and denials of service.

e. Communicate to the appropriate departments and committees of the results of committee findings for consideration and action as performed by the URC.

2. The URC is, preferably, a college graduate with experience in nursing/medical age-specific care, medical terminology, and good verbal and organizational skills.

CONFIDENTIALITY

Any and all information pertaining to the health care data and financial data of our patients will be kept in strict confidence by the UR Department.

II. DEFINITIONS

UR = Utilization Review
URC = Utilization Review Coordinator
HSI = Health Systems of Illinois (reviews Medicaid admissions for necessity and quality of care)
Livanta = reviews Medicare and state QIO admissions for necessity, quality of care, and data validation)
QIO = Livanta
PR = Physician Reviewer
DP = Discharge Planner
LOS = Length of stay

III. RESPONSIBILITY

Medical Staff
Hospital Administration
Utilization Review Department and Committee
Discharge Planner
Nursing Services

IV. EQUIPMENT

N/A

V. PROCEDURES

INFECTION CONTROL: N/A

ADMISSION REVIEW

1. The admission office notifies the UR department of all admissions and provides the following information:
    a) Completed copy of the *Face sheet* indicating the principle diagnosis and/or problem
    b) Copy of responsible payer information of applicable
    c) Signed and dated *An Important Message From Medicare* on all Medicare patients
    d) Copy of the *Daily Census Sheet*
    e) Copy of the *Night Census* form from nursing services which indicates attending physicians

2. The URC or assistant reviews the medical records of the acute admissions for appropriate level of care using screening criteria that was approved by the medical staff. If the admission meets the Acute Assessment Criteria (AAC) and the Acute Service Criteria (ASC) she/he will approve the admission and initiate discharge planning, if needed, by notifying the DP for an assessment of needs.
3. When there is a commercial insurance or certain diagnosis Medicaid admission, the URC or assistant notifies the appropriate payer with required information. The physician is notified of days certified or any denials to certify and appropriate measures are taken for each individual case.
4. In cases which do not meet criteria, the attending physician will be notified and further information to justify the admission will be obtained, or the physician will be asked to change the admission to a more appropriate level of care (e.g., Observation).
5. If the attending physician is unable to justify the acute admission and is not willing to adjust the level of care then a Physician Reviewer (PR) is asked to review the case. The PR is a member of the hospital medical staff, without conflict of interest, assigned responsibility by the Hospital Administrator to perform review functions referred by the URC to make an appropriate determination regarding medical necessity for the patient's level of care.
6. If the PR has reason to believe the admission was not necessary and the attending physician does not concur with the adverse decision, the case will be referred to the Hospital Administrator who may refer the case to a physician consultant. The PR will make the final determination after consulting with the physician consultant.
7. If the PR determines that the admission is not medically necessary, the URC will prepare letters of denial as required by Medicare and/or commercial payers. Prior to sending a letter of denial to a patient, all efforts will be made to notify the attending physician. If this cannot be done, a message will be left with his/her office personnel.
8. When there is a conflict between consideration of cost and quality care, it will be the responsibility of the URC and physician to resolve the matter in favor of quality care.

CONCURRENT REVIEW

1. Justification for continued stay is based on documentation in the medical record and is done periodically through out the patient stay in acute care. If the case continues to meet acute criteria, the URC or assistant will continue looking toward alternate care settings and communicate pertinent information to the attending physician.
2. In cases which do not meet criteria, the attending physician will be notified and further information to justify the admission will be obtained, or the physician will be asked to change the admission to a more appropriate level of care (e.g., Swing Bed).
3. If the attending physician is unable to justify the continued stay and is not willing to adjust the level of care then a Physician Reviewer (PR) is asked to review the case and the steps will be taken as in and under Admission Review.
4. There may be up to, not to exceed, 25 patients in the hospital at one time. This count is Acute Care and Swing Bed patients only. A review of the patient census and levels of care will be carried out as outlined in the *Inpatient Census Monitoring* policy and procedure.
5. The average length of stay (LOS) will be monitored daily. The Medical Staff will be informed of the current LOS in the monthly Medical Staff meeting to discuss any problems

that may need to be addressed in order to maintain our average annual LOS of 96 hours.

DENIALS

1. Denials will be specifically documented. The concurrence between the attending physician and the PR, based on documentation in the medical record, will suffice. If there is not concurrence, the case will be referred to the Hospital Administrator who may contact a consulting physician to review the case. Both the PR and the consulting physician must agree to deny the contested case. If there is not an agreement, the case will be reviewed by the Hospital Administrator and a decision will be made. An appeal of a denial will be available.
2. External review organization denials will be communicated to the appropriate physician by the UR department. If the attending physician does not agree with the denial the URC or assistant will assist with the appropriate appeal process for the organization making the denial.

APPEAL PROCESS

If the attending physician disagrees with the adverse findings of the PR, he/she may at any time request a reconsideration using the following guidelines:

1. If the patient is in the hospital at the time of the request, the reconsideration should be reviewed within 24 – 72 hours following the request.
2. If the patient has already left the hospital, the request must be in writing and submitted to the URC within 2 months of the date of the initial adverse determination unless such time is extended for good cause.
3. A PR that was not involved in the initial determination will review the evidence and findings which the adverse determination was based and any additional evidence submitted by the attending physician.
4. The PR performing the reconsideration will maintain documentation on at least the following:
    a) The case record which was submitted to the initial PR when the attending physician proposed to provide the service.
    b) The findings of the initial PR which led to an adverse initial determination.
    c) The complete record of the hospital stay of the patient.
    d) Any additional documentary information submitted by the physician with his/her request for reconsideration.
    e) Any oral presentation which the attending physician may choose to present to the PR conducting the reconsideration.
5. The PR will make a reconsidered determination affirming, modifying, or reversing the adverse initial determination.

RETROSPECTIVE REVIEW

Retrospective review will be performed every month for the previous month and reported in the monthly Medical Staff and UR meeting as follows:

- Every 10^{th} Acute Care admission
- All inpatient Deaths

- All inpatient discharges Against Medical Advice (AMA)
- All Swing Bed admission (beginning 4/1/06)
- Every 10th Observation admission (beginning 4/1/06)
- All Blood and Blood Component Transfusions
- All Surgical cases
- All Re-admissions
- Every 10th Emergency Room (ER) discharge
- All ER Deaths
- All ER Transfers
- All ER discharges AMA
- Any other unusual case needing to be discussed per request

DISCHARGE PLANNING

Discharge Planning is initiated on admission by the physician and/or nursing staff. The UR department works closely with the attending physician, nursing services, and Social Services to ensure that all patients receive appropriate referrals and services when needed as follows:

1. Discharge planning does not require a physician order and begins with the admission assessments completed by the nursing staff.
2. Referrals are made by the physician, nursing staff, patient/family, and/or the UR department to the Discharge Planner (DP). The DP is the hospital Social Worker and the URC when the Social Worker is unavailable.
3. Discharge planning will include placement in alternative care facilities and arrangement for appropriate community resources to improve or maintain the patient's health status on an outpatient basis.
4. Collaboration with nursing, other members of the health care team, the patient's family or significant other, attending physician and the patient will be documented in the medical record.

WORKING HOURS

The UR department will review admissions within one working day of admission, Monday through Friday, each week, excluding the holidays observed by the hospital. If the admission occurs on the weekend or holiday, the review will be done the first working day following.

EVALUATION OF THE UR PLAN

This plan will be reviewed annually and updated or modified as necessary based upon the ongoing evaluation of UR activities and their relationship to the quality of patient care.

VI. DOCUMENTATION

1. Minutes are taken at every Medical Staff and UR meeting where this information is reported and they are kept in the Administrator's Office.
2. All other required documentation is kept in the UR office.