## Cabinet Peaks Medical Center

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| Originating Department: | Index: | |
| **Quality Risk Management** | UR-102 | |
| Affected Departments/Employees: | Original Effective Date: | Revised Date: |
| Medical Staff, Quality Management, Acute Care Nursing, Health Information Management, Patient Financial Services | 07/23/96 | 03/18/15 |

**Utilization Review Plan**

**Purpose:**

The purpose of the Utilization Review (UR) Program is to assure that the medical care rendered to patients at Cabinet Peaks Medical Center (CPMC) is evaluated for appropriateness, consistency and quality while efficiently utilizing services in the most cost effective manner across the acute care continuum. The UR program should also ensure that the right services are delivered to patients in the right setting with the right resources resulting in the right clinical outcomes at the right reimbursement. This plan will conform to applicable standards of the Center for Medicare and Medicaid (CMS) regulations.

**Policy:**

It is the policy of Cabinet Peaks Medical Center to have in effect a UR plan that provides for review of services furnished by the Medical Center and by members of the medical staff to patients.

**Supportive Data:**

The Cabinet Peaks Medical Center Board of Directors has delegated to the UR Committee the authority and responsibility to carry out this UR plan.

**Procedure:**

1. Utilization Review Committee:
   1. The Utilization Review Committee is a standing subcommittee of the Medical Staff Executive Committee.
   2. Per the CMS Hospital Conditions of Participation, the UR Committee must consist of two or more practitioners who are MD’s or DO’s. A quorum of one physician member must be present at each meeting.
   3. Non-physician members may include the Chief Executive Officer, Quality/Risk Management/UR Coordinator, Utilization Review Staff, Chief Nursing Officer, Health Information Manager, and Patient Financial Services Manager.
   4. The UR Committee’s reviews may not be conducted by any individual who has a direct financial interest in the Medical Center, or ownership, and no physician should participate in the review of a case in which he or she is professionally involved.
   5. The committee should ensure that the procedures for the review of medical necessity of admissions to the Medical Center, the appropriateness of the setting, the medical necessity of extended stays, and the medical necessity of professional services are accomplished.
   6. The Committee should meet at least quarterly and maintain minutes.
2. Scope and Frequency of Review:

UR staff will review all Inpatient, Outpatient Observation, and Swing Bed medical records daily to determine medical necessity of admissions to the Medical Center, duration of stays, and professional services furnished, including drugs and biologicals.

1. Determination Regarding Admissions or Continued Stays:
   1. UR staff will use Medicare policies and McKesson InterQual Guidelines® as criteria for making a determination of medical necessity.
   2. If the UR staff cannot determine medical necessity based on the documentation in the medical record, the practitioner(s) responsible for the care of the patient will be asked to document additional information to justify medical necessity. If additional documentation is not provided or still does not meet criteria, the UR staff will refer the case to a physician member of the UR Committee for review.
   3. The determination that an admission or continued stay is not medically necessary may be made by one physician member of the UR Committee if the practitioner(s) responsible for the care of the patient concur with the determination or fail to present their views when afforded the opportunity. In all other cases, the determination must be made by at least two physician members of the UR Committee.

In the event that one of the UR Committee physicians is the practitioner responsible for the care of the patient, the Chairperson of the appropriate committee or the Chief of Staff will serve as the second physician.

* 1. Before making a determination that an admission or continued stay is not medically necessary, the UR Committee must consult the practitioner(s) responsible for the care of the patient and afford the practitioner(s) the opportunity to present their views.
  2. If the UR Committee physician decides that admission to or continued stay in the Medical Center is not medically necessary, written notification must be given, no later than 2 days after the determination, to the Medical Center’s Patient Financial Services Department, the patient (or next of kin), and the practitioner(s) responsible for the care of the patient. . Patient notice will follow the Medicare Beneficiary Hospital Issued Notice of Non-Coverage (HINN). <http://www.cms.hhs.gov/bni/>
  3. In no case may a non-physician make a final determination that a patient’s stay is not medically necessary or appropriate.
  4. In making a medical necessity determination, the physician reviewer(s) will consider the following: 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 Medical Center's bylaws and admissions policies, and the relative appropriateness of treatment in the Medical Center setting. Other factors to be considered when making the decision to admit include such things as:
     1. The severity of the signs and symptoms exhibited by the patient;
     2. The medical predictability of something adverse happening to the patient;
     3. The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the Medical Center for 24 hours or more) to assist in assessing whether the patient should be admitted; and
     4. The availability of diagnostic procedures at the time when and at the location where the patient presents.
  5. The UR Committee determination will be documented in the patient’s medical record by the reviewing physician(s).

1. Extended Stay Review:
   1. Critical Access Hospitals are required to have an inpatient annual average length of stay no greater than 96 hours (4 days). The quarterly average length of inpatient stay report should be reviewed by the UR Committee at their regularly scheduled meetings.
   2. UR/Discharge Planning staff should attend the interdisciplinary hospitalist huddles.
   3. For patients with an extended stay, the huddles should address the reasons for continued hospitalization, estimated time the patient will need to remain in the Medical Center, and plans for post-Medical Center care.
   4. The percentage of inpatient Medical Center stays greater than 7 days should be reviewed by the UR Committee at their regularly scheduled meetings.
2. Performance Improvement:
   1. The following data may be presented to the UR Committee for review:
      1. Inpatient, swing bed, and observation payment medical necessity denials and appeals
      2. Non-billable observation hours
      3. Potentially avoidable days
      4. One-day inpatient stays
      5. Inpatient stays greater than seven days
      6. Three-day stays prior to swing bed or admission to an extended care facility
      7. Average length of inpatient stays
      8. Readmission rates
      9. Other pertinent data
   2. The committee should suggest practitioner educational topics regarding clinical documentation and other UR-related issues for presentation to the general Medical Staff.
3. Confidentiality:
   1. All findings of the UR Committee discovered in their routine course of business shall be deemed confidential (Montana Code Annotated 50-16-201, 202, 203, 204, and 205) and shall not be made available to any internal source except those responsible for participating in the implementation and review of the UR Plan and the Medical Staff Executive Committee.
   2. No external sources shall have access to the findings of the UR Committee except as required by the Fiscal Intermediary, authorized State Agencies, the Department of Health and Human Services, the Quality Improvement Organization (QIO), as appropriate, and certification/ licensure agencies in the performance of their specified duties.

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| **Rule/Cite/Tag:** | | | | | |
| §482.30 Medicare Conditions of Participation Standards for Hospital Utilization Review  MCA 50-16-201, 202, 203, 204, and 205 | | | | | |
| **Medical Center Policy Cross Reference:** | | | | | |
| (UR-002) Concurrent Utilization Review Procedure | | | | | |
| **List Historical Policy Version Dates:** | | | | | |
| UR Plan 08/13/01, 02/23/06, 01/30/12, 12/10/12, 11/11/13 | | | | | |
| Approved By: | | | Approval Date: | | |
|  | ***See Hard Copy For Signature*** |  |  | 02/25/15 |  |
|  | Barbara Dumont, RN, Quality Risk Manager |  |  |  |  |
|  | ***See Hard Copy For Signature*** |  |  | 03/18/15 |  |
|  | Charles LaGoy, DO., Medical Chief of Staff |  |  |  |  |
|  | ***See Hard Copy For Signature*** |  |  | 02/26/15 |  |
|  | Bruce Whitfield, CEO |  |  |  |  |