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| Beartooth Billings Clinic | POLICY MANUAL**UTILIZATION MANAGEMENT PROGRAM**Effective Date: 3/27/19Policy #:Approved:  |
|  | Reviewed/Revised: |

**POLICY STATEMENT**

The Utilization Management Program ensures efficient and effective utilization of hospital resources as a part of Beartooth Billings Clinics’ ongoing effort to maintain high quality patient care.

**DEFINITIONS**

Utilization Management: The evaluation of all activities that are in place to ensure the patient gets the right care, in the right place, at the right time, every time

Utilization Review: The process where organizations determine whether health care is medically necessary for a patient or an insured individual (Utilization Review Accreditation Commission (URAC))

Extended Stay: Stays that exceed the goal length of stay, based on admission status. Critical Access hospital regulations state that the average Inpatient LOS must be less than 96 hours.

Physician Advisor: A Doctor of Medicine or Osteopathy of the facility shall serve as the Physician Advisor (PA) for the Utilization Review committee. The PA is the primary resource for the Utilization Review team, will review specific cases as needed and interact with the treating physician or the payors medical director to mediate differences and negotiate resolution; assist with education of the medical staff in regard to appropriate utilization of services and essential documentation; serve as the medical staff liaison on issues pertaining to federal and state regulations, payor issues, and resource utilization successes & challenges

MCG: Evidence based guidelines utilized to assist with determining appropriate admission status, appropriate length of stay and assistance with discharge planning; formerly Milliman Care Guidelines

**PROCEDURE**

Establish a Utilization Management Plan and a Utilization Review Committee that provides for review of services furnished by Beartooth Billings Clinic and its providers for patients regardless of payer source.

**The Utilization Review Committee**

In compliance with Medicare Conditions of Participation, the Utilization Review Committee will be established.

Committee membership should include at least Providers ( one of which is an MD ), as the committees reviews may not be conducted by any individual who 1) has a direct financial interest in the hospital or 2) was professionally involved in the care of the patient whose case is being reviewed.

Other members of the UR Committee shall include representatives from the following departments: Finance, Case Management, Medical Records, Administration, and Nursing. Other members may be assigned as needed.

The UR committee shall meet quarterly, or more often as necessary. Committee reports shall be presented to the Executive QI Committee and Medical Staff.

**The Utilization Management Plan**

The Utilization Management Plan will be developed by the UR Committee to identify and address unusual patterns of care that do not meet standards for best practice, quality of care or are outside the hospital’s endorsed benchmarks. For example, the committee may:

* Review medical records of any patient admitted to the hospital or treated on an outpatient basis
* Review denied or potentially deniable inpatient, outpatient observations and skilled days of care
* Suggest practitioner educational topics regarding clinical documentation and other UR-related issues for presentation to the Medical Staff
* Track delays of service, utilization of ancillary services
* Refer individual cases where there is concern patient quality of care was compromised to the appropriate department
* Recommend appropriate changes in hospital procedures and medical staff practices that will result in a more efficient utilization of hospital services

**Hospital Admissions and Utilization Review**

All patients admitted to Acute Care must have an appropriate status order.

* Outpatient with Observation Services
* Inpatient
* Skilled Swing Bed
* Private Pay (formerly Swing Intermediate)
* Hospice Respite
* Hospice

**Hospital Stay Review Process**

Pre-Admission certification will be obtained by the Financial Office for all Inpatient, Outpatient stays & procedures, and swing bed stays.

Admission Review: Each inpatient admission, outpatient with observation services & swing bed admission will be reviewed for appropriate level of care and medical necessity. Criteria for admissions will be evaluated using MCG. Admission reviews will be completed within one business day of admission.

Continued Stay Review: Each patients’ chart will be reviewed to evaluate the continuing need for hospitalization utilizing nationally recognized guidelines. Should the patient not continue to meet criteria for continued stay, based on chart review, the Patient Care Navigator or designee will coordinate with the admitting/attending physician for discharge orders or additional clinical documentation for continued stay. Continued stay reviews will be conducted at least every other day during the hospital stay.

**Denial Procedure**

In House Denials: Should a patients’ case fail to meet admission, level of care or continued stay criteria based on nationally recognized guidelines, the PCN or designee shall contact the admitting/attending provider for discharge order, change in status or additional clinical documentation to refelect the need for admission, level of care or continued stay. If the provider fails to provide this, the PCN nurse or designee shall contact a provider on the UR Committtee for secondary review & assistance.

Payor denials & Appeals:

The PCN or designee will assist as necessary. Decision to pursue a written appeal shall be evaluated on a case-by-case basis, and shall include a member of Finance and the PCN.

**Utilization Review/Case Management Staff Roles & Responsibilities**

The PCN will screen and review all admissions to the hospital utilizing MCG guidelines to determine medical necessity. She/he must be proficient utilizing these criteria. She/he will communicate with payors to provide clinical information as requested. She/he must work well with providers, business office and other departments as needed to coordinate appropriate care for patients & move the patient along the continuum of care to ensure the proper care is being provided without over- or under-utilization of services.

She/he will also coordinate with social services as needed for discharge planning and assistance.

Reporting Structure:

The Utilizaiton Review committee shall meet quarterly. Reports generated by the committee shall be reported to the Executive QI Committee.

Plan Reivew:

This plan shall be reviewed annually, and revised as needed to reflect current practices and regulations.

References:

Daniels, Stefani & Hirsch, Ronald “The Hospital Guide to Contemporary Utilization Review” 2015