UTILIZATION MANAGEMENT PLAN TEMPLATE

INTRODUCTION

[Insert hospital name] ("Hospital") will perform Utilization Management functions according to pertinent regulations and instructions. This document identifies the fundamental requirements of a comprehensive Utilization Management Plan that satisfies Medicare Conditions of Participation, Medicaid Program requirements, all federally funded program requirements and both case and utilization management requirements for all payers. This "Utilization Management Plan" or "UM Plan" provides for 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 **(42 CFR §482.30)**. Hospital-specific utilization management procedures required by the Medical Staff, Utilization Management Committee or state regulatory agencies may be added to the UM Plan.

PURPOSE OF THE UTILIZATION MANAGEMENT PLAN

The Utilization Management Plan describes the Hospital's establishment and implementation of utilization review to ensure the quality, appropriateness and efficiency of care and resources furnished by the facility and medical staff. Under this UM Plan, the organization:

1. Delineates the responsibilities and authority of personnel for conducting internal utilization review, for conducting delegated review under managed care contracts and facilitating external review under managed care and other payer contracts;
2. Outlines processes to review the medical necessity of admissions, extended stays, professional services, and appropriateness of setting;
3. Outlines processes to review outlier cases based on extended length of stay and/or extraordinarily high costs;
4. Defines processes to review potential overutilization, underutilization and inefficient utilization of resources;
5. Defines processes for coverage determinations, denials, appeals and peer review within the organization; and
6. Identifies framework for reporting, corrective action and documentation requirements for the utilization management process

OBJECTIVE OF THE UTILIZATION MANAGEMENT PLAN

The objective of the Utilization Management Plan (UM Plan) is to maintain high-quality, medically necessary and efficient treatment for all patients, regardless of payment source, by ensuring that patients receive the appropriate care at the appropriate time in the appropriate setting.

Annual Review of UM Plan

1. The UM Plan must be reviewed at least annually and revised as necessary.
2. The annual review and all revisions must be submitted and approved by the Utilization Management Committee (UMC), Medical Executive Committee (MEC) and Governing Board.

UTILIZATION MANAGEMENT PLAN TEMPLATE

ESSENTIAL REQUIREMENTS FOR EFFECTIVE UTILIZATION REVIEW

A. This UM Plan:

1. Delineates the responsibilities and authority of personnel for conducting internal utilization review, for conducting delegated review under managed care contracts and facilitating external review under managed care and other payer contracts;
2. Outlines processes to review the medical necessity of admissions, extended stays, professional services, and appropriateness of setting;
3. Outlines processes to review outlier cases based on extended length of stay and/or extraordinarily high costs;
4. Defines processed to review potential overutilization, underutilization and inefficient utilization of resources;
5. Defines processes for coverage determinations, denials, appeals and peer review within the organization; and
6. Identifies framework for reporting, corrective action and documentation requirements for the utilization management process

B. UM Plan Minimum Requirements

1. Commitment, cooperation and communication by the Governing Board, the Medical Executive Committee, hospital administration, the UMC, Medical and hospital staff, and contracted services.
2. Use of objective review criteria, including outlier thresholds.
3. Maintenance of appropriate databases for aggregation of utilization management data.
4. Corrective action mechanisms and authority, including medical staff by-laws and department rules and regulations.
5. Integration of utilization review findings into quality improvement activities.
6. Compliance with applicable state utilization review/management statutes, including confidentiality and privilege of patient information.
7. Patient medical records will be provided for utilization management review.

COMPOSITION OF THE UTILIZATION MANAGEMENT COMMITTEE AND MEETING INFORMATION

A. Composition:

1. The Utilization Management Committee (UMC) shall be a standing committee of the Hospital's Medical Staff and shall comprise two or more physicians and other practitioners to perform the utilization management function. At least two members of the committee must be doctors of medicine or osteopathy, one of whom must be a member of the Hospital Medical Staff. The remaining members of the Committee may be dentists, podiatrists, optometrists, chiropractors or clinical psychologists within their scope of practice in the state. The Committee may be supported by representatives from case management and administration (*e.g.*, the CFO, nursing services, or health information management), but only physicians and other practitioners are members of the Committee "members" for regulatory purposes.

2. No person with a direct financial interest in the Hospital may participate in reviews conducted by the Committee. No person who is, or has been, professionally involved in the care of the patient whose case is being reviewed may participate in review. All members of the Committee must sign a Conflict of Interest Statement (see Attachment A) attesting that they have no direct financial interest in the Hospital.

B. Meetings

The Committee must meet as a separate and distinct committee with its own agenda and minutes. The Committee must meet, regularly throughout the year, as often as necessary to accomplish its functions, but no fewer than six (6) times per year

C. Minutes

Committee minutes must be maintained according to hospital policy and include the date and time of the meeting, attendees, standard reports, action item follow-up, focused reviews, audits, and action to be taken.. The minutes must exclude patient or physician names, but may include other identifiers. Summaries or minutes must be reviewed by the UMC, MEC, Governing Board, Medical Staff and other committees according to the Responsibilities Authority and Duties outlined in this Utilization Management Plan.

D. Standard reports

Standard reports presented at Committee meetings are for discussion and identification of action items, plan for improvement and resolution. Include:

1. Length of stay;
2. Excess Days by Payer
3. Avoidable days;
4. Disputes;
5. Appeal outcomes;
6. INTERQUAL/other Tenet approved clinical screening criteria, or other preadmission review results (cases or number of days that do not satisfy criteria for admission, continued stay and/or level of care, and secondary reviews results);
7. Number of Admission Hospital Issued Notice of Non-coverage (HINN) letters issued;
8. Number of Hospital Requested Reviews (HRR) for admission medical necessity;
9. Observation information, including the number of observation stays converted to inpatient, the average length of stay (hours) and the number exceeding 48 hours;
10. Number of cases converted from inpatient to outpatient observation or outpatient in accordance with CMS guidelines (Condition Code 44);
11. Percentage of medical necessity screenings performed within 24 hours of admission
12. Crimson data or other analytical tools in use;
13. TEMPO barrier data;
14. Case Management Dashboard Metrics;
15. EHR Report data

RESPONSIBILITIES, AUTHORITY, AND DUTIES FOR THOSE INVOLVED IN THE UTILIZATION MANAGEMENT PLAN

A. GOVERNING BOARD

1. Provides human, information, and physical resources needed by departments to perform their functions under the UM Plan.
2. Delegates responsibility for implementation of the UM Plan to the Medical Staff, UMC and Chief Executive Officer.
3. Requires the hospital and Medical Staff to implement and report on utilization management activities throughout the organization.

B. CHIEF EXECUTIVE OFFICER

Delegates oversight of utilization management to the Committee as a subcommittee of the Medical Executive Committee.

1. Assigns responsibility for medical necessity secondary review process and physician liaison between case management department and medical staff to the Physician Advisor or CMO.
2. Assures that admissions and continued stays are medically necessary and that medical and hospital resources are appropriately used.
3. Evaluates the effectiveness of utilization management activities.
4. Reports evaluation results to the Governing Board.

C. MEDICAL EXECUTIVE COMMITTEE

Criteria Development

1. Develops and/or approves general admission criteria.
2. Develops and/or approves specific admission criteria for specialty patient groups, such as psychiatric and physical rehabilitation patients.

Resource Utilization

1. Provides oversight to assure that health care furnished at the Hospital is consistent with professionally-recognized quality standards.
2. Provides oversight to assure consistently appropriate and medically necessary treatment for patients.
3. Provides oversight to assure efficient use of hospital health services and facilities.
4. Provides oversight to assure the maintenance of consistently valid, accurate and complete medical record information that reflects diagnoses, admissions, treatments, and continued care.
5. Receives, analyzes and acts on utilization management committee findings.

Peer Review

1. Evaluates and acts upon peer review information related to medical necessity, appropriateness of treatment and quality of care.
2. Provides for confidentiality of the peer review process and findings.
3. Provides focused review or other privilege restrictions for medical staff members with identified utilization management problems, including disputes.

Utilization Management Committee

1. Arranges for two or more appropriate practitioners to perform UM functions.
2. Schedules meetings.

Reporting

1. Provides an annual review, evaluation and approval of the UM Plan by the UM and Medical Executive Committees prior to submitting to the Governing Board.

D. HOSPITAL ADMINISTRATION

1. Demonstrates and fosters commitment to the goals and objectives of utilization management.
2. Creates an environment that promotes effective utilization management.
3. Engages the medical staff in utilization and case management functions.
4. Allocates adequate resources, including personnel, time, data collection tools and systems, to:
   a. Establish, promote and maintain utilization and case management functions;
   b. Promote coordinated care and services;
   c. Pursue effective internal utilization review; and
   d. Conduct effective utilization review of cases delegated by managed care organizations and other managed care cases regarding which the Hospital is at risk.
5. Ensures the Hospital satisfies the requirements of the Quality Improvement Organization (QIO) contract required by CMS for review of services and items provided to Medicare beneficiaries.
6. Ensures implementation of the UM Plan for the review of medical necessity of admissions, appropriateness of the setting, medical necessity of continued stay and medical necessity of professional services.
7. Ensures that UM Plan activities and outcomes are systematically monitored, measured, assessed and improved throughout the organization.
8. Participates in interdisciplinary and interdepartmental activities to improve procedures and promote the most efficient use of services and facilities.
9. Provides mechanisms for corrective or disciplinary action, as needed, to resolve barriers to effective utilization management and review.

E. UTILIZATION MANAGEMENT COMMITTEE

1. Administrative Procedures

   a. Complies with the UM Plan approved by the Medical Staff and Governing Body.
   b. Documents utilization management on claims without regard for payment source.
   c. Performs focused reviews with accompanying action plan and reports results.
   d. Determines whether under-utilization or over-utilization adversely affects quality of patient care and recommends the appropriate corrective action.
   e. Monitors the implementation of corrective action to achieve improvement in the utilization and case management function.

f. Establishes procedures for compliance with policy regarding notification of non-coverage to beneficiaries.
g. Provides for confidentiality of the peer review process and findings.
h. Establishes procedures for external utilization management representatives who perform on-site reviews in the Hospital, including facility sign-in process.
i. Recommend monthly meetings with a minimum of six (6) times per year, at the call of its chair, to manage the UM process.
j. Documents meetings with dates, duration, attendance, and committee activity.
k. Reports at least semi-annually to the MEC, the Governing Board and other committees as set forth in the UM Plan.
l. Reports findings from the QIO to the Medical Staff.
m. Delegates to case management (CM) staff, UMC/Subcommittee, physician member of the UMC and/or Physician Advisor (PA) the authority to act on day-to-day UM matters including, but not limited to, using screening criteria to evaluate the appropriateness of hospital stay and level of care, making determinations regarding the medical necessity/appropriateness of an admission/continued stay, and issuing notices of non-coverage or causing the admission category to be revised in accordance with CMS guidelines.
n. Reviews summary data, including the number of cases converted from inpatient to outpatient observation level of care using Condition Code 44.
o. Maintains confidentiality of patient identity in all utilization review records and reports.

2. Utilization Review and Peer Review Process

a. Monitors to ensure that only medically necessary care is provided.
b. Notifies the hospital administrator, the practitioner or practitioners responsible for care of the patient, and the patient, in writing, of the determination that an inpatient admission or a continued stay in the hospital is not medically necessary, within two days of that determination.
c. Makes medical necessity and appropriateness of care determinations independent of external utilization review decision-makers, such as managed care entities.
d. Conducts or arranges peer review for cases referred by the PA.
e. Recruits physician advisors when specialty expertise is required for medical and professional peer review.
f. Reviews all continued stay and cost outlier cases within specified timeframes.
g. Tracks, trends and analyzes outlier cases to identify patterns for performance improvement.
h. Reviews professional services to determine medical necessity and to promote the most efficient use of available health facilities and services (*e.g.*, availability and use of necessary services and therapeutic procedures, *i.e.*, underuse, overuse, appropriateness of use, and timeliness of scheduling operating rooms and diagnostic procedures). For purposes of this policy, professional services includes laboratory, physical therapy, nursing, and services provided by MDs/DOs and licensed practitioners with staff privileges at the Hospital.
i. Documents the outcome of cases reviewed for medical necessity, including approvals, disapprovals, and reasons, and actions taken to resolve identified problems.

j. Coordinates consultation with Conifer National Insurance Center and National Medicare Center regarding denials related to medical necessity of admissions, continued stays and professional services
k. Assists with appeals regarding medical necessity denials by third-party payers.

F. PHYSICIAN ADVISOR

1. If the PA is a member of the medical staff, the PA functions as a member of the UMC. If the PA is not a member of the medical staff, the PA shall serve as an advisor to the UMC and its members.
2. Represents or advises the UM Committee in day-to-day utilization management operations.
3. Provides clinical consultation to case management staff members.
4. Provides education to medical staff members regarding utilization and case management issues.
5. Performs secondary reviews to determine medical necessity on cases referred by the case manager.
6. Consults with the attending physician regarding admissions and continued stays that are identified by the case manager as not meeting applicable screening criteria.
7. Abstains from participation in reviews of cases in which the PA or a partner of the PA is, or has been, involved as an attending, consulting or treating physician.
8. Documents the clinical rationale for all medical necessity determinations, whether approved or denied
9. Assists case management staff in preparing appeals regarding denials of coverage and payment.

G. MEDICAL STAFF, EMPLOYEES AND CONTRACTED SERVICES

1. Assesses patient needs to determine the appropriate level of care, services and settings based upon standard criteria, payer guidelines, evidence-based medicine, and clinical judgment consistent with professional standards of practice.
2. Establishes clear, concrete and attainable care goals against which progress can be evaluated.
3. Identifies barriers to efficient treatment and timely discharge.
4. Provides efficient and appropriate care.
5. Maintains accurate and complete medical records.
6. Communicates and coordinates effectively with patients, families, healthcare providers and third-party payers regarding continuum of care transition and discharge needs.
7. Facilitates patient transition through the continuum of care using internal and external resources as appropriate.
8. Cooperates with, and participates in, the utilization management and peer review processes, including providing additional information as needed for appeals of adverse determinations by payers and external review organizations.

H. CASE MANAGEMENT STAFF

1. Director of Case Management

a. Delegates responsibilities to appropriate personnel to ensure 24/7 coverage for determining appropriate patient status and bed placement (See Regulatory Compliance policy COMP-RCC 4.18 Clinical Determination of Appropriate Patient Status)
b. Provides guidance to the medical staff and hospital personnel regarding medical necessity criteria and appropriate level of care determinations.

2. Case Manager

a. Reviews medical record documentation to obtain information necessary for UM determinations.
b. Uses only documentation properly authenticated in the medical record to make determinations using INTERQUAL or other Tenet approved clinical screening criteria.
c. Applies utilization review criteria objectively regarding outpatient observation services, inpatient admissions, continued stays, level of care and discharge readiness determinations, using INTERQUAL or other Tenet approved clinical screening criteria and/or other adopted guidelines. For payers that do not have an Authorization process ("No Authorization Payors"), INTERQUAL or other Tenet approved clinical screening criteria must be used for acute adult, pediatric, and long term acute care (LTAC) patients. For payors with an authorization process, the Hospital shall follow the authorization and continued stay review process established by the payor.
d. Specialty Program Reviews The Hospital Case Management reviewer must conduct an initial review for medical necessity, as soon as adequate clinical information is available to complete an accurate review, but within 24 hours of admission.
e. Admissions to SNF and LTAC must be screened within two calendar days.
f. Screens and coordinates admissions and transfers, including emergency and elective admissions, outpatient observations, and conversions from outpatient observation to inpatient care and inpatient to outpatient observation care in accordance with CMS guidelines and contractual agreements.
g. Reviews all outpatient observation stays daily.
h. Conducts utilization review regarding all admissions and continued stays, regardless of payer, including private and no-pay categories and cases that have been pre-authorized or certified by third-party payers.
i. Reviews all continued stays at frequency specified in the UM Plan, but at least every three days. Continued stay review for inpatient rehabilitation facilities will be conducted weekly as a component of team conference. Continued stay review for skilled nursing patients will be performed at least every seven (7) days.
j. Reviews the timeliness, safety and appropriateness of hospital services, including the use of drugs, biologicals and medical devices, in collaboration with the Hospital's Pharmacy and Therapeutics Committee and/or other committees responsible for review of the Hospital formularies and utilization of these items.
k. Participates in weekly complex case review meeting.
l. Performs retrospective or focused review as directed by the UM Committee.
m. Provides case management education to all relevant hospital departments and acts as a resource for questions and concerns.
n. Specialty Program Reviews:
(1) Facilities that perform Inpatient Rehab Facility (IRF) utilization management: applies Medical Condition Criteria as defined in 42 C.F.R. Part 412,

objectively to determine if admission to inpatient rehabilitation level of care is reasonable and necessary for the treatment of the patient's condition in terms of efficacy, duration, frequency, and amount; provides coordinated, comprehensive, and interdisciplinary services in an inpatient rehabilitation facility rather than in a less intensive setting such as a skilled nursing facility (SNF) or on an outpatient basis.

(2) Facilities that have SNF level of care and provide SNF utilization management: applies skilled nursing care criteria objectively to determine if admission to skilled nursing level of care is reasonable and necessary in terms of duration and quality.

I. Types of Review/ Review Process:

1. Pre-Admission Review for IRF and LTAC facilities

   a. For Payors with no authorization process, the reviewer must perform pre-admission review using INTERQUAL or other Tenet approved clinical screening criteria when a patient is referred for admission to LTAC and IRF level of care, and approves the admission only if the pre-admission criteria are met. Facilities that perform Acute Inpatient Rehab: applies Medical Condition Criteria as defined in 42 C.F.R. Part 412, and completes the preadmission review to objectively to determine if admission to inpatient rehabilitation level of care is reasonable and necessary for the treatment of the patient's condition in terms of efficacy, duration, frequency, and amount; provides coordinated, comprehensive, and interdisciplinary services in an inpatient rehabilitation facility rather than in a less intensive setting such as a SNF or on an outpatient basis.)
   b. For payors offering a preauthorization process, the Hospital will rely on the payor's preauthorization and continued stay review processes.
   c. Contact the referral source or physician requesting the service for additional information if the referral does not meet pre-admission criteria and the requested or ordered treatments or therapies could be performed at an alternate level of care,
   d. Approve the admission if additional information is subsequently provided supporting the admission.
   e. If additional information is not provided or provided and still fails to satisfy the admission criteria, and the physician agrees that an Alternative Level of Care (ALOC) is appropriate, the case manager or designee shall facilitate transfer.
   f. If patient does not meet admission criteria but the referring physician does not agree that an ALOC is appropriate, the case must be referred to the Physician Advisor or another physician member of the Committee for secondary review.
   g. The Secondary Reviewer will review the case and confer with the referring/ordering physician if the Secondary Reviewer believes that the patient does not satisfy admission criteria, and make an independent determination. If the secondary reviewer determines that an acute inpatient rehab or LTAC or IRF admission is medically necessary, the admission must be accepted. For Medicare beneficiaries admission acceptance is subject to beneficiary notice pursuant to Regulatory Compliance policy COMP-RCC 4.25 Hospital Coverage Notices for Medicare Inpatients.

2. Admission Review

a. The reviewer must perform an Admission Review using INTERQUAL or other Tenet approved clinical screening criteria no later than 24 hours after admission. Exception: Admission Reviews for LTAC, SNF, and IRF must be completed within 48 hours of admission
b. For payers with no authorization process
   (1) If INTERQUAL or other Tenet approved clinical screening criteria are met on the initial review, the admission shall be deemed appropriate
   (2) The reviewer assigns the continued stay review (CSR) for the hospital day 3. Exception: For SNF and LTAC continued stay review must be scheduled within first seven days. Behavioral Health continued stay review shall be assigned no later than 3 days from the date of admission. Continued stay for IRF is scheduled weekly as a component of team conferences.
   (3) If admission criteria are not satisfied, the reviewer must contact the attending physician for additional information. If additional information satisfies admission criteria the admission must be approved.
   (4) If additional information is not provided or provided and still fails to satisfy admission criteria, the case must be referred for secondary review.

3. Continued Stay Review

a. Continued Stay Review (CSR) must be performed for payors with no authorization process on hospital days 2 or 3, and at least every 3 days thereafter based on patient condition, prior INTERQUAL or other Tenet approved clinical screening criteria results and anticipated date of discharge. Exception: Continued Stay Reviews for SNF and, LTAC should occur at least every seven days. CSRs for inpatient rehab must occur weekly as a component of team conferences. Behavioral Health continued stay reviews shall occur at least every 3 days. For payors with an authorization process, the Hospital will Follow the procedure per contract language
b. If Continued Stay criteria are satisfied**,** the continued stay will be approved as ordered and next review date will be scheduled.
c. If Continued Stay criteria are not satisfied, the reviewer must contact the attending physician for any additional information that may support the stay.
d. If additional documented information satisfies the Continued Stay criteria, the continued stay will be approved as ordered and next review will be scheduled.
e. If additional information is not available or available and fails to meet continued stay criteria, the HCM will conduct a discharge review.
f. Discharge Review
   Discharge reviews must be performed when criteria for continued stay are not satisfied, or when help is needed in determining the next appropriate level of care within the facility or the appropriateness of discharge from the facility. If the case does not meet Continued Stay criteria, but discharge indicators are NOT met (*e.g.*, patient is falling outside of the clinical stability parameters for discharge), the CM will set the next review date for the next day, and resolve the barriers to discharge. If discharge indicators are met the CM will contact the physician and facilitate discharge or transition to the next appropriate level of care. If discharge indicators are met and the physician disagrees with discharge the case must be referred for secondary review.

4. Secondary Review Process

a. When an admission or continued stay review is referred by the Case Manager to the PA or physician member of the UMC for secondary review, the PA will review the case based on documentation in the medical record and discussions with the attending medical practitioner and make a determination using his or her medical judgment. PA determinations must be documented and supported with clinical rationale.
b. Before determining that an admission or continued stay is not medically necessary, the PA or physician member of the UM Committee must consult with the attending physician or the practitioner or practitioners responsible for the care of the patient and afford the attending physician or the practitioner or practitioners the opportunity to present their views.
   (1) If the PA or physician member of the UMC determines that an admission or continued stay is not medically necessary and the attending physician or practitioners responsible for the care of the patient agrees, or fail(s) to present views regarding the case, the Case Manager must facilitate discharge, transfer, or referral to the appropriate level of care.
   (2) If the attending physician or practitioners responsible for the care of the patient does not agree with the PA's determination, another physician member of the UMC must be consulted and a further determination made.
c. If the UMC or designee decides that admission to, or continued stay in the hospital is not medically necessary, the UMC or designee must give written notification to the hospital, the patient, the QIO and the practitioner or practitioners responsible for the care of the patient, no later than two (2) days after the determination. (See Regulatory Compliance policy COMP-RCC 4.25 Hospital Coverage Notices for Medicare Inpatients)
d. In the case of Managed Care (MC) patients, the Hospital case manager must notify the MC case manager regarding medical necessity determinations pursuant to the specific MC contract.
e. If the circumstances exist, the Hospital must include the state requirements in the individual hospital UM Plan.

J. Discharge Planning Process

The discharge planning process is initiated on admission. The CM Transition Assessment (TA) focuses on the patient's goals, preferences, and needs to facilitate timely and appropriate discharges based on the Transition Evaluation. It identifies patients with complex discharge planning needs arising from diagnoses, therapies, and psychosocial or other relevant circumstances as well as patients at risk for readmission. The discharge planning process facilitates transfers to appropriate level of care facilities throughout the continuum of care. Documentation of all discharge planning activities is completed in the case management documentation system and placed in the medical record. Current, accurate information regarding community resources to facilitate discharge planning is maintained in the Case Management Department.

K. Dispute / Appeal Responsibilities

The case management department works collaboratively to resolve disputes that arise based on decisions not to authorize services currently being provided (concurrent review disputes) by payers or designated utilization review organizations The department also works with the

Conifer National Medicare Center (NMC) and the National Insurance Center (NIC) to resolve retrospective disputes.

L. Case Management Relationship with Third-Party Payer Organizations

1. The Hospital's Director of Case Management must work to establish and maintain an effective and professional working relationship with third party payer organizations, including managed care and external utilization review organizations.

2. Hospital personnel must abide by the Hospital's Information Privacy and Security Program requirements for disclosure of protected health information.

3. The Case Manager must document clinical information as required by third-party payer contracts.

4. The Case Management Staff must provide/submit clinical review as required by third-party payer contracts under direction of Nurse Case Manager.

5. The Case Management Staff must facilitate physician-to-physician communication when appropriate regarding adverse determinations by third party payers or external utilization review organizations.

6. Access to medical records and supervision of medical record review at the Hospital by third party payer and external utilization review organizations must be facilitated by the Director of HIM to assure compliance with third party payer contracts and with procedures established by the UM Committee.

M. Information Management

1. UM Data must be collected, analyzed and maintained to address issues of over-utilization, under-utilization, appropriateness of resource use, medical necessity of services and appropriate level of care assignment, and compliance with applicable federal and state regulations. Relevant UM data must be collected and aggregated for tracking and trending reports using automated information systems wherever possible to optimize efficiency.

2. Utilization management files must be maintained separate from individual patient medical records.

REFERENCES:

- INTERQUAL or other Tenet approved clinical screening criteria
- Regulatory Compliance policy COMP-RCC 4.25 Hospital Coverage Notices for Medicare Inpatients
- Regulatory Compliance policy COMP-RCC 4.18 Clinical Determination of Appropriate Patient Status
- CMT.103 Hospital Case Management Transition Planning
- Regulatory Compliance policy COMP-RCC 4.01 Hospital Discharge/Transfer Policy for

Medicare Patients
- Quality, Compliance, and Ethics Program Charter

ATTACHMENTS:

Attachment A: Conflict of Interest Statement

GLOSSARY

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"**INTERQUAL**" means the McKesson product housed in Tenet's case management documentation system. INTERQUAL is utilized to provide objective feedback to physicians and hospitals on the Patient Status and Level of Care that may be appropriate for hospital patients. INTERQUAL is not a government product and serves only as a guideline to prompt feedback and discussion. The physician order determines Patient Status and Level of Care

"**Physician Advisor**" or "**PA**" means a physician working under contract with Hospital or in a medical staff position with authority delegated by the Utilization Management Committee for review of cases for clinical appropriateness and medical necessity of admissions, continued stays and services provided by Hospital.

"**Secondary Review**" means a clinical review performed by a physician on the Utilization Management Committee other than the ordering physician when INTERQUAL or other Tenet approved clinical screening criteria guidelines suggest a different Patient Status or Level of Care than that ordered.

"**Utilization Management Plan**" means the corporate plan that contains the essential requirements for the establishment and implementation of a utilization management process to ensure the quality, appropriateness and efficiency of care and resources furnished by the facility and medical staff. The purpose of the utilization management plan is to ensure that patients receive medically necessary and appropriate care at the appropriate time and in the appropriate setting.

Preface to

CONFLICT OF INTEREST STATEMENT

A copy of the final Conflict of Interest Statement is attached to be completed by UM Committee members. A conflict of interest (aside from ownership in the hospital) does not automatically disqualify a member from participating in any given review. Rather, the conflict is just a factor for the UM Committee Chairperson to evaluate when weighing decisions about specific member recusals. Language has been added to the form to clarify this point.

Two additional notes: 1) it is not mandatory that any hospital use this exact form - if other acceptable forms have already been developed and/or executed, that is fine; 2) it is suggested that each hospital have UM Committee members re-sign the Conflict of Interest Statement on an annual basis, and, of course, whenever a new member joins the UM Committee.

[NAME OF HOSPITAL]

UTILIZATION MANAGEMENT COMMITTEE

CONFLICT OF INTEREST STATEMENT

Effective Utilization Management is dependent upon a multidisciplinary team working together to ensure appropriate utilization of resources, while providing quality care to patients. To that end, and in order to avoid the appearance of any conflicts of interest between **[Hospital]** and any member of **[Hospital]**'s Utilization Management Committee ("UM Committee") and in accordance with Medicare Conditions of Participation set forth at 42 CFR § 482.30, no UM Committee member ("Member") may have a direct financial interest in **[Hospital]**. Direct financial interest is defined as an ownership interest in the hospital through stock or otherwise. In addition, no Member may participate in the review and/or authorization of clinical cases in which he or she is the primary care giver, is a participant in a specific situation under review, or has any involvement either in the case or with the practitioner that would impact him or her personally, professionally, or financially.* By signing below, Member acknowledges that no current conflict of interest or potential conflict of interest exists and agrees to notify the Chairperson of the UM Committee if any actual or potential conflict shall arise, and agrees to abide by the decision of the Chairperson, including a request that the Member recuse himself or herself from the review of the clinical case in question.

Name of Member: _____

Signature of Member: _____

Date: _____

*Examples of potential conflicts of interests that should be reported to the UM Committee Chairperson:

- Member is related to the treating or consulting practitioner on the clinical case
- Member is in a group practice with the treating or consulting practitioner on the clinical case
- Member is related to the patient who is the subject of the clinical case
- Member is a competitor of the treating or consulting practitioner on the clinical case

Please note that this list is not exhaustive, nor does the inclusion of any relationship listed below necessarily constitute a conflict. The idea is to disclose matters which may raise a conflict so that they may be evaluated.