

# The Hospital Guide to Contemporary Utilization Review

**Stefani Daniels, RN, MSNA, ACM, CMAC**  
**Ronald L. Hirsch, MD, FACP, CHCQM**

The  
**Hospital Guide**  
to **Contemporary**  
**Utilization Review**

**Stefani Daniels, RN, MSNA, ACM, CMAC**  
**Ronald L. Hirsch, MD, FACP, CHCQM**

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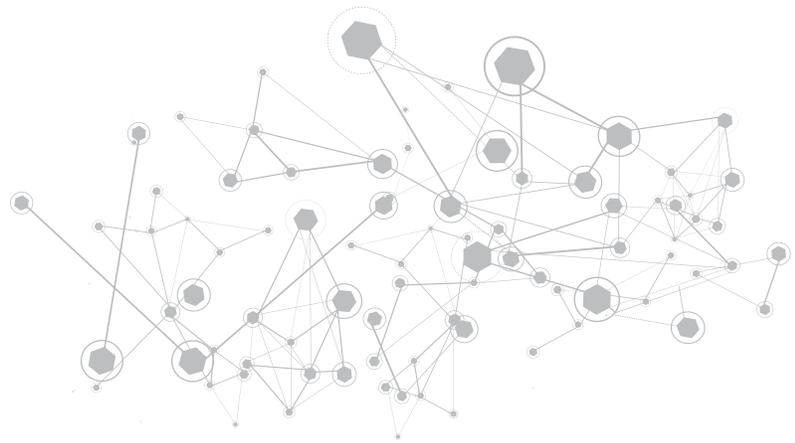
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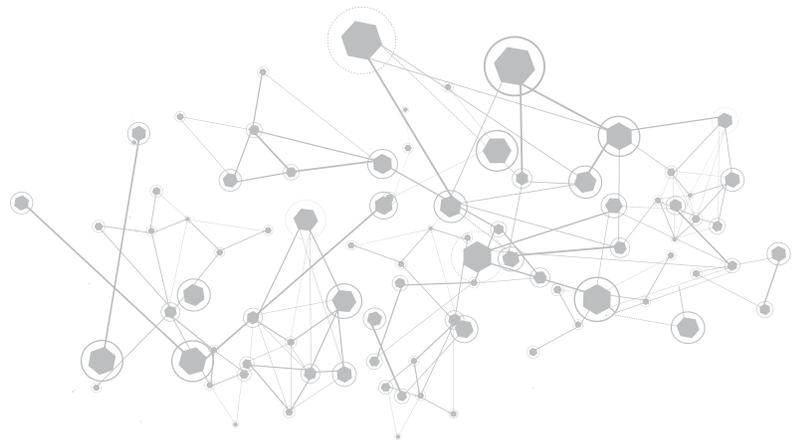
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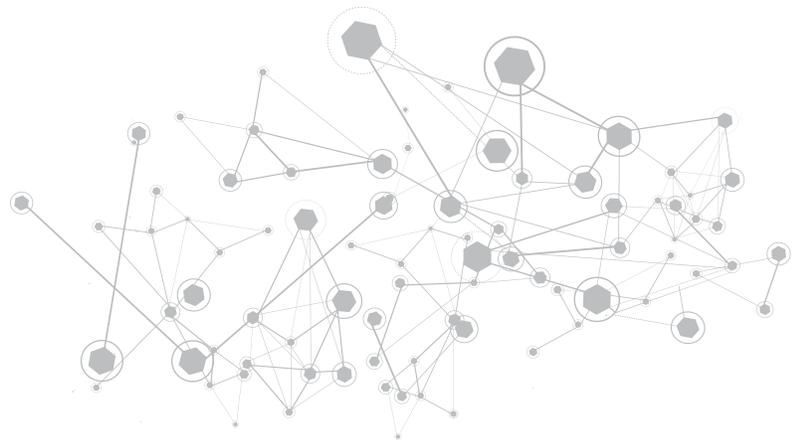
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# Continuing Education

## Contents

- Target Audience
- Statement of Need
- Learning Objectives
- Contact Hours
- Disclosure Statement
- Instructions

## Target Audience

- Case managers
- Utilization review (UR) coordinators
- UR committee members
- UR physician advisors
- Nurse managers
- Revenue cycle managers
- Compliance officers and auditors
- Healthcare lawyers and consultants

## Statement of Need

This book guides facilities through the steps necessary to establish a formal UR process, including tools organizations need to maintain compliance with CMS mandates relating to the utilization review process. The book describes the evolution of the UR process and provides suggestions on methodologies to meet the current regulatory requirements for the UR process and UR committee. Additionally, the book provides guidance on incorporation/partnerships/synergy between UR, case management, and revenue cycle.

## Learning Objectives

At the conclusion of this continuing education activity, the learner will be able to:

1. Identify the components of a best practice hospital UR program
2. Describe the legal obligations of the hospital to comply with chapter 42 *CFR* 482.30 of the Conditions of Participation (CoPs)
3. Use the publication as a tool to assess his or her own hospital's UR processes
4. Summarize the benefits of a dedicated UR team to promote compliance with the CoPs
5. Facilitate the development of a contemporary UR committee
6. Assess an organization's opportunities to improve processes to benefit patient care and hospital success
7. Recommend compliant language for the organization's UR plan
8. Collaborate with the organization's contract manager on a commercial contract that promotes partnerships for appropriate use of acute care resources
9. Seek out operational resources to perform high-quality reviews that fully comply with the CoPs
10. Explain the connection between a good UR plan and the hospital revenue cycle initiatives

## Contact Hours

HCPPro is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This educational activity for three nursing contact hours is provided by HCPPro.

Nursing contact hours for this activity are valid from April 27, 2015, through April 27, 2017.

This program has been pre-approved by the Commission for Case Manager Certification to provide continuing education credit to CCM board certified case managers. The program is approved for nine CE contact hours.

## Disclosure Statement

The planners, presenters/authors, and contributors of this CNE activity have disclosed no relevant financial relationships with any commercial companies pertaining to this activity.

## Instructions

In order to successfully complete this CNE activity and be eligible to receive your nursing contact hours for this activity, you are required to do the following:

1. Read this book, *The Hospital Guide to Contemporary Utilization Review*
2. Go online to: <http://app.keysurvey.com/votingmodule/s180/f/727103/1114/>
3. Complete the exam and receive a passing score of 80% or higher
4. Complete and submit the evaluation
5. Provide your contact information at the end of the evaluation

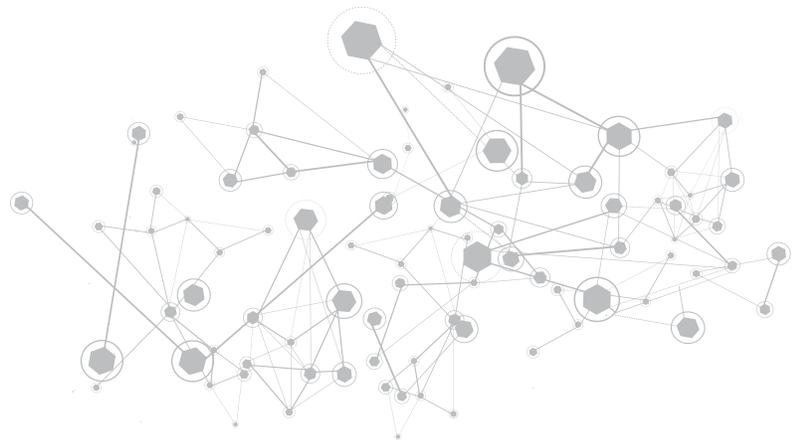
A certificate will be emailed to you immediately following your submission of the evaluation and successful completion of the exam. Please retain this email for future reference.

### NOTE

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## CHAPTER 1

# History of Utilization Review

### LEARNING OBJECTIVES

1. Differentiate between utilization review and utilization management
2. Discuss the history of utilization review

## Introduction

For staff members in case management, the business office, or the medical records department, the mention of the words utilization review (UR) draws a collective groan. For physicians, it's a reminder of their distrust of the insurance companies who are just trying to stick it to them, or of the avoidance tactics that kick in automatically when they see the "UR police" approaching them in the hospital hallway.

Many argue that the UR process can be tedious and intimidating and that working with the insurance companies on behalf of the patient, the physician, and the hospital is a frustrating exercise pitting the providers against the payers. The medical staff are frustrated by the payer reviewers and don't understand why their judgment is being called to task, when all they want is to ensure the patient's well-being. Physicians grumble about the intrusions and challenges they constantly encounter by the hospital's UR specialists, clinical documentation improvement specialists, case management medical directors or physician advisors, the government, and the insurance companies. They don't believe that good documentation is a cornerstone of good care. They are privately—and sometimes publicly—annoyed when they perceive that someone else is questioning their professional judgment.

Despite their siege mentality, physicians know that UR is essentially an audit of their documentation. Without a crystal ball, the payers and regulators who are looking over the physician's shoulder and overseeing the hospital's compliance processes depend upon that documentation to evaluate the appropriateness and medical necessity of a treatment, test, procedure, or hospitalization. UR has come a long way since the early days when physician and nurse reviewers relied on clinical experience to make decisions. Now, clinical policies, evidence-based protocols, and nationally recognized guidelines go a long way toward standardizing the review process.

## **Terminology: Is It Utilization Review or Utilization Management?**

Over the years, the use of the terms UR and utilization management (UM) became synonymous, which created confusion at hospitals. They are often used interchangeably and no consistent definition exists to distinguish one from the other. However, there are subtle differences between UR and UM in the real world of hospital operations, and each implies different obligations.

Typically, it's best to think of UM as a term to denote the full spectrum of all the strategies and initiatives that a hospital has put in place to ensure operating efficiency and appropriate use of hospital resources, all of which are owned by the hospital for the care of the community it serves. Generally speaking, UM initiatives tend to be prospective or concurrent activities that focus on resource use relative to patient outcomes and delivery of care efficiencies.

To orient your organization on the differences between UM and UR, consider using the RIGHT rule: UM consists of all the activities that are in place to ensure that the patient gets the right care, in the right place, at the right time, every time! As hospitals continue to work toward maximizing efficiency, UM increases, yet remains confusing to many hospital associates who stubbornly equate it with UR. For that reason, many hospitals are using the term clinical resource management (CRM) or simply resource management to distinguish the broad scope of UM from the more specific activities of UR.

The broad category of CRM or UM initiatives intended to drive efficiency rely upon a rigorous focus on performance outcomes throughout the hospital or healthcare system and may include:

- Monitoring of imaging services
- Concurrent and retrospective oversight of pharmaceutical usage
- Antimicrobial stewardship
- Blood product usage

- Use of evidence-based protocols and clinical guidelines
- Monitoring timeliness of delivery of care processes
- Identifying patient flow bottlenecks and barriers
- Facilitating transitions of care
- Cost oversight
- Access management processes

For example, the hospital may initiate a resource management program in collaboration with the radiology department to monitor the use of imaging technologies. The program may have mechanisms in place to screen the appropriateness of the ordered test in relation to the patient's current medical condition and comorbidities and the expressed intent of the test. Similarly, if a physician orders CT scans with and without contrast, a radiologist would review the need for the patient to undergo both scans. If the radiologist finds that the physician's clinical question may be answered by just one scan, he or she would contact the physician for a clarification order. Likewise, if a physician prescribes a costly medication when a less costly one is available and appropriate for the expressed need, the pharmacy director may call the prescribing physician to discuss alternative pharmaceuticals. In each of these cases, a peer-to-peer conversation might take place to discuss more appropriate and cost-effective options. (Today, given the quickly developing sophistication of electronic decision support systems, the screening process is often done electronically through the use of integrated evidence-based criteria.)

An example of UM geared toward improving efficiency may include a hospital working to centralize previously decentralized pre-admission, admission, and registration activities. This may allow personnel to consistently monitor access to inpatient and outpatient services and ensure compliance with federal, state, and contractual medical necessity. Likewise, greater efficiency might be achieved and patient flow improved if the hospital objectively examines the costs associated with the absence of clinical services on the weekends.

A front-burner issue in terms of UM strategies is the use of medically-endorsed evidence-based protocols. The protocols are generally created internally through the hospital's medical staff performance or quality improvement committees. Recommendations from professional societies and accepted medical research are incorporated into evidence-based protocols to be used as a guideline for delivery of patient care services to a selected group of patient populations. Concurrent monitoring of the use of resources against the protocols would be another UM initiative. This could be done on a real-time basis to provide the physicians with immediate feedback to improve their practice, or it can be done retrospectively as part of an effort to use analytics to drive performance improvement.

UR generally refers to the tools and methodologies hospitals and payers use to ensure appropriate use of acute hospital level of care. It is a tool used by the payer to determine whether the proposed or provided service meets medical necessity requirements under the patient's health plan. Initially, the payers or their contracted UR companies conducted all UR activities; the hospital UR specialist simply regurgitated information from the medical record to the payer representative on the other end of the phone. But over the years, with the modifications in payment models and the introduction of the Medicare and Medicaid programs, incremental changes were built into the process. Today, the reviewer must be well versed in the rules and regulations governing admission and continuing-stay policies for both the public and private sector.

There are as many definitions of UR as there are insurance companies, professional societies, and healthcare organizations. The most common definition comes from URAC, formerly the Utilization Review Accreditation Commission, a nonprofit accreditation agency that promotes review standards and guidelines for payers and third-party administrators to ensure that these organizations follow a process that is based on clinically sound review criteria. URAC defines UR as “the process where organizations determine whether health care is medically necessary for a patient or an insured individual.” According to the Institute of Medicine, UR is a “set of techniques used by or on behalf of purchasers of health benefits to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision” (Field & Gray, 1989). The process can be concurrent, as it usually is in the emergency department (ED), or prospective, as it is for elective procedures. In general in the hospital industry, UR is considered a retrospective assessment of the necessity and appropriateness of the allocation of acute care resources based on the documented certification of the patient's need for those services.

For the purposes of this book, the prospective, concurrent, and retrospective processes of UR will be our foci (see Figure 1.1).

**Figure 1.1****Utilization Review Activities**

- Prospective reviews of medical necessity are generally reserved for patients scheduled for elective procedures, transfers from other facilities or outpatient areas within an organization, or requests for direct admissions.
- Concurrent reviews of medical necessity are predominantly reserved for the ED where real-time conversations between the emergency physician, the admitting physician, and the utilization review specialist can result in decisions that best meet the patient's immediate needs. In addition to assessing medical necessity, concurrent reviews provide the opportunity to encourage accurate documentation of the patient's clinical condition, influence use of a medical protocol for selected diagnoses, initiate core measure compliance, and identify any present on admission indicators.
- Retrospective reviews to determine the appropriateness of continuing acute level of care are retrospective activities heavily dependent on the content and completeness of medical documentation.

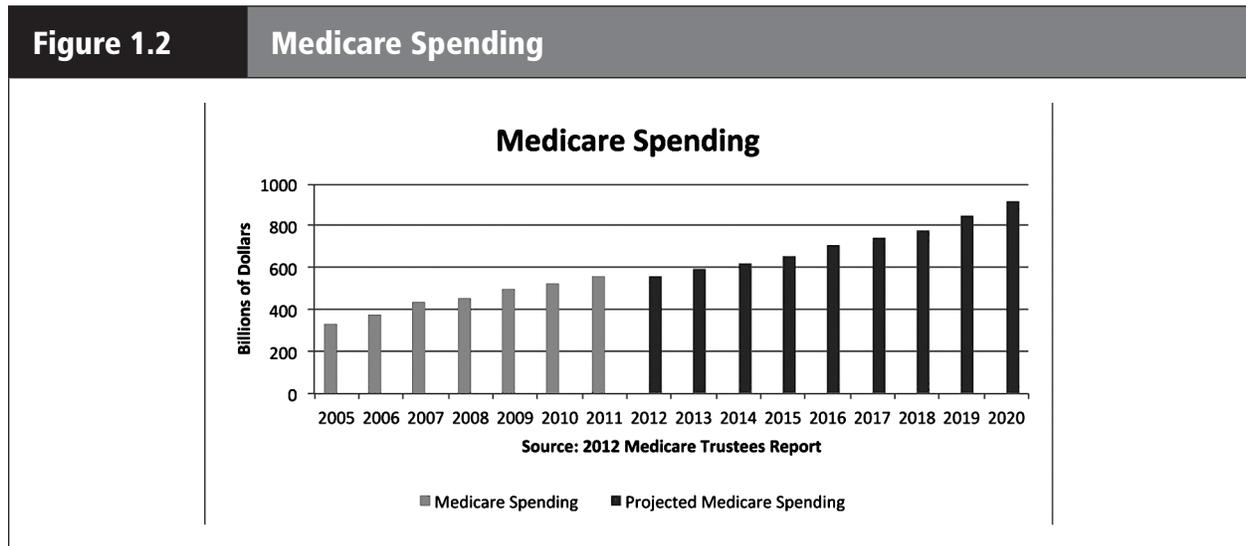
## History of Utilization Review

With the signing of H.R. 6675 in 1965, President Johnson authorized title XVIII of the Social Security Act: health insurance to almost all Americans age 65 or older. A payroll tax paid by employees, employers, and the self-employed funded Part A. On the other hand, Part B was a voluntary program open to all aged citizens and legal aliens who paid a monthly premium of \$3, which was estimated to be enough to fund 50% of Part B costs with federal revenues covering the remainder. Both programs sought to fill the gaps created by private insurance, which did not offer coverage to high-risk, elderly Americans or low-income individuals.

Before Medicare and Medicaid, the two-way relationship between the physician and the patient determined what acute care services the patient would receive. Having paid their premiums, the patients received those services and the insurer reimbursed the patient or paid the hospital directly. After the introduction of Medicare and Medicaid in 1966, the two-way relationship between the physician and the patient turned into a three-sided triangle where the insurer not only contracted with the patient, but also with the physicians and the hospitals. As the new player in the relationship, and the entity statutorily responsible for the appropriate use of taxpayer funds, the payer assumed the right to monitor the reasonableness and appropriateness of the services being provided.

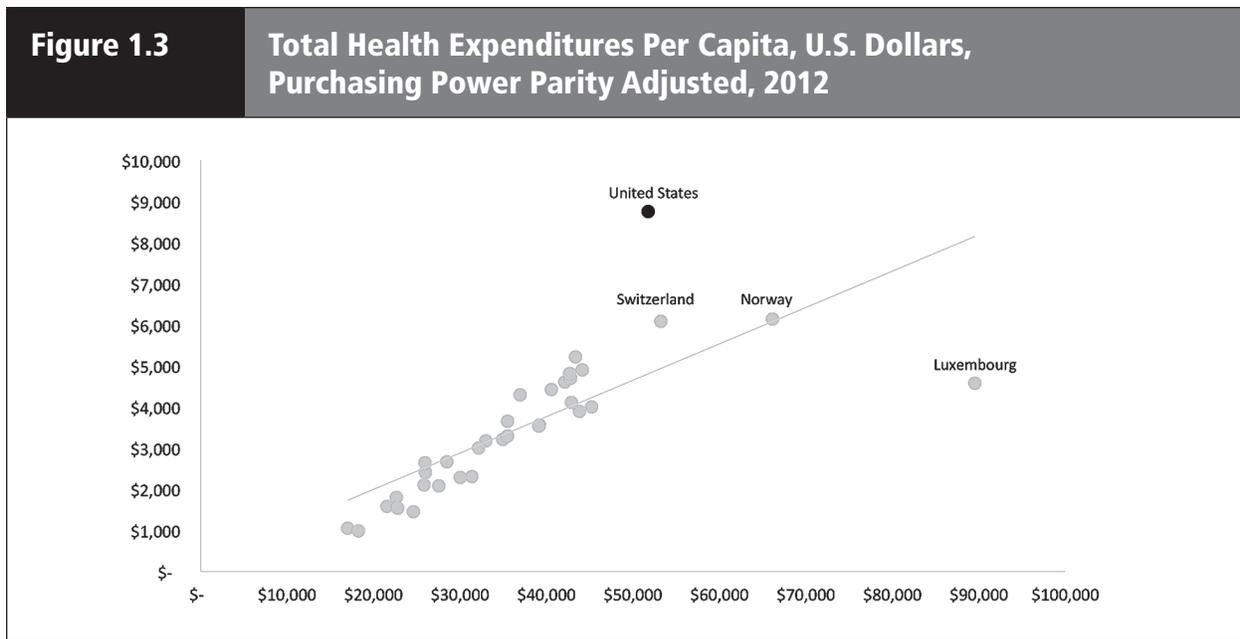
Almost immediately following its July 1, 1966 implementation, Medicare's expenditures exceeded the original estimates and continued to accelerate rapidly due to rising costs and the slow and steady increase in the number of beneficiaries (see Figure 1.2). The same increase in Medicare and Medicaid costs was also noted on the commercial side. As a result, healthcare spending in

2013 reached the unsustainable level of 17.2% of the nation’s gross domestic product (GDP). When someone asks you why we have a healthcare crisis, point to the fact that when 17.2% of the GDP goes to a single commodity, it leaves very little for everything else—schools lay off teachers, roads and bridges don’t get fixed, and libraries close. Figure 1.3 illustrates healthcare spending in the United States compared to other countries.



Source: Centers for Medicare and Medicaid Services.

Concurrent with the introduction of Medicare and Medicaid, private commercial insurers began to take a harder look at ways to curb increasing healthcare costs and introduced the concept of “medical necessity” in their contracts. “The vagueness of the term served providers and insurance companies well because it provided flexibility needed to make discrete coverage decisions” (Berghold, 1995). Essentially, coverage decisions were based on the medical judgment of the practicing physician.



Source: Kaiser Family Foundation analysis of 2013 OECD data: "OECD Health Data: Health expenditure and financing: Health expenditure indicators", OECD Health Statistics (database). doi: 10.1787/data-00349-en (Accessed on June 25, 2014). Notes: Because 2012 data was unavailable, 2011 total health expenditures per capita were used for Australia, the Netherlands, New Zealand, Portugal, and Spain. Health expenditures for Canada, Finland, Iceland, Japan, Slovenia, and Switzerland are estimated values. New Zealand health expenditure data reflect a difference in methodology.

The rapid escalation of Medicare and Medicaid costs is generally categorized into three causative factors:

- General inflation
- Increase in the volume of beneficiaries
- Increased intensity of services

It was the latter category, intensity of services, which accounted for expenses associated with the following:

- New technology
- New and more costly pharmaceuticals
- An increase in the use of selected services
- The use of more costly care when less costly services are available
- The misuse or overuse of services

These were major cost drivers and soon after the escalation of Medicare and Medicaid costs, states adopted regulations with different definitions of medical necessity largely based on

accepted medical practice. Several states subsequently added cost-effectiveness to their criteria for determining medical necessity.

The federal government made further regulatory and legislative efforts to gain better control over expenses and in 1969, “Congress created a new system for controlling services financed by Medicare and Medicaid. The original Medicare law had required hospitals to set up committees of their medical staffs to review whether services were actually necessary. But these UR committees, as they were called, had no formal criteria for evaluation, no power to deny payment, and no incentive to be effective” (Starr, 1992).

Persuaded by the American Medical Association in 1972 to let physicians monitor physicians, the federal government enacted Public Law 92-603, which included an amendment for the creation of physician-controlled, regional Professional Standard Review Organizations (PSRO) to monitor the quality and cost of medical services performed under Medicare and Medicaid. The PSRO was a system of UR committees run by medical organizations and based on peer review. “Medicine, as a profession, should accept the task of advising the individual physician where his pattern of practice indicates that he is over-utilizing hospital or nursing home services, over-treating his patients, or performing unnecessary surgery” (Professional Standards Review Organizations Committee on Finance, 1974).

The law went on to state that, “Government should not have to review medical determinations unless the medical profession evidences an unwillingness to properly assume the task” (Professional Standards Review Organizations Committee on Finance, 1974). However, the PSROs turned out to be a pricey venture and disappointed federal policymakers. They did not succeed in curbing costs and there is no evidence in the medical literature—or based on the personal experiences of your authors—that the organized medical community showed any real concern for monitoring utilization or decreasing costs. And so, “Where organized medicine is unwilling or unable to assume the responsibilities of a PSRO, or where performance of a particular organization is only pro forma or token ... the Secretary [of Department of Health, Education, and Welfare, a precursor to HHS] would arrange for the designation of another private or public organization or agency which has the professional competence to undertake the necessary functions” (Professional Standards Review Organizations Committee on Finance, 1974). Congress allowed the PSRO structures to sunset and in 1982, as part of the Tax Equity and Fiscal Responsibility Act (TEFRA) PL 97-248, professional review organizations (PRO) replaced the PSRO.

Medical decisions that had been the exclusive domain of the physician and patient were now going to be evaluated by an external reviewer who was accountable to the CMS program. The PROs assumed binding review for hospital services in accordance with Conditions of Participation (CoPs) 42 *CFR* §482.30 to ensure that healthcare services provided under Medicare and Medicaid were “medically necessary, conformed to appropriate professional standards, and were delivered

in the most efficient and economical manner possible” (*Federal Register*, 1984). In 2002, the PROs were renamed Quality Improvement Organizations (QIO), and most recently they morphed into beneficiary and family-centered care contractors as part of the recent quality improvement network and QIO restructuring.

By whatever name you call it, the processes used to evaluate the reasonableness and appropriateness of a medical intervention prescribed by physicians is by its very nature, a challenging position for anyone committed to advocating for the patient, the hospital, or the community. Although some organizations have been operating with closed medical staffs for decades and have consistently demonstrated thoughtful resource stewardship, many hospital cultures are not prepared to take the necessary steps to safeguard the use of the facility and the services it offers for patients qualifying for acute level of care.

UR and UM are no longer perfunctory activities; both are critical factors, as the dynamics of the marketplace change and new delivery-of-care and payment models are introduced. The importance of the UR specialist role will continue to grow, and the role UR specialists play will be integral in helping their facilities succeed. This book is intended to promote that growth by sharing insights, information, and best practices about UR to help the reader question past assumptions, prompt discussions, and generate new ideas.

# The Hospital Guide to Contemporary Utilization Review

Stefani Daniels, RN, MSNA, ACM, CMAC  
Ronald L. Hirsch, MD, FACP, CHCQM

*The Hospital Guide to Contemporary Utilization Review* is a comprehensive resource designed to identify utilization review (UR) best practices and provide guidance about developing and enhancing a contemporary UR committee. This book focuses on the latest UR and patient status requirements to help hospitals perform high-quality reviews and comply with regulations.

The book covers a range of topics, including compliance with the UR *Conditions of Participation*, legal obligations of a hospital, contract language, and compliant UR plan language to provide an understanding of the expectations of a UR program. Tips for interdepartmental collaboration are included to guide professionals through the process of selecting a physician advisor and partnering with nurses, case managers, and revenue cycle team members.

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