RESOLUTION OF THE BOARD OF DIRECTORS OF
THE UNIVERSITY OF WISCONSIN HOSPITALS AND CLINICS AUTHORITY

APPROVAL OF CREATION OF UWHC UTILIZATION REVIEW COMMITTEE

Whereas, University of Wisconsin Hospitals and Clinics Authority ("UWHCA") will be well served by creating a formal Utilization Review Committee; and

Whereas, the creation and operation of such a Utilization Review Committee is encouraged or required by Joint Commission rules, federal law and Wisconsin state law;

Now, Therefore, the UWHCA Board hereby approves the creation and operation of the UWHC Utilization Review Committee as described in the charter therefore as attached hereto.

November 5, 2014

UW Health
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UWHC Utilization Review (UR) Charter

DRAFT: September 24, 2014

Pending approvals from:	Approval Goal Date	
Completed: **Medical Board**	8/14/14	
Completed: **UWHC Administration**	9/12/14	
UWHC Authority Board	11/5/14	Dan Weissburg via Audit Committee

I. Purpose

The Utilization Review (UR) Plan, referred to by UWHC as the UR Charter, provides for review of services furnished to all patients, regardless of payer, to help ensure that quality patient care is provided in the most appropriate, cost effective manner.

UWHC's UR Charter is designed to meet the following:

- Federal Medicare Conditions of Participation for UR in CFR 42 §482.30.
- State Medicaid UR requirements in DHS 124.11.
- Joint Commission Legal and Regulation Compliance Standard LD.04.01.01, EPs 17 and 18.

II. Policy

The UR Charter is administered by a multidisciplinary committee that works collaboratively to help ensure appropriate use of resources and services for the optimal health benefit of patients and at reasonable costs to the patients, hospital, and third party payers. The UR Charter is approved by the medical staff, administration, and the UWHC Authority Board (Board) and is reviewed annually and revised as needed. The Board has delegated to the UR Committee the authority and responsibility to carry out the UR functions. UR Committee core and other members maintain the confidentiality of all utilization review activities, including any findings and recommendations.

III. UR Committee

The UR Committee is a problem solving, action group consisting of a core group of members plus additional individuals as the situation requires. UR Committee core and other members:

- Do not have a direct financial interest in the hospital (i.e., ownership of 5% or more).
- Are not involved in the care of the patient whose case is being reviewed.

The UR Committee core group includes:

- Director of Coordinated Care
- Two internal physicians designated as UR advisors
- Director of Access Services
- Compliance and Privacy Officer
- Director of Internal Audit
- Outcomes Manager*
- Billing Manager
- Medicare/Medicaid Utilization Coordinator
- Program Manager – Medicare/Medicaid UR

*All other Outcomes Managers are members of the UR Committee as needed.

The UR Committee is co-chaired by the Director of Coordinated Care and an Internal Physician Advisor. The UR Committee core group meets quarterly with a focus on oversight and process/system improvement. UR Committee meeting minutes reflect the quarterly activities performed.

IV. Reviews

Reviews are performed at the following times to:

- Help ensure that quality patient care is provided in the most appropriate, cost effective manner.
- Help ensure that claims for reimbursement of services are accurately submitted.

A. Pre-admission Review

Reviews of scheduled surgical and medical admission are performed by the Access Services team.

B. Admission Review

Each admission is subject to review by a Registered Nurse Case Manager (RN CM) within 24 hours of admission for: medical necessity and appropriateness for hospital care; initiation of discharge planning; and appropriate admission status.

C. Continued Stay Review

Throughout the length of stay, RN CMs monitor each admission to: help ensure optimal efficiency and effectiveness of care and discharge planning; identify and record avoidable days; and facilitate a change in admission status as needed.

D. Extended Stay Review

An extended stay is defined as an admission of 15 or more days. These cases are reviewed weekly in the *Long Stay Meeting* by a multi-disciplinary team that includes some members of the UR Committee core group and Outcome Managers. *Long Stay* meeting minutes include members in attendance, decisions made, and actions taken.

E. UR Committee Reviews

- ***Review of Professional Services***
  - Admissions identified from multiple sources, including Extended Stay and Retrospective reviews, are reviewed by members of the UR Committee to evaluate the medical necessity of hospital care and efficient use of resources and services.
  - Avoidable Day and other UR-related reports are reviewed to: identify process gaps and system delays; identify opportunities for improvement; facilitate process and system improvements to ensure the most efficient use of resources and services; and evaluation of actions taken.
  - When other real or potential utilization-related issues are identified, ad hoc reviews are performed with activities including: analysis and profiles and patterns of care; feedback to the medical staff of the results of the profile analysis; documentation of specific actions taken to correct aberrant practice patterns or other utilization review

problems; and evaluation of the effectiveness of action taken.

- ***Medical Necessity Decisions***
  When the UR Committee identifies an inpatient admission that is not medically necessary, the attending physician is notified and afforded the opportunity to present his/her views before the final determination is made. Determination that such an admission is not medically necessary:
  – May be made by one member of the UR Committee if the attending physician concurs.
  – Must be made by two members of the UR Committee if the physician does not concur.

  When the UR Committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than two days after the determination, to the patient, and attending physician.

F. Retrospective Review

- Medicare and Medicaid short-stay admissions are reviewed by UR RNs to ensure the appropriateness of the status order (inpatient or outpatient) for accurate claim submission.
- Admissions identified from multiple sources, including government post-payment reviews, are reviewed by UR RNs to evaluate: medical necessity; efficiency of care; and/or appropriateness of admission status for accurate claim submission.
- The Denial Management team reviews admissions that are denied by commercial payers.

V. Approval/ Review

Senior management sponsor: Senior Vice President Medical Affairs

Author: Program Manager – Medicare/Medicaid UR

Reviewed by: Director of Coordinated Care
Director of Internal Audit
Compliance and Privacy Officer

Approved by/date:

- **Board:**
- **Administration**: September 12, 2014.
- **Medical Staff:** August 14, 2014

Reviewed at least once every three years by: UR Committee

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Utilization Review (UR) Plan Requirements

May 27, 2014

Joint Commission

- The hospital has a UR plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. (Legal and regulation compliance Standard LD.04.01.01, EP 17.)
- UR activities are implemented by the hospital in accordance to this plan. (Legal and Regulation Compliance Standard LD.04.01.01, EP 18.)

SURVEY PROCEDURES

UR Plan

- Determine that hospital has UR plan and verify that:
  - UR activities as described in plan are being performed.
  - UR committee minutes include dates, members in attendance, and extended stay reviews with approval or disapproval noted in a status report of any actions taken.

UR Committee

- Determine the composition of the UR committee.
- Determine that the governing body has delegated to the UR committee the authority and responsibility to carry out the UR function.
- Verify that UR Committee members:
  - Are not financially involved in the hospital (ownership of $\geq$ 5%).
  - Are not participants in the development or execution of the patient's treatment plan.

Medical Necessity Decisions

- Determine if the medical necessity for Medicare and Medicaid patients is reviewed with respect to admission, duration of stay, and the professional services furnished.
- Review a sample of medically necessary decisions involving admissions or continued stay that are not medically necessary and determine that these decisions are made by: one member of the UR committee if the physician concurs; or at least two member of the UR committee in all cases not qualified under the above.
  - Verify that the providers were informed of the UR Committee's expected decision and were given an opportunity to comment.
  - Verify that all involved parties are notified of the decision that care is medically not necessary no later than two days following the decision.

Extended Stays

- Review facility's definition of extended stay in the UR plan.
- Verify that UR plan requires periodic reviews of: each current Medicare/Medicaid inpatient admission that is reasonably assumed to be an outlier case; and extended stays that exceed the outlier threshold for the diagnosis.

Review of Professional Services

- Determine that the committee performs reviews of professional services related to medical necessity and efficient use of available health facilities and services. Possible topics include:
  - Availability and use of necessary services – underused, overuse, appropriate use.
  - Timeliness of scheduling of services – operating room diagnostics.
  - Therapeutic procedures.

Federal UR Requirements (CFR 42 §482.30)

Condition of Participation: Utilization Review

Hospital must have UR Plan that provides for review of services furnished to patients entitled to benefits under Medicare and Medicaid programs.

UR Committee

- UR Committee consisting of two or more practitioners must carry out the UR function. At least two members of the committee must be doctors of medicine or osteopathy.
- The committee's reviews may not be conducted by any individual who: has direct financial interest in that hospital; or was professionally involved in the care of the patient whose case is being reviewed.

Scope and Frequency of Review

- Review of Medicare and Medicaid patients with respect to the medical necessity of:
  - Admissions.
  - Durations of stays.
  - Professional services.
- Review of admissions may be performed before, at, or after hospital admission.
- Reviews may be performed on a sample basis.
- For duration of stays, may review only cases that reasonably appear to be outlier cases based on extended length of stay.
- For professional services, may review only those cases that reasonably appear to be outlier cases based on extraordinarily high costs.

Determination Regarding Admissions or Continued Stays

- Determination that an admission or continued stay is not medically necessary:
  - May be made by one member of the UR Committee if the practitioner or practitioners responsible for the care of the patient concurs.
  - Must be made by at least two members of the UR Committee in all other cases.
- Before making a determination that an admission or continued stay is not medically necessary, the UR committee must consult the provider(s) responsible for the care of the patient and afford the provider(s) the opportunity to present their views.
- If the UR Committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than two days after the determination, to the hospital, the patient, and the provider(s).

Extended Stay Review

- UR committee must review all cases reasonably assumed to be outlier cases because the extended length of stay exceeds the threshold criteria for the diagnosis. Not required to review an extended stay that does not exceed the outlier threshold for the diagnosis.
- UR committee must review professional services provided, to determine medical necessity and to promote the most efficient use of available facilities and services.

State UR Requirements (DHS 124.11)

UR Plan

- Every hospital shall have in operation a written utilization plan designed to ensure that quality patient care is provided in the most appropriate, cost-effective manner. UR program shall address potential over-utilization and under-utilization for all categories of patients, regardless of source of payment.

Description of Plan

- Delineation of responsibilities and authority of persons involved in the performance of UR activities, including members of the medical staff, any UR committee, non-physician health care professionals, and administrative personnel.
- Conflict of interest policy stating that reviews may not be conducted by any person who has a proprietary interest in any hospital or by any person who was professionally involved in the care of the patient whose care is being reviewed.
- Confidentiality policy applicable to all utilization review activities, including any findings and recommendations.
- Description of the process by which the hospital identifies and resolves utilization-related problems, such as examining the appropriateness and medical necessity of admissions, continued stays and supportive services, as well as delays in the provision of supportive services. The following activities shall be incorporated into the process:
  - Analysis of profiles and patterns of care.
  - Feedback to the medical staff of the results of profile analysis.
  - Documentation of specific actions taken to correct aberrant practice patterns or other utilization review problems.
  - Evaluation of the effectiveness of action taken.
- Procedures for conducting review, including timeframes for admission and continued stay reviews.
- Mechanism for provision of discharge planning. DHS 124.05(2)(j)

Responsibility for Performance

- UR plan approved by: medical staff (responsible for performance of UR); and administration and governing body (responsible for ensuring that plan is effectively implemented).

Reviews

- Written measurable criteria approved by medical staff.
- Medical necessity determinations based on information documented in medical record.
- Attending physician shall be notified whenever it is determined that an admission or continued stay is not medically necessary and shall be afforded the opportunity to present his/her views before final determination is made. At least 2 physician reviewers shall concur on the determination when the attending physician disagrees.
- Written notice of any decision that an admission or continued stay is not medically necessary shall be given to appropriate hospital department, the attending physician, and the patient no later than 2 days after determination.

Records and Reporting

- Records shall be kept of hospital utilization review activities and findings. Regular reports shall be made to the executive committee of the medical staff and to the governing body. Recommendations relevant to hospital operations shall be reported to administration.

Prepared by Becky Borchert, MS, RN
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