

2008 Utilization Management Adherence Audit

I. Utilization Management Committee Activity

IPA #/ NPI#

Date

Nurse Liaison:

Member survey by IPA score for referral satisfaction: _____ <83 REQUIRES CA

PCP survey score for PCP referral satisfaction: _____ <83 REQUIRES CA

	May 2008	Jun 2008	Jul 2008	Aug 2008	Sep 2008
MONTHLY REQUIREMENTS (10)					
Chair/members present (specialty representation) Match with specialty list. List matches:					
# Physicians at meeting (TOTAL):					
(3) # Specialists at meeting (1 OR >) :					
Minutes signed within 5 weeks of last meeting (1)					
Denials/ Appeals					
Denials reported consistent with log, include summary of categories (medically necessary, out-of-network, benefit), number in each category (5)					
Appeals reported consistent with log, include summary of categories (medically necessary, out-of-network, benefit), number in each category (5)					
Document number of inpatient case PA referrals and the number resulting in denial. (2)					
QUARTERLY REQUIREMENTS					
Complaints					
Complaints match log (3 months), number documented in minutes (include category, such as: access, referrals, PCP), resolution documented, timeframe met. Include BH. If no complaints, must be noted. (2)					
CMF Reporting					
Quarterly reports reviewed and discussed, including delegated BH and telephone reports, if applicable (2)					
Denial File Results					
Discussion of quarterly denial file results from HMO, any non-compliance and corrective action, if applicable (2)					

SEMI-ANNUAL REQUIREMENTS					
Utilization					
Track/trend utilization data (min 4 areas, including 1 BH) for 6 months, include planned interventions to address utilization issues (10)					
Discussion of trend, issues, planned interventions (5)					
Discussion of 6 month summary of avoidable days, reasons for delayed discharge, and any IPA physician patterns. Include corrective action for physicians with identified patterns. (5)					
Referrals					
2 Qtrs (6 months of data in graph or table format) for specialty (any identified and total), out of network, BH referrals (total) documented/maintained. Include interventions for identified trends. (10)					
Inter-rater Reliability					
Inter-rater for medical criteria for UM staff, includes # cases, # staff reviewed, results, discussion of corrective action (5)					
Inter-rater for medical criteria for Medical Director, Pas, includes # cases, # staff reviewed, results, discussion of corrective action (5)					
Inter-rater for UM decision-making timeframes. Summary of # staff reviewed, # cases, results and discussion of corrective action (5)					
ANNUAL REQUIREMENTS					
UM Plan					
Review and approval of MG/IPA UM Plan, including BH (2) OR if Delegated BH – include approval of BH UM Plan	Date:				
Medical Criteria					
Review and acceptance of nationally recognized medical criteria (2)	Date:				
Nationally recognized criteria used (current):					
Review and approval of MG additional criteria, guidelines, clinical pathways, etc. if applicable. Must include how developed and policy for use.	Date:				
Review and approval of BH medical criteria (2)	Date:				
BH criteria used:					
Medical Criteria (including BH) matches UM Plan					
Additional criteria matches UM Plan					
UM Program Evaluation					
Review and evaluation of UM program (8)	Date:				
Goals identified in UM Plan discussed/approved (2)					
Review and discussion of goals match UM plan (1)					
Evaluation of planned interventions for each goal, results, opportunities for improvement. New goals identified. (1)					

Review of UM Policy and Procedures (5 for applicable)					
UM staff onsite at facility, if applicable	Date:				
Staff orientation/ training/ performance review	Date:				
Diagnoses, procedures, physicians not requiring pre-certification and/or concurrent review, if applicable	Date:				
Additional criteria, clinical pathways, guidelines used for UM decision-making and the process for development and approval, if applicable	Date:				
Case closure due to insufficient information	Date:				
Standing referrals	Date:				
Appeals	Date:				
PHI	Date:				
Confidentiality	Date:				
Information systems, security, integrity, storage, disaster recovery	Date:				
Tracking avoidable days for IPA physicians and method for corrective action and non-compliance	Date:				
Hospitalist, Practitioner Rounder Program if applicable	Date:				
PCP Notification of Member of Approved Certification if applicable	Date:				
Reporting					
Review and discussion of HMO PCP UM Survey results with interventions if referral question less than 83% (1)					
Review and discussion of HMO member survey by MG referral question results with interventions if referral question less than 83% (1)					

Total possible score: 102 (Excluding CMF not applicable = 100)

Enter Medical Group/ IPA Name: _____

Enter MG/IPA Number: _____ Date of Audit: _____

Reviewer: _____

II. CASE FILE REVIEW

The Nurse Liaison will choose twenty cases from the MG/IPA admission logs while on site. The files will be chosen to reflect: four emergent, four concurrent, two behavioral health pre-service, two behavioral health concurrent, two skilled nursing facility, two home health, two cases with referrals to the physician advisor, and two long stay cases. Any type of case which is not available will be replaced with another type of case. The cases will be chosen from the last six months prior to the audit. Twenty cases will be reviewed to determine the MG/IPA case file score (140 points). Cases can be reviewed at the time of audit for assessment of the Hospitalist Program Criteria. Automatic audit points may be achieved with documented Hospitalist Program requirements (twice daily visits, AM and PM, by PCP or Hospitalist).

Note:

Case management cases will be audit separately and will not be scored for 2008.

Emergent (Initial) - 4 cases, 1 pt each box, total 32

	Case 1	Case 2	Case 3	Case 4	
Review/ cert. form completed within 24 hours of receipt of request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clinical documented with source	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Estimated length of stay documented (original and additional)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Medical criteria including code	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Member and Practitioner notification within time frame	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
All required elements documented: patient name, Patient ID, date of review, name of physician(s), diagnosis, procedure, admit date, facility name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge planning initiated on initial review, potential plan documented	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Home, family, environment assessment on initial review	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Case was reviewed by PCP or hospitalist in AM and PM every day of stay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA <input type="checkbox"/>

Concurrent - 4 cases, 1 pt each box, total 28

	Case 1	2	3	4	
First concurrent review form completed within 24 hours of receipt of request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Subsequent concurrent reviews 1 day prior to end of additional length of stay assigned	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA <input type="checkbox"/>
Clinical documented with source	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Additional estimated length of stay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA <input type="checkbox"/>
Medical criteria including code	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Practitioner notification within time frame, or MG policy assumes approval	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge need documented prior to estimated discharge date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Case was reviewed by PCP or hospitalist in AM and PM every day of stay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA <input type="checkbox"/>

Behavioral Health Emergent (Initial) - 2 cases, 1 pt each box, total 16
(If no behavioral health cases available, choose medical emergent cases)

	Case 1	Case 2	
Review/ cert. form completed within 24 hours of receipt of request	<input type="checkbox"/>	<input type="checkbox"/>	
Clinical documented with source	<input type="checkbox"/>	<input type="checkbox"/>	
Estimated length of stay documented (original and additional)	<input type="checkbox"/>	<input type="checkbox"/>	
BH Medical criteria including code	<input type="checkbox"/>	<input type="checkbox"/>	
Practitioner notification within time frame	<input type="checkbox"/>	<input type="checkbox"/>	
All required elements documented: patient name, Patient ID, date of review, name of physician(s), diagnosis, procedure, admit date, facility name	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge planning initiated on initial review, potential plan documented	<input type="checkbox"/>	<input type="checkbox"/>	
Home, family, environment assessment on initial Review	<input type="checkbox"/>	<input type="checkbox"/>	
Case was reviewed by PCP or hospitalist in AM and PM every day of stay	<input type="checkbox"/>	<input type="checkbox"/>	NA <input type="checkbox"/>

Behavioral Health Concurrent - 2 cases, 1 pt each box, total 16

(If no BH, choose medical concurrent)

	Case 1	Case 2	
First concurrent review form completed within 24 hours of receipt of request	<input type="checkbox"/>	<input type="checkbox"/>	
Subsequent concurrent reviews 1 day prior to end of additional length of stay assigned	<input type="checkbox"/>	<input type="checkbox"/>	NA <input type="checkbox"/>
Clinical documented with source	<input type="checkbox"/>	<input type="checkbox"/>	
Additional estimated length of stay	<input type="checkbox"/>	<input type="checkbox"/>	NA <input type="checkbox"/>
BH/ Medical criteria including code	<input type="checkbox"/>	<input type="checkbox"/>	
Practitioner notification within time frame, or MG policy assumes approval	<input type="checkbox"/>	<input type="checkbox"/>	
Documentation of PCP notification of BH care	<input type="checkbox"/>	<input type="checkbox"/>	
Appointment for follow-up care documented, within 7 days	<input type="checkbox"/>	<input type="checkbox"/>	
Case was reviewed by PCP or hospitalist in AM and PM every day of stay	<input type="checkbox"/>	<input type="checkbox"/>	NA <input type="checkbox"/>

Skilled Nursing - 2 cases, 1 pt each box, total 16

(If no skilled, choose pre-cert or emergent case)

	Case 1	Case 2	
Initial review summary documented within 7 days of admission	<input type="checkbox"/>	<input type="checkbox"/>	
Documented plan of review; for example, "case will be reviewed every 7 days"	<input type="checkbox"/>	<input type="checkbox"/>	
At least one concurrent review	<input type="checkbox"/>	<input type="checkbox"/>	
Clinical documented with source	<input type="checkbox"/>	<input type="checkbox"/>	
Estimated additional length of stay documented	<input type="checkbox"/>	<input type="checkbox"/>	
Documentation of care plan	<input type="checkbox"/>	<input type="checkbox"/>	
All required elements documented: patient name, patient ID, date of review, name of physician(s), diagnosis, procedure, admit date, facility name	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge planning initiated on initial review, potential plan documented	<input type="checkbox"/>	<input type="checkbox"/>	
Case was reviewed by PCP or hospitalist in AM and PM every day of stay	<input type="checkbox"/>	<input type="checkbox"/>	NA <input type="checkbox"/>

Home Health - 2 cases, 1 pt each box, total 10
 (If no home health, choose pre-cert or emergent case)

	Case 1	Case 2
Initial review summary documented within 24 hours of receipt	<input type="checkbox"/>	<input type="checkbox"/>
Clinical documented with source	<input type="checkbox"/>	<input type="checkbox"/>
Estimated number of HHC visits documented	<input type="checkbox"/>	<input type="checkbox"/>
Documentation of care plan	<input type="checkbox"/>	<input type="checkbox"/>
All required elements documented: patient name, patient ID, date of review, name of physician(s), diagnosis, procedure, admit date, facility name	<input type="checkbox"/>	<input type="checkbox"/>

Case Not Meeting Criteria, Referred to PA - 2 cases, 1 pt each box, total 10
 (If not applicable, choose concurrent review case)

	Case 1	Case 2
Documentation explains PA's decision to approve or deny	<input type="checkbox"/>	<input type="checkbox"/>
Date sent to PA	<input type="checkbox"/>	<input type="checkbox"/>
Determination of PA (approval, denial)	<input type="checkbox"/>	<input type="checkbox"/>
Determination within 24 hours of receipt of request	<input type="checkbox"/>	<input type="checkbox"/>
If PA approves continued stay, PA approved additional length of stay documented.	<input type="checkbox"/>	<input type="checkbox"/>

Long Stay Case - 2 cases, 1 pt each box, total 12

	Case 1	Case 2
Admission date AND initial date referred to PA documented	<input type="checkbox"/>	<input type="checkbox"/>
Home, family, environment assessment on initial review	<input type="checkbox"/>	<input type="checkbox"/>
Discharge planning initiated on initial review, potential plan documented	<input type="checkbox"/>	<input type="checkbox"/>
Clinical documented	<input type="checkbox"/>	<input type="checkbox"/>
Referral to PA for weekly review	<input type="checkbox"/>	<input type="checkbox"/>
Medical criteria continued to be met until discharge or weekly PA reviews for extension of length of stay	<input type="checkbox"/>	<input type="checkbox"/>

Informational (one check only)

*Discharged to SNF

OR

Discharged to HHC

OR

Discharged to home

OR

Patient expired

**Case was reviewed by PCP or hospitalist in
AM and PM every day of stay**

NA

TOTAL CASES REVIEWED _____

SCORE _____

*Not scored