

**MEDICAL ASSOCIATES HEALTH PLANS
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL
POLICY NUMBER: PP 62**

POLICY TITLE: PROCEDURE FOR VERIFYING UTILIZATION REVIEW
CONSISTENCY

POLICY STATEMENT: To verify consistency in the use of established Utilization Review criteria among Case Managers and to verify consistency in decision-making by Chief Medical Officer and Associate Medical Director/designated physician reviewer.

PROCEDURE

1. Utilization Review Criteria are referenced by the Case Managers conducting concurrent or retrospective hospital utilization review.
2. Daily reports of all hospital admissions, including diagnosis, procedure, length of stay tally, and concurrent review notes, are available to the Director of Health Care Services, Manager of Health Care Services/Quality Improvement (HCS/QI), and the Chief Medical Officer. These reports are reviewed based on established U.R. criteria.
3. Cases where the rationale for appropriate admission or continued length of stay is questioned will then be discussed by the Director of Health Care Services and/or the MAHP Chief Medical Officer with the Case Managers.
4. Cases are also discussed during monthly staff meetings as a team approach to identifying alternative treatment plans and/or case management opportunities. Results of these discussions are documented into the minutes of the staff meetings.
5. Suggestions for revisions to existing U.R. criteria are forwarded to the Utilization Management Committee for consideration of inclusion into the criteria.
6. Audit among U. R. Case Managers is completed annually. Director of Health Care Services, Manager, and Case Managers review Concurrent Review notes using existing UR criteria. The Case Manager performs reviews only on their peers. Any difference noted in reviews will be documented on the review form and reviewed by the Director of Health Care Services. Any issue of non-compliance will be discussed with the original reviewer and at a staff meeting so that consistency among reviewers will be achieved. If a trend is noted regarding failure to comply with UR criteria, and compliance is not achieved after discussion of UR criteria with the Director of Health Care Services and the reviewer in question, additional training will be provided. Failure to comply with UR criteria will be documented on the annual performance evaluation of the Case Manager and disciplinary action will be taken. Audit results are shared with staff and reported to Executive Director and Utilization Management Committee.
7. Audit among physician reviewer(s) is performed on a minimum basis of annually. Chief Medical Officer and Associate Medical Director review/designated physician reviewer "case scenarios" independently. Decisions are then reviewed for consistency by the Director of Health Care Services. If any discrepancy is found, it is reviewed/discussed among the Chief Medical Officer, physician reviewer(s) and the Manager of HCS/QI. Audit results are shared

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with staff and reported to the Utilization Management Committee.

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Manager of Health Care Services/Quality Improvement

Date

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Director of Health Care Services/Quality Improvement

Date

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