The Utilization Review Plan is the responsibility of the Medical Staff Peer Review Committee of Van Wert County Hospital as a standing committee of the Medical Staff. There will be at least two or more practitioners carrying out the UR function. Committee members may not be financially involved in the hospital (ownership of 5% or greater) nor be participants in the development or execution of the patients treatment plan. The plan has been approved by the Executive Committee of the Medical Staff and Governing Body.

The purpose of the Utilization Review Plan is to evaluate effective and appropriate utilization of health care resources and make recommendations for the optimum use of hospital resources and facilities. The Peer Review Committee Utilization review committee accomplishes this by monitoring appropriateness of admission, continued stays, use of ancillary services, and also reviewing trends of resource consumption by using objective criteria on how well professional medical care services, procedures, and facilities are being used.

The Peer Utilization Review Committee and its members shall:

1. Oversee the hospital-wide program of patient care and resource utilization of patients.

2. Review and recommend changes in the medical care criteria standards as established by the Medical Staff and to recommend changes in hospital procedures or Medical Staff practices as indicated by analysis of review findings. This will be an ongoing process.

3. Oversee admission certifications and extend stay review, as well as professional services. These reviews will be conducted on all patients admitted to the hospital, in accordance with applicable statutes and regulations. Review for medical necessity for admission, extended stay and professional services shall be rendered regardless of payer source.


5. The Medical Staff members of the Peer Review Committee will serve as Physician Advisors (PA) for the Case Managers.

6. Review and analyze data profiles that are received from peer review agencies and other external review agencies.

7. Annually review and, if necessary, revise the Utilization Review Plan.

8. Provide follow-up chart review and physician/clinical service education for Utilization Review issues, when necessary.

9. A function of the UR committee is to review long stay and cost outliers on a monthly basis. (cases will be reviewed at the next UR committee meeting following the patients discharge)
ADMINISTRATION

Van Wert County Hospital shall provide staff to perform the utilization function and will provide other resources as necessary to implement the Plan.

CASE MANAGEMENT DEPARTMENT

Admission and concurrent review on all patients will be conducted by the Case Management Department. The Case Management Department is responsible for the daily activity necessary to meet the regulations for review and responsibilities of the Plan. The Case Manager is responsible for efficient and effective functioning of the utilization review aspect of the department. The Case Management Department reports to the Vice President of Nursing Services.

REVIEW PROCESS

Admission review shall be conducted on predetermined patients within one working day of admission (Monday-Friday). The determination of the need for admission is based on written criteria and standards. The following criteria sets will be used:

1. Severity of Illness; Intensity of Service
2. Surgical Necessity Criteria (Inpatient only List)
3. Outpatient Procedures
4. Levels of Care
5. E H R

Information used to certify admission shall include, but not limited to:

1. Identification of the patient
2. Admission date
3. Surgery date
4. Admitting physician
5. Reason for admission (diagnosis/symptoms)
6. Physician’s plan of care
7. Documentation of emergency admission
8. Payer
9. Anticipated Length of Stay

Extended stay review will be performed at least every two to three days until discharge, unless authorized for longer periods of time by payer.

The Case Manager or designee will screen all admissions and extended stay reviews for medical necessity and appropriateness and will document same on the Utilization Review Form. All decisions by the Case Manager or designee will be based on approved Medical Staff criteria and nursing judgment.

Whenever the Case Manager or designee is unable to determine the medical necessity for admission certification or extended stay, a note may be placed in the medical record or a discussion with the attending physician should occur stating there is insufficient documentation of medical necessity for the admission and/or continued stay.

In addition, the Case Manager or designee will refer the review to the PA for guidance and/or intervention. If approved by the PA the attending physician shall be so notified and an appropriated date for subsequent extended stay review will be selected and noted on the patient’s record.
If the admission certification or extended stay is disapproved by the PA, the PA will contact the attending physician for clarification of his/her treatment plan to continue the acute care hospitalization and/or to assist with the recommendation of the appropriate level of care.

If the 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 concur with the determination or fail to present their views when afforded the opportunity: and

- 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 practitioner or practitioners responsible for the care of the patient, and afford the practitioner or practitioners the opportunity to present their views.

If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than 2 days after the determination, to the hospital, the patient, (and single state agency in the case of Medicaid) practitioner or practitioners responsible for the care of the patient.

In no case may a non-physician make a final determination that a patient’s stay is not medically necessary or appropriated.

If the PA has conferred with the attending physician and still wishes to deny the case, and if the disapproved case is a Medicare, Medicaid, Champus, Blue Cross/Blue Shield or other contracted third party payer patient, a letter of denial will be issued per the payor’s rules and regulations. The Case Manager will deliver the denial notice to the patient. If the patient is incompetent, the denial notice will be sent by certified mail to the legal representative and the Case Manager will attempt to contact the legal representative by phone. Copies of the written denial will be sent to the attending physician and the appropriate review agency. If at any time thereafter the patient meets the criteria for medical necessity, the patient’s insurance coverage will be reinstated per payer’s rules and regulations.

All utilization review forms and reports are considered confidential material.

**IDENTIFICATION OF UTILIZATION REVIEW RELATED PROBLEMS FOR FOCUS REVIEW**

Through the analysis of data profiles generated by any peer review agency and other external review groups, documented utilization review experience and review of TQM studies, the Committee shall identify problems for focus review. These problems may be associated with over and underutilization of services by questionable patterns of care.

Identified utilization related issues will be referred to the Medical Staff Peer Review Committee. The Committee may assign a study of those utilization related issues identified through concurrent and retrospective studying by the Medical Staff Committees and/or hospital departments. This will be carried out by using in-depth criteria and standards during concurrent review and/or retrospective study.

Conversely, analysis of data profiles, documented utilization review experience, and TQM studies should result in identification of appropriate diagnosis problems, physicians, and/or classes of patients for which it can be documented that routine review is not required. The identification of the area of excellent utilization for services and facilities will result in focusing out those areas from continuous review.