I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an “Affiliate”); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare facility in which an Affiliate either manages or controls the day-to-day operations of the facility (each, a “Tenet Hospital”) (collectively, “Tenet”).

II. PURPOSE:

The purpose of this policy is to ensure standardized utilization review processes are conducted in accordance with regulatory requirements, accreditation standards and payer contracts for patients admitted to Inpatient or Outpatient status.

III. DEFINITIONS:

A. “Admitting or Attending Physician” means, in the context of this policy, a physician or any licensed independent practitioner who is legally accountable for establishing the patient’s diagnosis and has been granted admitting privileges by the Tenet Hospital’s Medical Staff. Emergency Department physicians may be considered Admitting or Attending Physicians when they have been granted admitting privileges by the Medical Staff.

B. “Physician Order” means an order from the Physician admitting the patient to the Tenet Hospital or the Physician responsible for the patient’s general medical management during the admission. The order may be electronic, in writing, or be a telephone/verbal order as allowed by the Tenet Hospital’s medical staff bylaws.

C. “Federal health care program” means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, including, but not limited to, Medicare, Medicaid/Medi-Cal, managed Medicare/Medicaid/Medi-Cal, TriCare/VA/CHAMPUS, SCHIP, Federal Employees Health Benefit Plan, Indian Health Services, Health Services for Peace Corp Volunteers, Railroad Retirement Benefits, Black Lung Program, Services Provided to Federal Prisoners, Pre-Existing Condition Insurance Plans (PCIPs) and Section 1011 Requests.

D. “Authorization” means a process by which the hospital contacts the payer to seek authorization/preauthorization/precertification for the patient status and treatment ordered by the Admitting Physician.

E. “INTERQUAL or other Tenet approved clinical screening criteria” mean clinical decision support guidelines licensed for use by hospitals and managed
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<tr>
<td>HOSPITAL CASE MANAGEMENT UTILIZATION REVIEW PROCESS</td>
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Care companies to evaluate the appropriateness of medical interventions and level of care based on clinical criteria and standards.

F. “Physician Advisor” or “PA” means a physician working under contract with the Tenet Hospital or in a medical staff position with authority delegated by the Utilization Management Committee for review of cases for clinical appropriateness and medical necessity of admissions, continued stays and services provided by the Tenet Hospital.

G. “Secondary Review” means a clinical review performed by a PA or physician member of the Utilization Management Committee when INTERQUAL or other Tenet approved clinical screening criteria suggest a different patient status or level of care than that ordered by the patient’s Physician and/or a potential quality concern.

H. “Peer to Peer” means the discussion between two medical practitioners representing the patient, one on behalf of the hospital provider and the other on behalf of the commercial/managed care plan, to resolve any conflict between what the Admitting or Attending Physician has ordered and what the commercial/managed care plan will authorize for treatment of the patient.

I. “Case Management” means a collaborative process of assessment, planning, facilitation, care coordination, and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality, cost-effective outcomes.

J. “Inpatient” means any person who has been admitted to a Tenet Hospital for bed occupancy for purposes of receiving hospital services.

K. “Outpatient” means a person who has not been admitted by the Tenet Hospital as an Inpatient but is registered on the Tenet Hospital records as an Outpatient and receives services from the Tenet Hospital. The duration of services and time of day are not determinative of Outpatient Status. Observation Services are considered an Outpatient level of care.

L. “Patient Status” means Inpatient or Outpatient.

M. “Level of Care” means the level of Outpatient Services (for example, outpatient surgery or outpatient observation) or Inpatient Services (for example, inpatient acute, inpatient intermediate or telemetry, inpatient critical or ICU) and other Levels of Care designated by the Tenet Hospital.

N. “Observation Services” or “Observation” means assessment, short-term treatment, reassessment, and stabilization before decision to admit to Inpatient or discharge.
O. “Qualified Hospital Case Management staff” means Case Management staff (Registered Nurse, Licensed Vocational Nurse or Social Work) who have successfully completed Tenet INTERQUAL or other Tenet approved clinical screening criteria annual education and passed the exam with a minimum passing score of 85% or above.

IV. POLICY:

Qualified Case Management reviewers using McKesson INTERQUAL or other Tenet approved clinical screening criteria will conduct an initial medical necessity review within 24 hours of admission for all patients whose payer does not have an authorization process. If the patient meets inpatient criteria the Case Management reviewer must schedule a follow up or continued stay review for hospital day 3. If the patient meets for Outpatient Observation the reviewer must schedule the next review for the following day.

For payers with an Authorization Process, Tenet Hospitals will complete a clinical review within 24 hours of admission and follow up or continued stay reviews as requested by the payer, but no less frequently than every third day after the initial review. Tenet Hospitals will complete an INTERQUAL or other Tenet approved clinical screening criteria review when there is a lack of agreement between the Patient Status, Level of Care and/or Length of Stay ordered by the Physician and authorized by the payer.

Tenet Hospital Case Management cannot abdicate their utilization review responsibilities, but must collaborate with ACOs, physician groups, and health plan case management staff to coordinate patient care in our hospitals.

V. PROCEDURE:

A. Qualified Case Management reviewers will conduct and document medical necessity reviews using McKesson INTERQUAL or other Tenet approved clinical screening criteria within 24 hours of admission for all patients whose payer does not have an authorization process.

B. For patients whose payers do not have an authorization process, Tenet Hospitals will have documented INTERQUAL or other Tenet approved clinical screening criteria reviews and follow the Secondary Physician Review process outlined in Regulatory Compliance policy COMP-RCC 4.18 Clinical Determination of Appropriate Patient Status.

C. For patients whose payers have an authorization process, Tenet Hospitals will follow the payer’s authorization process and within 24 to 48 hours of admission the Case Manager will confirm documentation of a match between the physician order and authorization by the payer for patient status, level of care and/or length of stay. When there is not a match between the physician order and authorization by the payer for patient status, level of care and/or length of stay, refer to Section
V.E. Managing a Concurrent Denial/Dispute for Patients Whose Payers Have an Authorization Process.

D. Authorization and Communication Process for Patients Whose Payers Have an Authorization Process

1. Patient Access will notify the payer of all Outpatient Observation or Inpatient admissions to the hospital, confirm the pre-authorization or notification for services during the patient registration and financial clearance process and document the authorization or notification number as well as payer representative name and phone number in the hospital Admission/Discharge/Transfer (ADT) system to ensure that the HCM can submit clinical information to the payer. (Refer to Avoiding Disputes and Denials Process – Failure Points.)

2. Case Management staff will provide/submit clinical information to the payer within the required timeframe per the plan contract (usually within 24 hours of admission) and request authorization for:

   a. the admission status and level of care as ordered by the Physician, and

   b. the number of days anticipated for hospital length of stay.

3. Case Management staff must confirm the receipt of the submitted patient clinical information and authorization for level of care and length of stay, and record the communication in the case management documentation system. (Refer to Avoiding Disputes and Denials Process – Failure Points.)

4. Case Management staff will provide/submit clinical updates to the payer during the patient’s hospital stay per the plan contract (but no less frequently than every three days).

5. If services or length of stay exceeds the original authorization, Case Management staff will conduct a follow up clinical review to provide the clinical rationale and request authorization for additional services or length of stay.

6. Case Management staff will document all payer communications in the case management documentation system including Payer Representative contact name and number, authorization number, date, and any pertinent information.
7. Case Management staff will facilitate the authorization for post-acute services from the payer when ordered by the Physician to support the patient transition from the acute hospital setting.

8. Case Management staff will provide/submit payer notification of patient discharge, transfer, or death, and confirm all days have been authorized or not authorized.

9. Case Management staff will document this notification and authorization or lack of authorization in the case management documentation system within 48 hours of discharge, transfer or death. (Refer to Avoiding Disputes and Denials Process – Failure Points.)

E. Managing a Concurrent Denial/Dispute for Patients Whose Payers Have an Authorization Process

1. Upon notification of a concurrent denial/dispute, the Case Management staff must enter the following Intervention Type into Allscripts: “Payer Request Form Considered/Pending,” which produces activity code QPTCP that holds the account on the Interactive Claims Editor (ICE) while attempts are made to resolve the denial/dispute. For Tenet hospitals using other systems, place patient account on manual bill hold and document reason for hold in billing notes.

2. If the concurrent denial/dispute is based on a discrepancy regarding the admission status, level of care or length of stay ordered by the Physician and what is authorized by the payer, the HCM must perform an INTERQUAL or other Tenet approved clinical screening criteria review and proceed with the Secondary Review process if INTERQUAL or other Tenet approved clinical screening criteria fail. (Refer to Avoiding Disputes and Denials Process – Failure Points.)

3. Case Management staff will make every effort to initiate a “Peer to Peer” Review if the INTERQUAL or other Tenet approved clinical screening criteria review or Secondary Review process supports the admission status, level of care or length of stay ordered by the Physician.

a. Case Management staff will provide the clinical rationale and the name of the plan Medical Director and contact information provided by the payer to the physician designated to represent the patient on behalf of the Tenet Hospital. The physician representative could be the Attending/Admitting Physician, PA, and/or the Chief Medical Officer.
b. Case Management staff will provide the hospital physician representative with pertinent clinical information including findings from the INTERQUAL or other Tenet approved clinical screening criteria review, previous PA determination(s), pertinent medical records and/or plan benefit information.

c. The physician representative will contact the payer Medical Director or designee immediately the same day that the denial determination is received, or no later than 24 hours following receipt, to discuss the clinical rationale for the patient status, level of care and/or length of stay provided to the patient.

(1) If the payer Medical Director concurs with the patient status, level of care and/or length of stay ordered by the Admitting/Attending Physician, the physician representative will notify Case Management staff.

(a) Case Management staff will contact the Payer Representative to request documentation of the reversal of the denial determination.

(b) Case Management staff will enter this Intervention Type into Allscripts: “Payer Request Form Considered – Not Required,” which produces activity code QPTCX that releases the account from the ICE. For Tenet hospitals using other systems, release patient account from manual bill hold and document reason in billing notes.

(2) If the payer Medical Director does not concur with the patient status, level of care and/or length of stay ordered by the Admitting/Attending Physician, the hospital physician representative will notify Case Management staff.

(a) Case Management staff will notify the Admitting/Attending Physician.

(b) Case Management staff will enter this Intervention Type into Allscripts: “Payer Request Form Considered – Not Required” which produces activity code QPTCX that releases the account from the ICE. For Tenet hospitals using other systems, release patient account from manual bill hold and document reason in billing notes
(c) Case Management staff must task the denial to Conifer through Allscripts. In the absence of Allscripts, utilize the hospital-specific communication process.

(3) Case Management staff will document in the case management documentation system when the Peer to Peer Review occurred (date and time), the name of the payer Medical Director, the name of the physician designated to represent the patient on behalf of the Tenet Hospital, and the outcome whether the determination was upheld or overturned.

(4) If the denial is received post discharge, the Peer to Peer Review must be completed within 10 days of discharge.

(5) If the INTERQUAL or other Tenet approved clinical screening criteria and or secondary review process does not support the admission status, level of care or length of stay ordered by the Physician, the Case Management staff must inform the Admitting/Attending Physician and attempt to resolve the discrepancy by obtaining corrected orders from the Physician.

(a) If corrected orders are obtained and the discrepancy is resolved, the Case Management staff will enter this Intervention Type in Allscripts: “Payer Request Form Considered - Not Required,” which produces the activity code QPTCX that releases the account from the ICE. For Tenet hospitals using other systems, release patient account from manual bill hold and document reason in billing notes.

(b) If corrected orders are not obtained and the discrepancy is not resolved, the Case Management staff will enter this Intervention Type in Allscripts: “Payer Request To Change Status Form Completed,” which produces the activity code QPTCC and the claim will be billed as directed by the managed care or commercial insurance company. For Tenet hospitals using other systems, complete the Payer Request to Change Status Form which allows the claim to be billed as authorized by
F. Resolving Conflicts Between Authorized and Ordered Services for Patients Whose Payers Have an Authorization Process

When there is not a match between the Physician order and the authorization by the payer, qualified Case Management staff will conduct medical necessity review using INTERQUAL or other Tenet-approved clinical screening criteria to support the clinical basis for follow up with the Physician and the payer. The Case Management staff must use the Payer Request to Change Form to document payer communications and instructions. The Case Management staff must send completed forms to the Tenet Hospital’s Director of Revenue Analysis within one business day of the discussion with the payer representative. The Director of Revenue Analysis must ensure all forms are scanned into VIWeb or hospital-specific financial system for access by Conifer.

G. Case Management staff will communicate appropriate clinical information to the payers with an authorization process timely and accurately to comply with managed care and other payer contracts and document the medical necessity to support the requested authorization for hospital services.

H. Responsible Person

The Tenet Hospital’s Director of Case Management is responsible for ensuring that all personnel adhere to the requirements of this policy, that these procedures are implemented and followed at the Tenet Hospital, and that instances of noncompliance with this policy are reported to his/her Supervisor and the Tenet Vice President of Case Management, PMI.

I. Auditing and Monitoring

Audit Services will audit adherence to this policy as part of the full scope audit process.

J. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.
V. REFERENCES:

- Allscripts/MIDAS Standard Operating Procedures (SOP) and Job Aids

- American Case Management Association (ACMA) Standards of Practice and Scope of Services, revised 2012

- Regulatory Compliance policy COMP-RCC 4.18 Clinical Determination of Appropriate Patient Status

- Case Management policy PMI.CMT.101 INTERQUAL Application and Training

- Quality, Compliance, and Ethics Program Charter

- Avoiding Disputes and Denials Process – Failure Points

VI. ATTACHMENTS:

- Attachment A: Payer Request to Change Form