Tenet Health	**Regulatory Compliance Policy**	**No.** **COMP-RCC 4.52**
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	UTILIZATION MANAGEMENT PLAN	**Effective Date:** **04-30-20**
		Previous Versions Dated: **05-18-17; 05-12-16; 03-19-15; 08-07-14; 01-30-14; 02-07-13; 10-13-10**
		Corporate Review Dated: **04-14-20**

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 of 50% or more; and (3) any hospital or entity in which an Affiliate either manages or controls the day-to-day operations of the entity (each, a "Tenet Hospital") (collectively, "Tenet").

II. PURPOSE:

The purpose of this policy is to identify the elements of a comprehensive utilization management plan, which is necessary to satisfy Medicare Conditions of Participation, Medicaid Program requirements,[1] and utilization management requirements for all payers.

III. DEFINITIONS:

A. "**INTERQUAL®**" means the Change Healthcare product housed in Tenet's case management documentation system. INTERQUAL is utilized to provide objective feedback to physicians and hospitals on the Patient Status and Level of Care that may be appropriate for hospital patients. InterQual® is not a government product and serves only as a guideline to prompt feedback and discussion. The physician order determines Patient Status and Level of Care.

B. "**INTERQUAL or other Tenet approved clinical screening criteria**" means clinical decision support guidelines licensed for use by hospitals and managed care companies to evaluate the appropriateness of medical interventions and level of care based on clinical criteria and standards.

C. "**Physician Advisor**" or "**PA**" means a physician working under contract with 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.

D. "**Secondary Physician Review**" means a clinical review performed by a physician on the Utilization Management Committee other than the ordering physician when InterQual® or other Tenet approved clinical screening criteria guidelines suggest a different Patient Status or Level of Care than that ordered.

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[1] See 42 C.F.R. § 482.30.

E. "**Utilization Management Plan**" means the hospital-wide plan that contains the essential requirements for the establishment and implementation of a utilization management process to ensure the quality, appropriateness and efficiency of care and resources furnished by the Tenet Hospital and medical staff. The purpose of the utilization management plan is to ensure that patients receive medically necessary and appropriate care at the appropriate time and in the appropriate setting.

IV. POLICY:

All Tenet Hospitals must develop a Utilization Management Plan ("UM Plan") incorporating the definitions and procedures set forth in this policy, using the attached template, to govern utilization management processes in their facilities. Each Tenet Hospital may add to its UM Plan hospital-specific utilization management procedures required by the Medical Staff, its Utilization Management Committee or state regulatory agencies. Each Tenet Hospital's Utilization Management Committee (the "UM Committee" or "Committee"), the Medical Executive Committee, and the Governing Board must review and evaluate its UM Plan at least once a year, and as revised. To the extent that the Centers for Medicare and Medicaid Services has issued a blanket waiver of any of the requirements of this policy during times of national emergency (e.g. COVID-19 pandemic), the requirements of this policy are waived during the effective period of the waiver.

V. PROCEDURE:

A. Overview

Each Tenet Hospital's UM Plan must:

1. Delineate the responsibilities and authority of personnel for conducting internal utilization review, for conducting delegated review under managed care contracts and facilitating external review under managed care and other payer contracts;

2. Outline processes to review the medical necessity of admissions, extended stays, and professional services, and appropriateness of setting;

3. Outline processes to review outlier cases based on extended length of stay and/or extraordinarily high costs;

4. Define processes to review potential overutilization, underutilization and inefficient utilization of resources;

5. Define processes for coverage determinations, denials, appeals and peer

review within the organization; and

6. Identify framework for reporting, corrective action and documentation requirements for the utilization management process.

B. Plan Minimum Requirements

1. Commitment, cooperation and communication by the Governing Board, the Medical Executive Committee, Hospital Administration, the UM Committee, Medical and hospital staff, and contracted services.

2. Use of objective review criteria, including outlier thresholds.

3. Maintenance of appropriate databases for aggregation of utilization management data.

4. Corrective action mechanisms and authority, including medical staff by-laws and department rules and regulations.

5. Integration of utilization review findings into quality improvement activities.

6. Compliance with applicable state utilization review/management statutes, including confidentiality and privilege of patient information.

7. Patient medical records will be provided for utilization management review.

C. UM Committee Composition and Operation

1. Composition

a. The UM Committee is a standing committee of the Tenet Hospital Medical Staff and must comprise two or more physicians and other practitioners to perform the utilization management function. At least two members of the committee must be doctor of medicine or osteopathy and at least one physician must be a member of the Tenet Hospital's Medical Staff. The remaining members of the Committee may be dentists, podiatrists, optometrists, chiropractors or clinical psychologists within their scope of practice in the state. The Committee may be supported by representatives from case management and administration (*e.g.*, the CFO, nursing services, or health information management),

but only physicians and other practitioners are members of the Committee for regulatory purposes.

b. No person with a direct financial interest in the Tenet Hospital may participate in reviews conducted by the Committee. No person who is, or has been, professionally involved in the care of the patient whose case is being reviewed may participate in the review. All members of the Committee must sign a Conflict of Interest Statement (see Attachment A) attesting that they have no direct financial interest in the Tenet Hospital.

2. Meetings

The Committee must meet as a separate and distinct committee with its own agenda and minutes. The Committee must meet as often as necessary, regularly throughout the year, to accomplish its functions, but no fewer than four (4) times per year.

3. Minutes

Committee minutes must be maintained according to hospital policy and include the date and time of the meeting, attendees, standard reports, action item follow-up, focused reviews, audits, and action to be taken. The minutes must exclude patient or physician names but may include other identifiers. Summaries or minutes must be reviewed by the UM Committee, Medical Executive Committee, Governing Board, Medical Staff and other committees according to the Responsibilities, Authority, and Duties outlined in this UM Plan.

4. Standard reports

Standard reports presented at Committee meetings are for discussion and identification of action items, plan for improvement and resolution. Include:

a. Length of stay;

b. Excess Days by payer;

c. Avoidable days;

d. Disputes;

e. Appeal outcomes;

f. InterQual® or other Tenet approved clinical screening criteria or other preadmission review results (cases or number of days that do not satisfy criteria for admission, continued stay and/or level of care, and secondary reviews results);

g. Number of Admission Hospital Issued Notice of Non-coverage (HINN) letters issued;

h. Number of Hospital Requested Reviews (HRR) for admission medical necessity;

i. Observation information, including the number of observation stays converted to inpatient, the average length of stay (hours) and the number exceeding 48 hours;

j. Summary report of the result of all cases reviewed by the PA, including the number of cases converted from inpatient to outpatient observation or outpatient in accordance with CMS guidelines (Condition Code 44);

k. Percentage of medical necessity screening performed within 24 hours of admission;

l. Crimson data or other analytical tools in use;

m. TEMPO® barrier data;

n. Case Management Dashboard metrics

o. Readmission Review of cases readmitted within 30 days of previous inpatient admission

p. Discharge Disposition reporting

q. Secondary Review -report data; and

r. Review of medical necessity of professional services will be completed by the appropriate peer review committee in accordance with medical staff bylaws. On an annual basis, the results of utilization review process conducted by the peer review committee related to utilization or medical necessity will be

reported in aggregate by procedure category to the UM Committee.

D. Authority and Responsibility

1. Tenet Hospital Governing Board

a. Provides human, information, and physical resources needed by departments to perform their functions under the UM Plan.

b. Delegates responsibility for implementation of the UM Plan to the Medical Staff, UM Committee and Chief Executive Officer (CEO).

c. Requires the Hospital and Medical Staff to implement and report on utilization management activities throughout the organization.

2. Tenet Hospital Chief Executive Officer

a. Delegates oversight of utilization management to the Committee as a subcommittee of the Medical Executive Committee.

b. Assigns responsibility for medical necessity secondary review process and physician liaison between Case Management Department and Medical Staff to the PA or Chief Medical Officer.

c. Assures that admissions and continued stays are medically necessary and that medical and hospital resources are appropriately used.

d. Evaluates the effectiveness of utilization management activities.

e. Reports evaluation results to the Governing Board.

3. Medical Executive Committee

a. Criteria Development

(1) Develops and/or approves general admission criteria.

(2) Develops and/or approves specific admission criteria for specialty patient groups, such as psychiatric and physical rehabilitation patients.

b. Resource Utilization

(1) Provides oversight to assure that health care furnished at the Tenet Hospital is consistent with professionally-recognized quality standards.

(2) Provides oversight to assure consistently appropriate and medically necessary treatment for patients.

(3) Provides oversight to assure efficient use of hospital health services and facilities.

(4) Provides oversight to assure the maintenance of consistently valid, accurate and complete medical record information that reflects diagnoses, admissions, treatments, and continued care.

(5) Receives, analyzes and acts on utilization management committee findings.

c. Peer Review

(1) Evaluates and acts upon peer review information related to medical necessity, appropriateness of treatment and quality of care.

(2) Provides for confidentiality of the peer review process and findings.

(3) Provides focused review or other privilege restrictions for Medical Staff members with identified utilization management problems, including disputes.

d. UM Committee

(1) Arranges for two or more appropriate practitioners to perform UM functions.

(2) Schedules meetings.

e. Reporting

Provides an annual review, evaluation and approval of the UM

Plan by the UM Committee and Medical Executive Committee.

E. Hospital Administration

1. Demonstrates and fosters commitment to the goals and objectives of utilization management.

2. Creates an environment that promotes effective utilization management.

3. Engages the Medical Staff in utilization and case management functions.

4. Allocates adequate resources, including personnel, time, data collection tools and systems, to:

   a. Establish, promote and maintain utilization and case management functions;

   b. Promote coordinated care and services;

   c. Pursue effective internal utilization review; and

   d. Conduct effective utilization review of cases delegated by managed care organizations and other managed care cases regarding which the Tenet Hospital is at risk.

5. Ensures that the Tenet Hospital satisfies the requirements of the Quality Improvement Organization (QIO) contract required by the Centers for Medicare and Medicaid Services (CMS) for review of services and items provided to Medicare beneficiaries.

6. Ensures implementation of the UM Plan for the review of medical necessity of admissions, appropriateness of the setting, medical necessity of continued stay and medical necessity of professional services.

7. Ensures that UM Plan activities and outcomes are systematically monitored, measured, assessed and improved throughout the organization.

8. Participates in interdisciplinary and interdepartmental activities to improve procedures and promote the most efficient use of services and facilities.

9. Provides mechanisms for corrective or disciplinary action, as needed, to resolve barriers to effective utilization management and review.

F. UM Committee

1. Administrative Procedures

a. Complies with the UM Plan approved by the Medical Staff and Governing Body.

b. Documents utilization management on claims without regard for payment source.

c. Performs focused reviews with accompanying action plan and reports results.

d. Determines whether under-utilization or over-utilization adversely affects quality of patient care and recommends the appropriate corrective action.

e. Monitors the implementation of corrective action to achieve improvement in the utilization and case management function.

f. Establishes procedures for compliance with policy regarding notification of non-coverage to beneficiaries.

g. Provides for confidentiality of the peer review process and findings.

h. Establishes procedures for external utilization management representatives who perform on-site reviews in the Tenet Hospital, including facility sign-in process.

i. Meets as often as necessary, with a minimum of four (4) times per year, at the call of its chair, to manage the utilization management process. Monthly meetings are recommended.

j. Documents meetings with dates, duration, attendance, and committee activity.

k. Reports at least semi-annually to the Medical Executive Committee, the Governing Board and other committees as set forth in the UM Plan.

l. Reports findings from the QIO to the Medical Staff.

m. Delegates to case management staff, UM Committee subcommittee, a physician member of the UM Committee, and/or PA the authority to act on day-to-day utilization management matters including, but not limited to, using screening criteria to evaluate the appropriateness of hospital stay and level of care, making determinations regarding the medical necessity/ appropriateness of an admission/continued stay, and issuing notices of non-coverage or causing the admission category to be revised in accordance with CMS guidelines.

n. Reviews summary data, including the number of cases converted from inpatient to outpatient observation level of care using Condition Code 44.

o. Maintains confidentiality of patient identity in all utilization review records and reports.

2. Utilization Review Process

a. Monitors to ensure that only medically necessary care is provided.

b. Notifies the Tenet Hospital administrator, the practitioner or practitioners responsible for care of the patient, and the patient, in writing, of the determination that an inpatient admission or a continued stay in the Tenet Hospital is not medically necessary, within two (2) days of that determination.

c. Makes medical necessity and appropriateness of care determinations independent of external utilization review decision- makers, such as managed care entities.

d. Conducts or arranges peer review for cases referred by the PA.

e. Recruits PAs when specialty expertise is required for medical and professional peer review.

f. Reviews all continued stay and cost outlier cases within specified timeframes.

g. Tracks, trends and analyzes outlier cases to identify patterns for performance improvement.

h. Reviews professional services to determine medical necessity and

to promote the most efficient use of available health facilities and services (*e.g.*, availability and use of necessary services and therapeutic procedures, *i.e.*, underuse, overuse, appropriateness of use, and timeliness of scheduling operating rooms and diagnostic procedures). For purposes of this policy, professional services include laboratory, physical therapy, nursing, and services provided by MDs/DOs and licensed practitioners with staff privileges at the Tenet Hospital.

i. Documents the outcome of cases reviewed for medical necessity, including approvals, disapprovals, and reasons, and actions taken to resolve identified problems.

j. Coordinates consultation with Conifer National Insurance Center and National Medicare Center regarding denials related to medical necessity of admissions, continued stays and professional services.

k. Assists with appeals regarding medical necessity denials by third-party payers.

G. Physician Advisor

1. If the PA is a member of the Medical Staff, the PA functions as a member of the UM Committee. If the PA is not a member of the Medical Staff, the PA shall serve as an advisor to the UM Committee and its members.

2. Represents or advises the UM Committee in day-to-day utilization management operations.

3. Provides clinical consultation to case management staff members.

4. Provides education to Medical Staff members regarding utilization and case management issues.

5. Performs secondary reviews to determine medical necessity on cases that do not meet InterQual® or other Tenet approved clinical screening criteria

6. Abstains from participation in reviews of cases in which the PA or a partner of the PA is, or has been, the attending, consulting or treating physician.

7. Documents the clinical rationale for all medical necessity determinations, whether approved or denied.

8. Assists case management staff in preparing appeals regarding denials of coverage and payment.

H. Medical Staff, Hospital Employees and Contract Services

1. Assesses patient needs to determine the appropriate level of care, services and settings based upon standard criteria, payer guidelines, evidence-based medicine, and clinical judgment consistent with professional standards of practice.

2. Establishes clear, concrete and attainable care goals against which progress can be evaluated.

3. Identifies barriers to efficient treatment and timely discharge.

4. Provides efficient and appropriate care.

5. Maintains accurate and complete medical records.

6. Communicates and coordinates effectively with patients, families, healthcare providers and third-party payers regarding continuum of care transition and discharge needs.

7. Facilitates patient transition through the continuum of care using internal and external resources as appropriate.

8. Cooperates with, and participates in, the utilization management and peer review processes, including providing additional information as needed for appeals of adverse determinations by payers and external review organizations.

I. Case Management Staff

1. Director of Case Management

   Provides guidance to the Medical Staff and Hospital personnel regarding medical necessity criteria and appropriate level of care of service determinations.

2. Case Manager

   a. Reviews medical record documentation to obtain information necessary for utilization management determinations.

b. Uses only documentation properly authenticated in the medical record to make determinations using InterQual® or other Tenet approved clinical screening criteria

c. Applies utilization review criteria objectively regarding outpatient observation services, inpatient admissions, continued stay, level of care and discharge readiness determinations, using InterQual® or other Tenet approved clinical screening criteria For payers that do not have an authorization process, Tenet approved clinical screening criteria must be used for acute adult, pediatric, and long term acute care (LTAC) as applicable. For payers that offer an authorization process, the Tenet Hospital will follow the authorization and continued stay review process established by the payer.

d. Conducts an admission review for medical necessity as soon as adequate clinical information is available to complete an accurate review, but within 24 hours of admission.

e. Screens admissions for skilled nursing facility (SNF) and long term acute care (LTAC) within 48 hours (see Regulatory Compliance policy COMP-RCC 4.18 Clinical Determination of Appropriate Patient Status).

f. Screens and coordinates admissions and transfers, including emergency and elective admissions, outpatient observations, and conversions from outpatient observation to inpatient care and inpatient to outpatient observation care in accordance with CMS guidelines and contractual agreements.

g. Reviews all outpatient observation stays daily.

h. Conducts utilization review regarding all, excluding healthy delivering mothers and babies, admissions and continued stays, regardless of payer, including private and no-pay categories and cases that have been pre-authorized or certified by third-party payers.

i. Reviews all continued stays at frequency specified in the UM Plan, but at least every three days. Continued stay review for inpatient rehabilitation facility (IRF) will be conducted weekly as a component of team conference. Continued stay review for SNF

and LTAC patients will be performed at least every seven days.

j. Reviews the timeliness, safety and appropriateness of hospital services, including the use of drugs, biologicals and medical devices, in collaboration with the Tenet Hospital's Pharmacy and Therapeutics Committee and/or other committees responsible for review of the Tenet Hospital formularies and utilization of these items.

k. Participates in weekly complex case review meeting.

l. Performs retrospective or focused review as directed by the UM Committee.

m. Provides case management education to all relevant hospital departments and acts as a resource for questions and concerns.

n. Specialty Program Reviews

(1) Hospitals that perform IRF utilization management: applies Medical Condition Criteria as defined in 42 C.F.R. Part 412 objectively to determine if admission to IRF level of care is reasonable and necessary for the treatment of the patient's condition in terms of efficacy, duration, frequency, and amount; provides coordinated, comprehensive, and interdisciplinary services in an IRF rather than in a less intensive setting such as a SNF or on an outpatient basis.

(2) Hospitals that have SNF level of care and provide SNF utilization management: applies skilled nursing care criteria objectively to determine if admission to SNF level of care is reasonable and necessary in terms of duration and quality.

J. Types of Review/ Review Process:

1. Pre-Admission Review IRF and LTAC facilities

a. For payers with no authorization process, the reviewer[2] must

[2] For purposes of this Section V.J. of this policy, "reviewer" means the case management or other clinical personnel designated by Tenet Hospital to conduct utilization management functions in coordination with Case Management.

perform pre-admission review using InterQual® or other Tenet approved clinical screening criteria when a patient is referred for admission to LTAC and IRF level of care and approve the admission only if the pre-admission criteria are met. For payers with an authorization process, the Tenet Hospital will rely on the payer's authorization and continued stay review processes.

b. Contact the referral source or physician requesting the service for additional information if the referral does not meet pre-admission criteria and the requested or ordered treatments or therapies could be performed at an alternate level of care.

c. Approve the admission if additional information is subsequently provided supporting the admission.

d. If additional information is not provided or is provided and still fails to satisfy the admission criteria, and the physician agrees that an Alternative Level of Care (ALOC) is appropriate, the case manager or designee must facilitate transfer.

e. If patient does not meet admission criteria but the referring physician does not agree that an ALOC is appropriate, the case must be referred to the PA or a physician member of the UM Committee for Secondary Review.

f. If the Secondary Reviewer believes that the patient does not satisfy admission criteria, the Secondary Reviewer will review the case and confer with the referring/ordering physician and make an independent determination. If the Secondary Reviewer determines

that an LTAC or IRF admission is medically necessary, the admission must be accepted. For Medicare beneficiaries, admission acceptance is subject to beneficiary notice pursuant to Regulatory Compliance policy COMP-RCC 4.25 Hospital Coverage Notices for Medicare Inpatients.

2. Admission Review

a. The reviewer must perform an Admission Review using InterQual® or other Tenet approved clinical screening criteria no later than 24 hours after admission. Exception: Admission Reviews for LTAC, SNF, and IRF must be completed within 48

hours of admission.

b. For Payers With No Authorization Process

(1) If InterQual® or other Tenet approved clinical screening criteria are met on the admission review, the admission will be deemed appropriate.

(2) The reviewer assigns the Continued Stay Review (CSR) for hospital day 3. Exception: For SNF and LTAC, continued stay review should be scheduled within first seven days. Behavioral Health continued stay review is assigned no later than three days from the date of admission. Continued stay for IRF is scheduled weekly as a component of team conference.

(3) If admission criteria are not satisfied, the reviewer must contact the attending physician for additional information. If additional information satisfies admission criteria the admission will be approved.

(4) If additional information is not provided or provided and still fails to satisfy admission criteria, the case must be referred for Secondary Review.

3. Continued Stay Review

a. CSR must be performed for Payers with no authorization process on hospital day 3, and at least every 3 days thereafter, based on status, patient condition, prior InterQual® or other Tenet approved clinical screening criteria and anticipated date of discharge. (Exceptions: CSR for Behavioral Health must occur at least every 3 days from the date of admission. SNF and LTAC reviews must occur at least every seven days. CSR for IRF must occur weekly as a component of team conference.) For payers with an authorization process, the Tenet Hospital will follow the procedure per contract language.

b. If Continued Stay criteria are satisfied**,** the continued stay will be approved as ordered and next review date scheduled.

c. If Continued Stay criteria are not satisfied, the reviewer must

contact the attending physician for any additional information that may support the stay.

d. If additional documented information satisfies the Continued Stay criteria, the continued stay will be approved.

e. If additional information is not available, or available and fails to meet continued stay criteria, the HCM will conduct a discharge review.

4. Discharge Review

Discharge reviews must be performed when criteria for continued stay are not satisfied, or when help is needed in determining the next appropriate level of care within the facility or the appropriateness of discharge from the facility. If the case does not meet Continued Stay criteria, but discharge indicators are NOT met (*e.g.*, patient is falling outside of the clinical stability parameters for discharge), the Case Manager must set the next review date, for the next day, and resolve the barriers to discharge. If discharge indicators are met, the Case Manager will contact the physician to facilitate discharge or transfer to the next appropriate level of care. If the discharges indicators are met and the physician disagrees with discharge, the case must be referred for Secondary Review.

5. Secondary Review Process

a. When an admission or continued stay case is referred by the Case Manager to the PA or member of the UM Committee for Secondary Review, the Secondary Reviewer must review the case based on documentation in the medical record and discussions with attending medical practitioner and make a determination using his or her medical judgment. Secondary Review determinations must be documented and supported with clinical rationale.

b. Before determining that an admission or continued stay is not medically necessary, the UM Committee, PA, or a physician member of the UM Committee must consult with the attending physician or the practitioner or practitioners responsible for the care of the patient and afford the attending physician or the

practitioner or practitioners the opportunity to present their views.[3]

(1) If the PA or a physician member of the UM Committee determines that an admission or a continued stay is not medically necessary and the attending physician or practitioners responsible for the care of the patient agrees or fail(s) to present views regarding the case, the Case Manager shall facilitate discharge, transfer, or referral to the appropriate level of care. Any determination to transfer a patient from the inpatient level of care to the observation level of care resulting from the Secondary Review process must involve a physician member of the UM Committee and must also comply with the requirements of Condition Code 44, as set forth in Regulatory Compliance policy COMP-RCC 4.18 Clinical Determination of Appropriate Patient Status.

(2) If the attending physician or practitioners responsible for the care of the patient does not agree with the PA or a physician member of the UM Committee's determination that a continued stay is not medically necessary, another physician member of the UM Committee must be consulted, and a further determination made.

c. If the UM committee or designee decides that continued stay in the Tenet Hospital is not medically necessary, the UM committee or designee must give written notification to the Tenet Hospital, the patient, the QIO and the practitioner or practitioners responsible for the care of the patient, no later than two days after the determination. (See Regulatory Compliance policy COMP-RCC 4.25 Hospital Coverage Notices for Medicare Inpatients.)

d. In the case of Managed Care (MC) patients, the Tenet Hospital case manager shall notify the MC case manager regarding medical necessity determinations pursuant to the specific MC contract.

e. If the circumstances exist, the Tenet Hospital must include the state requirements in the individual hospital UM Plan.

[3] 42 C.F.R. §§ 482.30, 482.12(c)

K. Discharge Planning Process

The discharge planning process is initiated on admission. The CM Transition Assessment (TA) focuses on the patient's goals, preferences, and needs to facilitate a timely and appropriate discharge. It identifies patients with complex discharge planning needs arising from diagnoses, therapies, and psychosocial or other relevant circumstances, as well as patients at risk for readmission. The discharge planning process facilitates transfers to appropriate level of care facilities throughout the continuum of care. Documentation of all discharge planning activities is completed in the case management documentation system and placed in the medical record. The hospital must assess its discharge planning process on a regular basis. The assessment must include ongoing, periodic review of a representative sample of discharge plans, including those patients who were readmitted within 30 days of a previous admission to ensure that the plans are responsive to patient post-discharge needs. Current, accurate information regarding community resources to facilitate discharge planning is maintained in the Case Management Department. (See Case Management policy CMT.103 Hospital Case Management Transition Planning.)

L. Dispute/Appeal Responsibilities

The Case Management Department works collaboratively to resolve disputes that arise based on decisions not to authorize services currently being provided (concurrent review disputes) by payers or designated utilization review organizations. The Department also works with the Conifer National Medicare Center (NMC) and the National Insurance Center (NIC) to resolve retrospective disputes.

M. Case Management Relationship with Third-Party Payer Organizations

1. Case Management at the Tenet Hospital must work to establish and maintain an effective and professional working relationship with third party payer organizations, including managed care and external utilization review organizations.

2. Tenet Hospital personnel must abide by the Tenet Information Privacy and Security Program manual requirements for disclosure of protected health information.

3. The Case Manager must document clinical information as required by third-party payer contracts.

4. The Case Management Staff must provide/submit clinical review as required by third-party payer contracts under direction of Nurse Case Manager.

5. The Tenet Hospital Case Management Staff must facilitate physician-to-physician communication when appropriate regarding adverse determinations by third party payers or external utilization review organizations.

6. Access to medical records and supervision of medical record review at the Tenet Hospital by third party payer and external utilization review organizations must be facilitated by the Director of HIM to assure compliance with third party payer contracts and with procedures established by the UM Committee.

N. Information Management

1. Utilization management data must be collected, analyzed and maintained to address issues of over-utilization, under-utilization, appropriateness of resource use, medical necessity of services and appropriate level of care assignment, and compliance with applicable federal and state regulations. Relevant utilization management data must be collected and aggregated for tracking and trending reports using automated information systems wherever possible to optimize efficiency.

2. Utilization management files must be maintained separate from individual patient medical records.

O. Responsible Person

The CEO and the Medical Staff Leadership at the Tenet Hospital are responsible for ensuring that all individuals adhere to the requirements of this policy. The CEO and the Medical Staff Leadership shall immediately report instances of policy noncompliance to the Compliance Officer.

P. 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.

VI. REFERENCES:

- InterQual® or other Tenet approved clinical screening criteria
- Regulatory Compliance policy COMP-RCC 4.01 Hospital Discharge/Transfer Policy for Medicare Patients
- Regulatory Compliance policy COMP-RCC 4.18 Clinical Determination of Appropriate Patient Status
- Regulatory Compliance policy COMP-RCC 4.25 Hospital Coverage Notices for Medicare Inpatients
- Case Management policy CMT.103 Hospital Case Management Transition Planning
- Quality, Compliance, and Ethics Program Charter

VII. ATTACHMENTS:

- Attachment A: Conflict of Interest Statement

- Attachment B: UM Plan Template