UTILIZATION MANAGEMENT: OVERVIEW

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INTRODUCTION

Utilization Management is not new to the health care industry. Programs to manage health care utilization have existed for more than twenty years. It was initially designed to screen for appropriateness of hospital admissions as well as length of stay. During the 1960's and 1970's nearly all physicians and hospitals were paid on **a fee for service** basis. The system allowed the physician to admit patients with no restriction on the types of services or interventions provided. No one questioned whether theses rendered services are appropriate or needed which led in some cases to overuse and increasing costs.

Utilization Management is the management and evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities to provide the highest quality of patient care in the most cost effective and efficient setting.

With the increased awareness of the overuse of the system, **Professional Standard Review Organizations (PSROs)** was created. Its purpose was to evaluate the care rendered to patients enrolled in **Medicare** by local peer review (Medicare: A federal program that pays for certain health care expenses for people aged 65 or older) to control the soaring healthcare cost and prevent financial loss. Around this time, John Thompson and Robert Fetter of Yale University developed **diagnosis related groups (DRG'S)**, a method that categorize patients by diagnosis leading to appropriate resource management and consequently, method of reimbursement changed from reasonable cost to predetermined fixed price.

Insurance companies, the private sector realized the importance of using DRG's in increasing hospital profits and realized that their costs has increased, so they set up their own methods and hired nurses to review concurrently the chart instead of denying cases after the fact.

Utilization Management process has evolved from the Utilization review process into a comprehensive system whose main objectives are not only to evaluate the necessity of admissions but to assure appropriate use of hospital resources.

OBJECTIVES

All patients, regardless of type of insurance or source of payment, are monitored for **over-utilization, under-utilization, and inefficient** scheduling of resources.

The primary objectives of utilization review are the following:

1. Assure Care at a Level Appropriate to Patient Needs:
Utilization review monitors the level of care on an ongoing basis to ensure that patients receive care in a facility appropriate to their needs. A patient in an acute care facility requires the continuous availability of physicians, skilled nursing services, surgical services and/or ancillary services. Utilization review evaluates the medical necessity, appropriateness, and timeliness of admissions, continued stays, and support services.
2. Provide Professional Accountability:
Utilization review provides professional accountability for the utilization of health care resources to the patient and the person or organization paying for his/her care. It addresses issues of quality and cost controls to ensure the highest quality patient care at the lowest cost and the ongoing minimization of patient risk.

3. Educate the Medical Staff and Other Health Care Professionals:
The ongoing utilization review activity and the identification of problem areas provide continuous education on quality of care and utilization issues to the Medical Staff and other health care professionals.

STRUCTURE

The Quality Management department has four functions:
1. Performance Improvement
2. Risk Management and Safety
3. Utilization Review process which monitors overuse, underuse and misuse and
4. Case Management.

UTILIZATION MANAGEMENT SERVICES

The following are the main types of UM services. Each one reflects management of the utilization of resources in various stages of the delivery of health care services.

a. Concurrent Review:
The concurrent review process is performed at the onset of and during care, for medical necessity, appropriateness of care and services, or any other dimensions of performance. The medical necessity of continued stay or continued treatment is assessed at specific intervals throughout the hospitalization (continued stay review) and will continue as long as the utilization review officer determines that the hospital stay is medically necessary and appropriate. The appropriateness of resource utilization is assessed, including ancillary services, setting or level of care.

The quality and risk of care provided is assessed on an ongoing basis because of the potential adverse impact of an occurrence or failure to treat, utilization of resources and patient quality of life and outcome of care.

b. Retrospective Review:
Review is performed after care has been rendered i.e. it occurs after discharge. Retrospective review offers a complete picture of the service provided, timeliness, patient outcomes and findings can be compared to cost of care. Certain problem patterns may be easily identified. Cases are selected if:
- Additional information is required to complete the review process.
- Additional information is required by third party payers.
- Evaluation is required for reconsideration following denial; make recommendations and/or take appropriate actions.
Since Retrospective review attempts at problem resolution occur after the fact, it may be ineffective.

c. Prospective Review:

The medical need for care is assessed before care is rendered. The most suitable health care setting and treatment is determined in advance, based on costs and benefits (appropriateness and "resource utilization review").

The privilege status of the admitting or treating physician is verified: admitting patients, treatment, surgical privileges, approved suspension status (if medical record is incomplete, prior to admission). The financial assessment of the patient's ability to pay for treatment is completed prior to all elective admissions or outpatient treatment.

d. Focused Review:

Review for a predetermined reason is concentrated on a selected sample of cases.

The Utilization and Case Management Review Committee will identify patients requiring focused review based on internally identified problem areas or areas where the greatest potential benefits exists for a designed study. Focused review consists of admission and continued stay review that is conducted for a pre-determined period. The purpose of such review is to monitor over-utilization, under-utilization, and/or inefficient scheduling of resources. Findings are presented to the Utilization and Case Management Review Committee.

e. Support Service Review:

The effectiveness and appropriateness of support services (Dietary, physical therapy, inhalation...) are reviewed through special studies conducted by the Utilization Review Subcommittee, other Medical Staff committees, or by the providers of the services. Studies are conducted concurrently or retrospectively.

*The utilization review is based on clinical guidelines and structured processes.

REQUIREMENTS FOR EFFECTIVE UM

- Top Level Commitment
- A recognition that Utilization Management is an integral part of the overall quality Management and organization wide performance improvement
- Involvement of treating physicians
- Appropriate and effective review processes
- Utilization Manager Skills: The most important skill that a Utilization Manager needs is excellent communication techniques. Many physicians believe that Utilization Managers are "nurses telling doctors how to practice medicine". They resist reviewers thinking that they are stepping on their toes however their review can often prevent the insurance denial process. (see appendix 1)
- Utilization Management documentation: As in all aspects of medical care, documentation in Utilization Management activities is crucial. Proper documentation of facts helps in validating the diagnosis, appropriateness of admission and the necessity of the treatment plan. Most Third party payers will not pay for services if they do not find evidence in the medical record that this service has been provided or was necessary. Some doctors inadequately documents assessments or plans in the medical records which leads most often to insurance denials. This will both affect the patient and the hospital.

Appendix 1: Practical tactics for effective communication with physicians about utilization management:

1. Focus on the patient. The patient centered approach diffuses suspicion and allows the reviewer and the physician to focus on the same goal.
2. Be colloquial and not adversarial in your approach to physicians. Gain a reputation for solving problems, not becoming one.
3. Be succinct and to the point about your needs and concerns. Physicians are busy and have low tolerance for rambling conversation with reviewers.
4. Make sure you have an accurate and thorough clinical assessment of the situation before your conversation with the physician.
5. Be assertive not aggressive.
6. Keep lines of communication open and follow through on what is discussed. More trust will be gained because of good follow-through than any other approach you may use.
7. Make sure in your conversation that the physician understands UM and its procedures.

UTILIZATION MANAGEMENT (UM) PROCESSES

Utilization Management (UM) processes include but are not limited to the following:

A. Variance monitoring of specific populations of patients, based on clinical pathways or other criteria. Clinical pathways should be used in quality and utilization management to monitor the process of care and the appropriateness of the patient's movement through that process. Identified inappropriate and inefficient variances from the clinical pathway should be documented (clinical pathway give a daily plan of care for a particular illness and standardize the care). (Variance is a deviation from evidence based daily plan of care with no clear justification in the medical record).

B. Monitoring of organizational performance in all its dimensions:

Appropriateness	Efficiency
Availability	Respect and Caring
Continuity	Safety
Effectiveness	Timeliness
Efficacy	

C. Reviewing admissions of ***high-cost patients, selected diagnoses, high and low outliers.*** NOTE: This could include all admitted acute 1-day stays, observation stays, unplanned readmissions/ reoperations within 30 days and unplanned ED revisits within 24hrs.

D. Monitoring ***of length of stay per diagnosis in attempt to control costs*** (lag days and variances). Length of stay is the most fundamental attempt at controlling costs of health care. Lag days and variances are inappropriate acute inpatient days. They may occur at the beginning of a hospital stay, during the stay or at the end of the hospitalization when a patient could have been discharged. These are also called ***avoidable delays/days*** and can be prevented by follow up and monitoring. It is fundamental to mention that the causes of variances which may lead to lag days and undesired outcomes are generally assigned to four categories: 1-patient / family reasons 2-practioner reasons 3-institutions/systems reasons 4-community reasons.

Monitoring can occur by looking at the **type of patient length of stay duration:**

- Rapid Turnover screening (up to 2 days)
  ⟹ Inappropriate admission
- Short-Stay Observation (3-5 days)
  ⟹ Utilization Management and discharge planning
- Long stay (6 to 10 days)
  ⟹ Clinical care management and transition into alternative level of care
- Long term (weeks, months, years).
  ⟹ Rehabilitation, Home care, Revenue consideration

FACTORS CONTRIBUTING TO UTILIZATION PROBLEMS

- The lack of actual cost awareness by physicians and professional staff
- Ordering tests and services out of habit
- Inefficient scheduling of tests and services
- The lack of direct financial incentives to physician for proper resource utilization.
- The lack of appropriate community services at all level of care.
- Fear of malpractice by physicians.

MOVING TOWARD MANAGING UTILIZATION

There are several steps to be followed in order to implement a Utilization Review Plan:

1. Create a Utilization Review Committee that includes representation of members of the larger institution.
2. Develop the utilization review plan
3. Put a tactical plan for implementation and clarify the data to be reviewed. This include focusing on major areas where problem of utilization has been identified through analysis of the collected data, and then putting a strategy for minimizing the use of resources and channeling them to appropriate services to improve efficiency. Example of data to be collected are :length of stay, potentially avoidable days, continued stay reviews, hospital utilization manager interventions related to days of care/costs saved, denials, readmissions and reoperations .
4. Educate physicians and hospital staff about the importance of Utilization.

CONCLUSION

The goal of Utilization Management is to improve the use of resources. It is not just about controlling cost, but it is making sure that the resources are in place so that patients are getting the most appropriate care in the most appropriate setting. This is a proactive effort that has mutual benefits for both patients and the hospital.

References

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