VOLUME 4: MEDICAL SERVICES	Effective Date: 12/2003
CHAPTER 34	Revision Date: 05/2015
4.34.2 UTILIZATION MANAGEMENT MEDICAL SERVICES REVIEW PROCEDURE	Attachments: Yes☐ No☒

I. PROCEDURE OVERVIEW

The purpose of this procedure is to provide a general outline of the California Correctional Health Care Services (CCHCS) Utilization Management (UM) medical services committee structure and responsibilities, review processes, documentation requirements, and processes to appeal denial decisions.

II. DEFINITIONS

Concurrent Review: Review to evaluate the ongoing need for acute, sub-acute, or non-acute levels of care, including review of admissions, continued stays and discharge planning activities.

Emergency Health Care Request: An order for specialty services as determined by the provider that meets the definition of medical emergency.

InterQual®: A library of evidence-based clinical decision support criteria.

Medical Emergency: Any medical condition as determined by medical staff for which immediate evaluation and treatment are necessary to prevent death, severe or permanent disability, or to alleviate disabling pain. A medical emergency exists when there is a sudden, marked change in an individual's medical condition so that action is immediately necessary for the preservation of life, alleviation of severe pain, or the prevention of serious bodily harm to the patient or others.

Medical Necessity: Health care services that are determined by the attending physician to be reasonable and necessary to protect life, prevent significant illness or disability, or alleviate severe pain, and are supported by health outcome data as being effective medical care.

Overutilization: Health care that is provided at a higher volume or higher cost than outcome studies using science-based methodologies and expert clinical judgment describe.

Prospective Review: Review conducted prior to services being rendered (e.g., to determine whether the patient's illness necessitates the requested level of care, or if services could be provided at a lower level of care).

Retrospective Review: Review to evaluate the medical necessity and appropriateness of treatment after it has been rendered, as well as to compare billed services with the actual treatment authorized.

Routine Health Care Request: Any health care request that includes, but is not limited to preventive care, screening, or care as routine follow-up and does not meet the definition of urgent care or an emergency, as determined by the licensed provider.

Underutilization: Health care that is provided at a lower volume or lower cost than outcome studies using science-based methodologies and expert clinical judgment describe.

High Priority Health Care Request: A request for immediate medical attention based on the patient's or non-health care staff's belief that a medical condition, signs, or symptoms require immediate attention by staff trained in the evaluation and treatment of medical problems.

III. UTILIZATION MANAGEMENT REVIEW PROCESS

The UM program shall review high cost, high risk, exceptional, and complex cases via an institutional and headquarters committee structure. This process includes up to four levels of review and shall cover prospective, concurrent, and retrospective reviews.

Emergent Requests For Services (RFS) shall be exempt from the prospective review process; however, an RFS shall be submitted within one (1) business day after the emergency consultation or procedure. All emergency consultations or procedures shall be reviewed by the institution Chief Medical Executive (CME), Chief Physician and Surgeon (CP&S) or designee and shall be subject to concurrent and retrospective reviews.

A. Levels of Review

1. First Level Review
   a. The institution UM Nurse or designee is the first level reviewer and shall:
      1) Review the following:
         a) Health care provider RFSs;
         b) Medical necessity for community hospital admissions and continued stay;
         c) Requests for selected consultations, diagnostic procedures, and outpatient services.
      2) Apply statewide program guidelines and criteria.
      3) Forward RFSs with corresponding statewide program guidelines and criteria to second level review for approval/denial:
         a) The first and second level review of urgent RFSs shall be processed within two (2) calendar days, and the first and second level review of routine RFSs shall be processed within seven (7) calendar days from the date the requesting physician signed the RFS.

2. Second Level Review
   a. The CME or designee is the second level reviewer and shall:
      1) Review all completed RFSs with corresponding statewide program guidelines and criteria from the first level reviewer.
      2) Approve or deny requested services:
         a) The first and second level review of urgent RFSs shall be processed within two (2) calendar days, and the first and second level review of routine RFSs shall be processed within seven (7) calendar days from the date the requesting physician signed the RFS.

3. Third Level Review
   The Institutional Utilization Management Committee (IUMC) is the third level reviewer. The IUMC shall review appealed cases within time frames to allow for service delivery within 14 calendar days of an order for urgent requests and within 90 calendar days of an order for routine requests, if a denial decision is reversed.

4. Fourth Level Review
   The Headquarters Utilization Management Committee (HUMC) is the fourth and final reviewer. The HUMC shall review appealed RFSs within time frames to allow for service delivery within 14 calendar days of an order for urgent requests and within 90 calendar days of an order for routine requests, if approved.

B. Documentation

1. Each health care provider requesting health care services shall complete an RFS before rendering non-emergency services and after emergency services are rendered for the purpose of concurrent/retrospective review.
2. If a decision regarding the RFS is deferred, referred to the next level of review, or denied, the CME, CP&S or designee shall document in the health record the reason for the deferral or denial. The PCP shall document the decision in the health record and provide the patient with alternate treatment plan strategies during the next visit, to be scheduled within 30 days of the deferral or denial of the specialty service.
3. For referrals to the IUMC, the referring PCP shall be responsible for requesting cases to be placed on the IUMC agenda. The PCP shall attend the IUMC to present the case for consideration if requested by the CME.
4. All approved RFSs will be routed to the designated specialty clinic staff or personnel for scheduling.
5. Completed, pertinent UM documentation shall be filed in the patient's health record, in accordance with established protocols.
6. All other UM documentation and computer databases shall be kept on file in the UM office for a minimum of three (3) years. Examples of pertinent documentation and computer records to be filed include:
   a. UM concurrent reviews
   b. Copies of other supporting documentation regarding referrals, community hospitalizations, emergency room visits, and IUMC minutes.

IV. UTILIZATION MANAGEMENT COMMITTEES

A. Institutional Utilization Management Committee

1. Responsibilities

   The IUMC duties shall include, but are not limited to the following:

   a. Review requests for services that do not meet medical necessity criteria which a provider wishes to appeal; requests for services that do not meet medical necessity criteria but which are approved; requests for services that are medical treatment services exclusions under 15 CCR § 3350; and cases of a high cost, high risk, high risk management nature.
   b. Review specialty care appeals and complex cases, and make referrals, as appropriate, to HUMC for fourth level review.
   c. Ensure institutional compliance with all UM program policies and procedures.
   d. Regularly review and analyze data sources regarding specialty referrals, institutional and community hospital bed utilization.

e. Develop and monitor corrective action plans that address under- and over-utilization issues and specialist access to care.
f. Ensure that institutions' medical staff receive training on UM policies and procedures, and provide feedback to providers regarding adherence to policies and procedures.
g. Identify gaps in provider network resources and elevate this information to the HUMC.

2. Membership

The IUMC shall consist of the following members:

a. Institution CME (Chairperson)
b. Institution Chief Executive Officer
c. Institution Chief Physician and Surgeon
d. Institution Chief Nursing Executive
e. Institution UM Nurse
f. Institution Warden, or Associate Warden for Health Care, if appropriate
g. Institution Physician and/or Mid-level Representative
h. Institution Mental Health, Dental, and Pharmacy Representative(s), if appropriate

IUMC members may choose a designee to serve in their absence; however, designees must be approved by the institution CME prior to the meeting.

3. Reporting Structure

The IUMC reports to the institution Quality Management Committee (QMC).

4. Committee Actions

a. The IUMC shall meet at least monthly or as often as necessary, and shall review the following:
   1) Denial decisions made by the secondary reviewer and challenged by the requesting provider.
   2) Specialty care referral data, including backlog data and application of evidence-based clinical decision support criteria (e.g., InterQual®) in the processing of referrals.
   3) Bed census data, including institutional and community hospital bed usage.
   4) Other available UM data, such as data regarding prescribing practices and orders for diagnostic or laboratory studies.
   5) RFSs for patients due to parole in less than 90 days or where the potential for continuity of care can be adversely impacted by a parole date greater than 90 days.

b. Reports with this data shall be submitted monthly to the institution QMC and HUMC. It is the IUMC's responsibility to ensure timely and accurate program utilization data and reports.

c. The IUMC shall be empowered to take the following actions:

1) Identify areas of under- and over-utilization, and address these areas for focused review, education and interventions for the PCP and specialist communities.

2) Coordinate the institution's participation in regional and statewide UM interventions.

3) Submit recommendations to the HUMC regarding the adoption of guidelines, the development of new UM policies or procedures, or the modification of existing UM policies or procedures.

4) Identify institution interventions, practices, and guidelines that have proven effective and refer that information to the HUMC.

5) Provide feedback to providers regarding adherence to policies and procedures.

6) Work with institution training staff to develop and implement UM training programs to increase adherence to UM policies and procedures.

B. Headquarters Utilization Management Committee

1. Responsibilities

The HUMC's duties shall include, but are not limited to the following:

a. Oversight of UM policies, procedures, criteria selections and standards.

b. Development and reporting of UM services indicators.

c. Analysis of trends and development of medical cost containment programs.

d. Assessment of effectiveness and efficiency of resource allocation and management.

e. Clearly define expectations related to UM activities for PCPs.

f. Evaluate, analyze and provide feedback to institution leadership on provider and institutional practice utilization patterns.

g. Provide direction for specialty care referrals and bed usage through defining medical necessity, selecting appropriate referral, admission and discharge criteria, and setting statewide standards for utilization management.

h. Assess and recommend interventions to correct either under- or over-utilization of medical care services, including assessments of access and availability of medical care.

i. Perform the fourth and final level of review and appeal for any requests for medical services.

2. Membership

a. The HUMC Chairperson shall be designated by the Statewide Chief Medical Executive.

b. The HUMC shall consist of, but not be limited to, the following members:

1) Assistant Statewide Medical Executive, or designee.

2) Deputy Medical Executive, Utilization Management, or designee.

3) Three (3) physician representatives.
4) Executive or Managerial representation from Medical, Nursing, Mental Health, Dental, and Quality Management, if appropriate.

3. Reporting Structure

The HUMC reports to the Headquarters QMC.

4. Committee Actions

a. The HUMC shall meet at least quarterly or as often as necessary, and shall review data describing the following:
   1) Health care access, including backlogs in specialty care referrals, bed census information, and gaps in the provider network.
   2) Adherence to UM standards, including adherence to established criteria.

b. The HUMC shall be empowered to take the following actions:
   1) Develop standardized definitions for medical necessity.
   2) Develop UM policies, procedures, and standards.
   3) Recommend the adoption of specified UM criteria.
   4) Develop interventions to correct under- and over-utilization of medical services.
   5) Implement interventions approved by the headquarters' QMC and monitor progress.
   6) Recommend strategies to improve the effectiveness and efficiency of resource allocation and management.
   7) Recommend strategies to increase provider network capacity.
   8) Refer institution-specific problems with health care access and/or compliance with standards and criteria to IUMC for appropriate action.
   9) Refer professional practice issues to the Professional Practice Executive Committee for action.
   10) Refer quality improvement issues to headquarters' QMC for action.
   11) Other actions as appropriate.

c. The HUMC shall develop an annual UM work plan that describes the following:
   1) Program areas identified as highest priority for that year.
   2) Interventions scheduled for implementation.
   3) Ongoing monitoring and evaluation of priority program areas and planned interventions.
   4) Any other important UM activity.

d. The annual UM work plan shall be submitted to headquarters' QMC for approval. The HUMC shall be responsible for regularly reviewing and approving the UM work plan, and communicating progress to headquarters' QMC.

C. Committee Quorum

A quorum shall exist when half of the HUMC's voting members are in attendance, and there shall be no less than three (3) voting members present in order to take action on any agenda item.

D. Committee Voting

Only licensed MD and DO committee members shall be allowed to vote on decisions to approve or deny a request.

E. Committee Proceedings Documentation

Records of committee proceedings shall be kept at a secure, accessible medical program site for a period of three (3) years. At a minimum, the record shall describe all committee actions and recommendations.

F. Confidentiality

The proceedings and records of the IUMC and HUMC shall be confidential and protected from discovery to the extent permitted by law, including, but not limited to, the California Evidence Code Section 1157 and California Civil Code.

V. REFERENCES

- California Code of Regulations, Title 15, Chapter 1, Subchapter 4, Article 8, Sections 3350, 3352, and 3352.1
- California Civil Code, Section 56 et seq.
- California Evidence Code, Section 1157
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 4, Chapter 8, Outpatient Specialty Services