Inpatient Utilization Review Program

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Current Prior Authorization Scope

- Audiology
- Diagnostic Imaging
- Inpatient out-of-state admissions
- PT/OT
- Private duty nursing
- Surgeries- elective and back surgeries
- Vision
- Behavioral Therapy
- Durable Medical Equipment (DME)
- Medical services including transplant and bariatric surgery
- Long-term home health (LTHH)
- Speech Therapy
- Synagis®

Note: For the above categories, all PARs for clients age 20 and under are reviewed according to EPSDT guidelines.

Inpatient Utilization Review Program

Through SB 18-266, the Department is implementing a comprehensive inpatient hospital review program in collaboration with our stakeholders

Program Goals

- Improve member's quality of care
- Facilitate better care planning and inpatient care transitions
- Reduce inappropriate hospitalizations, reduce misuse of services and upcoding that can occur
- Provide timely, accurate information and tools to our partners who can then assist those members needing the most assistance
- **The right care, in the right place, at the right time**

Inpatient Review Program Components

Review Type	Definitions
Admission	Pre-authorization for planned, elective, urgent/emergent, holiday or weekend admissions with guidance on length of stay and care settings. **Includes approximately 30% "Smart Review" or automatic approvals of requests that meet specific coding and clinical criteria**
Continued Stay/Complex Case Reviews	Review of pre-authorized admissions with greater than a 4-day length of stay to ensure that there are no early discharges that might potentially result in a new admission for the same admit diagnosis and complex case medical appropriateness review
Pre-Pay Retrospective Reviews	MMIS Vendor pends claims with select APR-DRGs before payment and request clinical documentation for appropriateness of medical necessity. If the clinical documentation doesn't support the medical necessity, then the claim is denied
APR-DRG Validation Reviews	Validation of documentation in the medical record to information submitted on the claim to ensure that the diagnoses and procedures, discharge status, and other variables as coded and/or reported by the hospital on its claim, match both the attending physician's description and the information contained in the patient's medical record. These reviews are post-pay. **5% random sampling of cases that include APR-DRG codes on select list**

Care Coordination with the RAEs

- Daily feeds to the RAEs detailing admissions that include potential high risk members prioritized
- Daily feeds to the RAEs detailing continued stays over 4 days prioritizing potential high risk members with their projected discharge date

Patient Prioritization

Daily reports will have patients listed in priority order to allow targeted coordination of care

List Order	History of Behavioral or Mental Health Diagnoses or last (2) years	Any Occurrence of all-cause 30 day readmissions over the last (2) years	Patients with high-ED (emergency department) utilization, with three (3) or more visits over the last year.	High-risk pregnancies
First	X	X	X	X
Second	X		X	X
Third		X	X	
Other	Any other subsets of the population, as identified			

Implementation Highlights

- Conducting meetings with key stakeholders
- Conducting hospital test connectivity and training
  - approximately 80% of hospitals are currently integrated
- Go live beginning of January 2019

Questions?

Contact Information

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Thank You!