Inpatient Utilization Review Program

Presented by: Erin Collins

September 11, 2018
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

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Definitions</th>
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</thead>
<tbody>
<tr>
<td>Admission</td>
<td>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</td>
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<tr>
<td>Continued Stay/Complex Case Reviews</td>
<td>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</td>
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<tr>
<td>Pre-Pay Retrospective Reviews</td>
<td>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</td>
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<tr>
<td>APR-DRG Validation Reviews</td>
<td>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</td>
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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

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