Utilization Review Metrics Aren’t Just for Physicians

Utilization review (UR) has a powerful reach throughout healthcare organizations today, impacting everything from medical necessity denials to revenue growth and strategic direction. Here’s what you need to know to boost revenue cycle performance.

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With the transition to value-based care and an increase in payer and regulatory scrutiny, hospitals need robust UR programs that use key metrics and internal benchmarking tools to address challenges, achieve optimal clinical results, and lead organizational change.

C-suite sees value in UR data

C-level executives are closely watching UR practices and metrics because of the strong connection to financial performance and compliance.

“CEOs care about utilization review metrics because they want high-level assurance that their organization is compliant with the regulations, they are getting a fair deal in commercial contracts, and they are using resources correctly,” says Kurt Hopfensperger, MD, JD, vice president of compliance and physician education at Optum Executive Health Resources. “UR data can support important decisions on the amount of reserves they should maintain for future audits and how to invest in clinical services,” he adds.

At the same time, CFOs recognize that UR is one of the largest drivers of consistency or variability in revenue, says Hopfensperger. They see how the revenue difference between outpatient and inpatient stays impacts revenue and net operating income. “The incremental effect of applying a consistent and compliant utilization review process can in many ways dwarf the returns in other areas,” he says. The observation/inpatient ratio can be a key barometer for how well a provider organization is performing in both the Medicare and commercial insurer arenas.

Chief compliance officers and case management directors, meanwhile, want benchmarks on the number of patients who did not receive first-level screening reviews or physician advisor reviews. First-level screening reviews are preliminary medical necessity reviews by case managers to identify cases that clearly should remain in observation status. These executives also want data on the number of times an initial physician order was revised by the treating physician based on UR.

Identifying top UR challenges

As UR data and insights continue to grow in importance, hospitals must address several problem areas. Hopfensperger says medical necessity compliance poses the biggest UR threat. While hospitals that participate in the Medicare program know best practice is to review each patient admission for medical necessity, length of stay, and professional services, it isn’t always enough. “They must dig deeper.” For example, they need to perform a rigorous review of length of stay issues in as close to real time as possible, while checking for outliers.

Performing inconsistent reviews of admission status using Medicare or commercial insurance criteria also presents headaches. Hospitals must review requirements from both payers in the same or a similar manner,
says Hopfensperger. Inconsistency can result in increased denials and reduced revenue. Moreover, hospitals with weak data and metrics experience constant challenges. “A fair number of hospitals still don’t know what data to collect on their own, and they don’t have the knowledge or statistics to develop effective metrics,” he says.

**Spotlight on UR metrics and benchmarking tools**

To this point, having the right combination of metrics and benchmarking data is the key to correctly and consistently applying UR processes, says Hopfensperger. The most important metrics include inpatient utilization rates, observation rate changes, avoidable days, and case manager performance. Condition code 44 rates, which reveal how often attending physicians are writing incorrect inpatient orders, are also critical. “You want data and benchmarking that will point to internal consistency or lack thereof,” he says. This is especially true when it comes to reducing medical necessity denials. According to Hopfensperger, there are four types of medical necessity cases that pose the highest audit risk:

1. **Short inpatient stays (less than two midnights).** These stays are routinely audited by commercial and government payers. **Metrics:** Review short-stay rates as well as internal and external audit results.

2. **Inpatient stays not supported by medical necessity.** Common reasons for such stays include convenience care and unreasonable care delays. **Metrics:** Review how often these cases fail internal criteria and physician advisor reviews. Look at double failure and medical necessity rates.

3. **Patient stays of three midnights followed by transfer to skilled nursing facility.** **Metrics:** Check data on the proportion of patients who have followed this exact pattern. Review Medicare PEPPER data and metrics to determine whether 100% of those patients were screened for medical necessity.

4. **Observation stays greater than 48 hours.** **Metrics:** Determine the percentage of patients who have received an internal review for medical necessity. Of those who failed inpatient medical necessity criteria and were not clearly observation, what percentage went to a physician advisor?

**Review methods and processes instrumental in UR success**

The UR review method should be based on evidence-based medicine and an extensive review of the medical literature—not a physician advisor’s opinion. It should also include feedback from commercial and government payers, auditors, and even Administrative Law Judges on what they consider to be an inpatient stay vs. observation. Reviews should be done in a timely manner and before the patient leaves the hospital. A final word of advice, says Hopfensperger: “It takes a lot to achieve optimal results. Yet, hospitals sometimes take it on faith that utilization review is working well. There is no need to do that. Just follow the data.”