St. David's South Austin Medical Center

Policy on Review of Concerns Related to Utilization

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1. POLICY, PURPOSES, AND DEFINITIONS

1.A ***Policy.*** It is the policy of St. David's South Austin Medical Center (the "Hospital") to provide quality and safe care in an effective and efficient manner, so that limited resources may benefit as many patients as possible.

1.B ***Purposes.*** This Policy is intended to supplement and be used in conjunction with the Hospital's Utilization Management Plan, Professional Practice Evaluation Policy ("PPE Policy"), and Medical Staff Professionalism Policy. This Policy has two primary purposes:

(1) ***Clarify the Role of the Utilization Review Committee ("UR Committee") in Managing Performance Issues.*** This Policy describes how the UR Committee will use collegial and educational efforts to:

(a) assist Practitioners in successfully addressing concerns that may be identified pursuant to the Utilization Management Plan regarding the medical necessity of admissions, continued stays, observation services, and other professional services; and

(b) promote a positive, educational approach to utilization and a culture of continuous improvement surrounding these issues; and

(2) ***Integrate and coordinate the efforts of the UR Committee with the Medical Staff Peer Review/Professional Practice Evaluation ("PPE") Process***. Specifically, this Policy describes how:

(a) concerns regarding the medical necessity of procedures and diagnostic tests are to be immediately referred for review through the PPE Policy;

(b) other utilization concerns that were identified through the Utilization Management Plan but that could not be successfully resolved by the UR Committee are also referred for review through the PPE Policy; and

(c) concerns regarding unprofessional conduct within the utilization process (e.g., refusal of a Practitioner to cooperate with utilization review activities) are referred to the Leadership Council for review under the Medical Staff Professionalism Policy.

1.C ***Definitions.***

(1) "Medical Staff Leader" means any Medical Staff Officer, Department Chairperson, division director, or committee chairperson.

(2) "Physician Advisor" means a physician who has been formally designated to play a role in the utilization review process. This includes, but is not limited to, physicians who are appointed pursuant to Hospital or Medical Staff policy to perform utilization functions (e.g., via direct assignment or committee membership) and physicians who perform these functions pursuant to a contractual relationship involving the Hospital (e.g., Chief Medical Officers and Medical Directors whose job responsibilities include utilization functions, or physicians who provide utilization services through an external agency). For purposes of this Policy, the term Physician Advisor includes physicians who may have been referred to as Medical Advisors, Physician Champions, or similar terms.

(3) "Practitioner" means any individual who has been granted clinical privileges and/or membership by the Board, including, but not limited to, members of the Medical Staff and Advanced Practice Professionals.

2. IDENTIFICATION OF CONCERNS RELATED TO UTILIZATION

2.A ***Review of Data*.** The UR Committee and its representatives will review data to identify potential utilization concerns involving Practitioners.

2.B ***Reported Concerns.***

(1) Practitioners or Hospital employees may report potential utilization concerns to the PPE Support Staff, a Medical Staff Leader, or a member of the UR Committee. All such reports will be forwarded to the PPE Support Staff.

(2) The Chair of the UR Committee will follow up with the individual who raised the concern in a manner consistent with Article 2 of the PPE Policy (e.g., thanking the individual for raising the concern, informing the individual that the matter will be reviewed but that the results of the review cannot be disclosed due to confidentiality requirements, and informing the individual that retaliation is not permitted against anyone who raises a concern about utilization).

3. UR COMMITTEE'S REVIEW OF UTILIZATION ISSUES INVOLVING ADMISSIONS, CONTINUED STAYS, AND CERTAIN PROFESSIONAL SERVICES

3.A ***Scope*.** This Policy does ***not*** replace the Utilization Management Plan. Instead, this Policy supplements and is to be used in conjunction with the Utilization Management Plan, Professional Practice Evaluation Policy, and Medical Staff Professionalism Policy. Please see Section 1.B for a summary of how this Policy relates to other Hospital policies and a list of the types of issues the UR Committee will refer to other committees.

3.B ***Review by UR Committee.***

(1) If, based on its own review of data or referral from another source, the UR Committee determines that a Practitioner appears to be engaging in a pattern of unnecessary:

(a) admissions,

(b) use of outpatient status with observation services,

(c) continued stays, or

(d) professional services ***(other than the medical necessity of procedures and diagnostic tests, which will be assessed under the PPE Policy in accordance with Section 4),***

it shall address the issue as outlined in this Section.

(2) If, at any time during its review, the UR Committee identifies a possible concern about the Practitioner's clinical competence that is not primarily related to utilization (e.g., concerns about poor operative technique or the use of inappropriate medications), the UR Committee shall refer that issue for review under the PPE Policy.

3.C ***Notice to Practitioner.*** The Practitioner shall be notified in writing of the general nature of the UR Committee's concerns and asked to attend a meeting to discuss the concerns. The Practitioner may also be requested to submit written information regarding the resource utilization issue prior to the meeting.

3.D ***Meeting with Practitioner.***

(1) The meeting with the Practitioner shall be held within ten days of the written notice of the concerns. The meeting may involve the entire UR Committee or one or more members. The relevant Department Chairperson shall be invited to attend. If the UR Committee determines that the issue may be related to practice patterns of the Practitioner's group, other members of the group may also be asked to attend.

(2) In order to promote the collegial and educational objectives of this Policy, all discussions and meetings with a Practitioner shall involve only the Practitioner and UR Committee members. No counsel representing the Practitioner or the UR Committee shall attend any of these meetings, and no recording (audio or video) shall be permitted or made.

3.E ***Failure to Attend Meeting or Provide Input.***

(1) If the Practitioner fails to attend the meeting with the UR Committee members or provide written input as requested, the Practitioner shall be required to meet with the Leadership Council to discuss why the requested input was not provided.

(2) Failure of the Practitioner to either attend the Leadership Council meeting, or provide the requested information to the UR Committee prior to the date of the Leadership Council meeting, will result in the automatic relinquishment of the Practitioner's clinical privileges until the information is provided.

(3) If the Practitioner fails to meet with the UR Committee members and provide any requested input within 30 days of the automatic relinquishment, the Practitioner's Medical Staff membership and clinical privileges will be deemed to have been automatically resigned.

(4) The automatic relinquishment or resignation of appointment and/or clinical privileges described in this section are administrative actions that occur by operation of this Policy. They are not professional review actions that must be reported to the National Practitioner Data Bank or to any state licensing board or agency, nor do they entitle the Practitioner to a hearing or appeal.

3.F ***Collegial and Educational Interventions to Address Utilization Concerns.*** If, based on its review and any information or input provided by the Practitioner, the UR Committee determines that a pattern of unnecessary admissions, use of outpatient status with observation services, continued stays, or professional services has occurred ***(other than the medical necessity of procedures and diagnostic tests, which will be assessed under the PPE Policy in accordance with Section 4)***, the UR Committee may take one or more of the following actions:

(1) ***Educational Letter.*** The UR Committee may send a letter of education and guidance to the Practitioner that identifies utilization goals and suggests measures by which to achieve those goals. The UR Committee may then monitor the Practitioner's utilization practices as necessary, depending on the circumstances.

(2) ***Collegial Intervention.*** The UR Committee may engage in a face-to-face collegial meeting with the Practitioner to discuss utilization issues.

(3) ***Periodic Meetings.*** The UR Committee may require the Practitioner to meet periodically with one or more members of the UR Committee for specific case review and analysis.

(4) ***Work with Case Managers, Physician Advisors, or Others.*** The UR Committee may require the Practitioner to meet and/or work directly with Case Managers, Physician Advisors of the Care Management Department, external physician advisors, or other physicians to better manage utilization issues.

3.G ***Referral for Review under PPE Policy.*** The UR Committee shall refer a matter for review under the PPE Policy when:

(1) a Practitioner continues to engage in a pattern of inappropriate utilization despite the UR Committee's collegial and educational efforts at intervention; or

(2) the UR Committee determines that a Performance Improvement Plan should be developed by the PPEC to address the utilization issues identified. The UR Committee may recommend elements of a Performance Improvement Plan

that it believes should be included (e.g., specific CME activities, second opinions, etc.).

4. REFERRAL OF ISSUES RELATED TO THE MEDICAL NECESSITY OF PROCEDURES OR DIAGNOSTIC TESTS FOR REVIEW UNDER THE PPE POLICY

4.A ***Referral.*** Any concern that a Practitioner may be performing unnecessary procedures or diagnostic tests, either reported to the UR Committee by a Practitioner or Hospital employee or identified by the UR Committee during its review activities, shall be referred for review under the PPE Policy. These issues generally require specialty-specific clinical expertise to assess, and that expertise can most effectively be obtained through the PPE process.

4.B ***Feedback to UR Committee.*** If a concern about the medical necessity of procedures or diagnostic tests is reviewed by the Professional Practice Evaluation Committee ("PPEC") through the PPE Policy (either as a result of a referral from the UR Committee or via the PPEC's own review), the PPEC will notify the UR Committee of any utilization issues that should be monitored with respect to the Practitioner's ongoing practice. The PPEC will also share information related to any "lessons learned" from these medical necessity reviews that may be useful to the UR Committee's activities.

5. REFERRAL OF ISSUES RELATED TO PROFESSIONAL CONDUCT FOR REVIEW UNDER MEDICAL STAFF PROFESSIONALISM POLICY

(A) All individuals who practice within the Hospital are expected to cooperate with the review process described in this Policy. Without limiting the foregoing, all individuals are expected to respond in a timely manner to requests for information (whether written, oral, or electronic) by the Case Management Department, Physician Advisors of the Case Management Department (internal or external), or UR Committee members. This includes returning phone calls, providing written information, and attending meetings when requested to do so.

(B) A Practitioner's failure to cooperate with the Utilization Review Committee's request for information or to attend a meeting will be addressed in accordance with ***Section 3.D*** above.

(C) A Practitioner's failure to cooperate with the utilization review process in any other manner will be referred to the Leadership Council for review under the Medical Staff Professionalism Policy (e.g., failure to communicate with Physician Advisors; failure to comply with the collegial and educational interventions developed by the UR Committee pursuant to ***Section 3.E***).

6. PRINCIPLES OF REVIEW AND EVALUATION

6.A ***Confidentiality.*** Maintaining confidentiality is a fundamental and essential element of the review process described in this Policy. All information generated pursuant to this Policy will be maintained in a confidential manner in accordance with the [State] peer review protection law. To the extent applicable, the confidentiality requirements set

forth in Article 6 of the PPE Policy will be used for guidance with respect to activities conducted under this Policy.

6.B ***Legal Protection for Reviewers.*** It is the intention of the Hospital and the Medical Staff that the process outlined in this Policy be considered patient safety, professional review, peer review, and quality assurance activity within the meaning of the Patient Safety Quality Improvement Act of 2005, the federal Health Care Quality Improvement Act of 1986, and Texas law. In addition to the protections offered to individuals involved in review activities under those laws, such individuals shall be indemnified and covered under the general liability insurance policies of Health Care Indemnity, Inc. (a subsidiary of HCA) and/or the Hospital when they act within the scope of their duties as outlined in this Policy and function on behalf of the Hospital.

6.C ***Delegation of Functions.*** When a function under this Policy is to be carried out by a member of Hospital management, by a Medical Staff Leader, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. However, the delegating individual or committee is responsible for ensuring the designee performs the function as required by this Policy.

Adopted by the Medical Executive Committee on March 13, 2020.

Approved by the Board on March 19, 2020.