

# Contra Costa Health Plan

*Utilization Mgmt.*

---

## Title: Tracking Utilization Management Systems

**Policy #: UM15.006**

Origin Date: 11/24/97

Revised: 04/01/00

10/01/02, 10/05, 03/06, 6/19/08, 12/7/11, 11/22/13

7/10/2018, 01/2019, 10/2019

Reviewed 5/2015, 3/2016, 01/2017, 01/2018

7/10/2018, 01/2019

Reviewed 12/31/2020, 6/2021, 2/2022, 5/20/2022,  
11/2023

Revised 7/24/25

Author: Dee Patrick, QM Director

Author: Florence Chan, UM/Auth Manager

Author: Florence Chan, UM Director

Author: Jose Yasul, MD, Medical Director

Reviewed: Lynn Soloway RN, Auth & UM Director

Revised: Joyce Al-Islam, RN, UM Nurse Manager

Reviewer: Dennis Hsieh, MD, JD, CMO

Reviewer: Irene Lo, MD, FACS, CMO

Author: Robert Auman, Program Mgr, BHD

**Reviewed and approved by Quality Council: 6/9/16, 4/27/17, 12/14/17, 2/28/19, 6/2021,  
Presented in UM Committee: 5/2022, 11/2023**

### Applies to:

Medi-Cal

BHC

Medicare

State Sponsored

Commercial

All  N/A

### Regulatory/Accreditation:

DMHC:

Other Reg. References:

CMS:

NCQA:

DHCS:

N/A

### Units:

Administration

Business Services

Marketing

Provider Affairs

Advice Nurses

Care Management

Member Services

Quality Management

All Staff

Health Ed/Cultural Ling.

Planning, Survey, Reg Affairs

Auth/Utilization Management

---

## POLICY

Under the direction of the Medical Director, Contra Costa Health Plan (CCHP) Utilization Management Department shall maintain a system to monitor and track services requests that are authorized, modified, and denied as well as referrals to in-network and out-of-network providers.

## PURPOSE

CCHP shall track and trend service requests that are authorized, modified, and denied as well as referrals to in-network and out-of-network providers to ensure that members are receiving requested services that are medically necessary. Identified trends, patterns, and deficiencies will be analyzed to determine what effects they have on an individual member or a segment of the Health Plan population. CCHP will validate findings, develop work plans, and implement processes to address trends, pattern and deficiencies that may potentially improve or adversely affect the management of health care resources for CCHP members.

## PROCEDURE

Data will be used to identify opportunities for quality improvement. Two categories of UM activities are tracked:

### 1) Program Activities

The impact and efficiency of the Utilization Management Program (UMP) is monitored through the collection of information about the UM process. An electronic database tracks the following UM processes, but are not limited to:

- Timeliness and determinations of authorization requests
- Inpatient hospitalization reviews

- In-network and out-of-network provider referrals
- CCS referrals (primarily applies to Medi-Cal)
- Clinical responses to provider appeals

This information is tracked continually and tabulated monthly. The data provides valuable information, which includes individual provider trends, frequency of authorized procedures that perhaps should not require prior authorization, and services that may be over and under-utilized (refer to policy UM15.008- Under/Over Utilization for detailed information). On no less than a quarterly basis, as part of Inter-Rater Reliability (IRR) or in conjunction with oversight audit activities, the Medical Directors, Medical Consultants, and UM Nurses will randomly sample the work quality of the Authorization and Utilization Management department. The following elements are reviewed:

a) For authorization request determinations:

- The appropriate level of personnel is making the determination.
- The decision-making process is timely.
- Decisions are clearly documented.
- For denial/modification, reference/citation/source is cited in the written notice.
- Reviewers are in compliance with CCHP policies and procedures.
- Decisions are consistent.
- Correct medical criteria and guidelines are used.
- Members and providers are notified with the appropriate CCHP letter with appeal rights, non-discrimination notices, and language tag lines attached.

b) For in-network and out-of-network specialty referrals:

- Timeliness of the authorization process
- Timeliness of when the member was seen by the specialty provider
- If the specialty consult/evaluation report is sent to the originating/requesting provider

When problems are identified, one of the following corrective actions may be indicated:

- Targeted (focused) review with a larger sample of cases will be instituted
- In-service and staff training
- Procedural changes
- Policy analysis and revision

Problems will be studied, and corrective action plans instituted. Corrective action will be monitored to ensure follow through.

## 2) Utilization Management Data

This data analysis process focuses on service utilization by members, primary care providers (PCP), and specialty providers with emphasis on identifying and correcting problems resulting from over- and under- utilization. Problems identified are defined as deviations from approved criteria and/or accepted standards of care. The information and data that support problem identification activities may include, but are not limited to the following:

- Results of individual case review
- Length of stay analysis
- Per member/per month statistics such as specialist visits, referrals, laboratory use
- Case mix and DRG reports

- Externally generated State and Federal reports
- Medical audits and utilization studies
- Cost outlier's cases

Problems will be studied and corrective action plans instituted. Corrective action will be monitored to ensure follow through.

A. Physician Review:

1. Method of Data Collection
  - a. Retrospective review of Prior Authorization Requests (PARs) for services denied by a Physician Reviewer
2. Staff Responsible
  - a. UM Director, UM Manager, and UM Charge Nurse
  - b. Medical Directors and UM Consultants
3. Sample:
  - a. The UM Director and UM Nurse Manager will coordinate, schedule, and conduct a quarterly Interrater Reliability Review (IRR) of PARs for services denied by a Physician Reviewer. The UM Director, UM Manager, and UM Charge nurse randomly selects 10-15 cases of initially denied services or 10-15 other type of cases as decided by the UM Physician's Group. Sample PARs selected are audited by a physician not involved in the initial review. The Questionnaire is Attachment A. The UM Director or designee will collect and score the questionnaires. The Medical Director reviews the IRR findings.
  - b. Over the course of a year period, a sample size of at least fifty (50) cases or 5% (whichever is less) of services denied (for a combination of UM PARS and Appeals) will be audited by each Physician
  - c. If there is no alternate physician available to perform an inter-rater reliability audit, a physician experienced in UM employed by a Medi-Cal Managed Care Plan performs the review.
4. Time Frame
  - a. The audit compliance summary for Physician Reviewers is reported quarterly to Quality Council.
5. Results:
6. An accuracy rate of 90% is targeted for IRRs. If a Physician falls below the 90% threshold remediation measures in the form of a corrective action plan is immediately initiated by the Chief Medical Officer or designee. Corrective action plans could include but are not limited to educational activities, supervision of decisions, increased oversight of UM decisions, or prohibiting the physician from making UM decisions. CCHP shall conduct interrater reliability testing for all new staff before they can conduct utilization review without supervision.

B.

UM Nurse Review:

1. Method of Data Collection
  - a. Retrospective review of Prior Authorization Requests (PARs) processed
2. Staff Responsible
  - a. UM Director, UM Manager, and UM Charge Nurse
  - b. Chief Medical Officer and UM Nurse Reviewers
3. Sample:
  - a. The UM Director, UM Nurse Manager, and UM Charge Nurse will coordinate, schedule and, conduct a quarterly Interrater Reliability Review (IRR) of PARs processed by UM Nurse Reviewers. The UM Director, UM Manager, and UM Charge Nurse randomly selects 10-15 cases processed in the previous 3 months. Sample PARs selected are given to all nurses involved in clinical decision making. The questionnaire is Attachment A. The UM Director

- will collect and score the questionnaires. The Chief Medical Officer reviews the results of the IRR.
- b. Over the course of a year period, a sample size of at least fifty (50) cases will be audited by each Registered Nurse Reviewer.
4. Time Frame
    - a. The audit compliance summary for UM Nurse Reviewers is reported quarterly to Quality Council.
  5. Results:
    - a. An accuracy rate of 90% is targeted for IRRs. If a UM Nurse reviewer falls below the 90% threshold, remediation measures in the form of a corrective action plan is immediately initiated by the Chief Medical Officer or designee. Corrective action plans could include but are not limited to educational activities, supervision of decisions, increased oversight of UM decisions, or prohibiting the nurse from making UM decisions.
  6. CCHP shall conduct interrater reliability testing for all new staff before they can conduct utilization review without supervision.

## **REPORTS**

Analysis of aggregated data as delineated in sections 1 and 2 above will be referred to the Chief Medical Officer for review. If warranted, action plans are developed and implemented. Data analysis and process modifications will be documented and prepared in an appropriate document utilizing memos, policies, tables, graphs, and/or other descriptive charts. A report will be prepared for the Chief Medical Officer or designee for review, presentation, and as appropriate, discussion in the UM Committee, and Quality Council. The Chief Medical Officer will discuss with the Health Plan providers any process modifications that are needed. Tracking of data will verify if the process has been implemented and whether it was successful. All results will be reported to the above groups with follow up and/or further action recommendations.