

Tips to Help Take the Hassle Out of Inpatient Utilization Review

The secrets are to think like a reviewer, hone your documentation skills and be a good communicator, says this FP who's seen both sides of UR.

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For the last 10 years, I've been on both sides of utilization review (UR). As a practicing physician, I know what it's like to get "those calls." As a part-time utilization reviewer, I'm usually satisfied with the interactions I have with physicians and the information I get from them. When a telephone review seems unsatisfactory, it's often because I feel I'm speaking a different language than the treating doctor. Perhaps I am. I've been trained in how to review cases, but doctors receive no training in how to be the recipients of "those calls."

I hope this article helps to fill that educational gap by helping you better understand the process of inpatient review and how you can help make it less painful. I'll explore what inpatient review means, present some typical cases and suggest how you can help minimize your aggravation with the process. The goal is to reduce the number of calls you have to return and the time you have to spend defending your work.

What's being reviewed?

Inpatient utilization review has two basic components:

- **Daily assessment of the patient's needs.** Does a patient who's just been admitted really need an acute level of care? Does an existing patient have a continuing need for acute care? Could the patient's needs be met in a different setting?

- **Retrospective review of the inpatient chart.** Did the patient need the level of care he or she received at each point in the hospitalization? Could the patient have been treated at a lower level of care?

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The review process may seem like nothing but a hassle to you, but it's a necessary evil. Studies have repeatedly shown great variations in care across the country for patients who have a given diagnosis or problem. Furthermore, practicing physicians often simply aren't aware of the options for lower-level care in their areas. ►

KEY POINTS

- To minimize the hassles of inpatient utilization review, learn to think like a reviewer.
- Ask yourself whether the patient's needs really require hospitalization and whether tests could be performed in outpatient facilities.
- Know the answers to the questions utilization reviewers are likely to ask.

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Covered in FPM Quiz



Utilization review is a “necessary evil” given the great variations in care for patients with like problems.



To reduce inpatient review hassles, practice thinking like a utilization reviewer.



Ask yourself whether the patient requires acute care and, if so, what his or her specific acute care needs are.



If a patient simply requires diagnostic tests, hospitalization may not be justifiable.

You be the reviewer

The first step in reducing your inpatient-review hassles is to practice thinking like a utilization reviewer. Here are three questions you should ask yourself about your inpatient treatment decisions, because you can bet the reviewers will be asking them:

- Does the patient require an acute level of care and, if so, what are the patient’s acute needs?

‘Rule out MI’ is an inadequate diagnosis to justify acute hospital care.

- If the patient needs a diagnostic test, can it be performed in another setting?
- How would changing small details of the clinical picture alter the need for hospitalization?

Let’s look at some cases to illustrate what happens when you ask yourself these questions.

Case 1

A 54-year-old man with chest pain is admitted at 4 p.m. on Tuesday. Cardiac enzyme tests are negative. The patient’s ECG is unchanged from testing before admission, and his pain has resolved. The physician, making rounds at 5 p.m. on Wednesday, decides to keep the patient hospitalized for treadmill testing on Thursday. A utilization reviewer calls.

Keeping in mind the questions above, how would you evaluate the situation? Here’s how I see it as a utilization reviewer (of course, as is often the case in medicine, there is certainly room for disagreement):

- The patient doesn’t appear to have acute needs. He is medically stable and didn’t have a myocardial infarction.
- The patient doesn’t need to be in the hospital to have the treadmill test. Based on the information given, he could safely undergo the test as an outpatient.
- If the patient had continued to have chest pain or unstable angina, were receiving a nitroglycerin drip or had gotten a positive enzyme test result, then the review decision would have been quite different.

The point I’m making is that “rule out MI” is an inadequate diagnosis to justify

acute hospital care after the initial observation period has passed. The decision to hospitalize should be based on the patient’s medical stability and acute needs. This patient certainly should have a diagnostic test, but he could safely undergo it as an outpatient.

Case 2

A 33-year-old man with diabetes is admitted with a wound infection, diagnosed as osteomyelitis, following wound debridement. Two days later, the patient has positive wound cultures, is afebrile and is receiving intravenous antibiotics. The patient’s white blood cell count is normalizing and his blood glucose level is stable. A utilization reviewer calls.

Once again, consider how you would evaluate the situation as a reviewer. Here’s how I see it:

- The patient has been diagnosed, has stable vital signs, is receiving a normal diet, and needs IV antibiotics and minimal wound care. His acute needs are ending.
- The patient’s needs could be met at a skilled nursing facility or perhaps through home antibiotic therapy with visits by a nurse for wound care and education.
- If the patient were still febrile, if cultures were pending, if the white blood cell count were rising or if the blood glucose level were out of control, then the review decision most likely would change.

Case 3

A 72-year-old woman with end-stage metastatic breast cancer is admitted because of dyspnea and back pain. Her pulmonary condition is stabilized, and her physician’s orders include parenteral medication and radiation therapy. A utilization reviewer calls.

We can all agree that the patient should get the care she needs; the big question is, ‘Where?’

What do you think about this case? I think it raises several questions:

- So far, all we know about her dyspnea is that it has improved. Is the patient receiving supplemental oxygen? What does her pulse oximetry show?
- What types of parenteral pain medications are being used, and how frequently are

they being administered? Are alternatives being considered? These might include morphine via patient-controlled analgesia, oral morphine, a fentanyl patch (Duragesic) or hydromorphone hydrochloride (Dilaudid).

- How aggressive does the patient want her care to be? Does she have a do-not-resuscitate order?

Depending on the answers to these questions, the patient might be a candidate for treatment at a lower-level care facility or at home.

The treating physician could help the review process by presenting a clearer picture of this patient's medical needs. The diagnoses of metastatic cancer and dyspnea are inadequate to justify treatment decisions in this case. Is the patient medically stable? If her treatment is palliative, would hospice care be appropriate? We can all agree that she should get the care she needs; the big question is, "Where?"

Making the right choice

The point of these cases is that reviewers need specific, detailed information to determine whether acute care is necessary or whether a lower level of care is appropriate. You can make those utilization review phone calls easier if you have certain information at your fingertips:

- Are the patient's vital signs stable?
- Has a diagnosis been made?
- Has a treatment plan been initiated and modified, if necessary?
- What acute nursing needs (and other needs) are present? Can these needs be met at a lower level of care?
- Have you considered alternatives to hospitalization? Why are they not feasible, in your opinion?

It's important to understand that reviewers don't simply use their "gut instincts" when they assess the care patients receive. Utilization review has come a long way since the early days when physician and nurse reviewers just relied on their own clinical experience to make decisions. Now, clinical policies, articles on best practices and reviewer training go a long way toward standardizing the review process. [For more information on using clinical policies in your care delivery, see "Where to Look for Good Clinical Policies," *FPM*, February 1999, page 28, and "How to Evaluate and Implement Clinical Policies," *FPM*, March

1999, page 28.] Of course, clinical judgment is still important, too. Every case is different, and guidelines can go only so far in helping to determine the right patient-care decisions.

Options for lower-level care

If you decide that your patient can be treated at a lower level of care, what are your options? Depending on your patient's needs, you might consider the following resources:

- A skilled nursing facility;
- The hospital's transitional care unit;
- A hospice, for terminal patients;
- A rehabilitation center, for patients needing physical, occupational or speech therapy;
- A convalescent/custodial care center (nursing home);
- Home nursing visits for help with wound care, IV medications or total parenteral nutrition;
- Outpatient diagnostic testing facilities;
- Outpatient physical, occupational or speech therapy.

The hospital's discharge planner is your ally in finding and arranging these services.

The best offense is good defense

Of course, the best way to deal with utilization reviewers' calls is by preventing them through good documentation. If the patient needs to be in the hospital, emphasize why in the chart. If the patient's status is "observation" or "24-hour stay" rather than "admission," make that clear; it will matter to some insurers. If the patient is unstable, specify how. Document the patient's acute needs (e.g., "unable to stand or walk to the bathroom,"

There are a couple of things you should be sure that no utilization reviewer ever sees or hears.

"still febrile," "vomiting every four hours despite IV Compazine") rather than simply stating that the patient has acute needs. Emphasize in the progress note any abnormal physical exam findings, vital signs or lab values. And make your progress notes legible.

There are also a couple of things you should be sure that no utilization reviewer ever sees or hears. Never state that a patient should be discharged if certain criteria are met and

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When a reviewer calls, be prepared to explain why you believe lower levels of care are not feasible for the patient in question.



Reviewers don't rely on gut instincts but on clinical guidelines in making their utilization decisions.



For patients who can be treated at lower levels of care, the options range from home visits to rehabilitation centers to hospice.



Good documentation of why a patient requires hospitalization can prevent phone calls from reviewers.



Never try to justify a hospitalization because the patient simply wants to stay.



If you disagree with a utilization reviewer's decision, you can request review by another physician or a formal appeal.

then fail to discharge when those criteria are met without explaining why. And finally, never state that “the patient wants to stay.”

The right way to disagree

The time still will come when you disagree with a utilization reviewer's decision. What then? First of all, don't take it personally; the

The reviewer isn't criticizing you but is exploring more cost-effective paths to the same destination you want to reach.

reviewer isn't criticizing you but is exploring more cost-effective paths to the same destination you want to reach. Second, remember there is always an appeals process. Ask if another physician can review the decision, or file an official appeal. This is your opportunity to state your case to another reviewer,

a medical director or an appeals committee. The hospital's UR department can assist you with this, in most cases.

Minimizing the aggravation of the review process is partly just a matter of good communication. When you think reviewers are wrong, don't scream at them or belittle them (something that I know from experience does happen). Start by being collegial on the phone, and hold the reviewer to the same standard. Present the patient's case briefly, as you might to a colleague in the hospital; but focus on the patient's needs and acuity, not just diagnosis and treatment. And despite your frustration with the process, try not to assume that the reviewer is there to make your life more difficult. Like you, he or she is trying to do a professional, ethical job – just with a different set of responsibilities. **FPM**

Editor's note: The opinions expressed in this article are those of the author alone and do not reflect the policies of any managed care organization.