Utilization Management Plans are Critical to Compliance Plans

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Compliance is relatively a black and white concept...either the center is compliant with its delivery of appropriate services, clinical documentation to support the necessity for those services and billing practices that charge/claim the services or it is not.

Experience in working with CBHOs nationally supports that this seemingly straight-forward concept when viewed at 10,000 feet above sea level creates significant challenges for many CBHOs as they implement the compliance concept in their day to day service delivery processes (“sea level”).

Four of the seven core concepts in a Corporate Compliance Plan (CCP) seem to create the most significant sea level operational challenges for CBHOs and are outlined below:

1. Develop and implement policy and procedures that reduce non-compliant behavior at the CBHO staff and agent level

2. Implement a systematic way to communicate compliance rules and procedures to staff and agents

3. Take appropriate steps to monitor staff and agents

4. Provide a systematic way to discipline/sanction staff and agents for non-compliant behavior

These four concepts can be best supported and fully implemented at sea level with staff and agents through the development and use of a separate Utilization Management Plan (UMP) that serves as a companion to and as operational support for the CCP. Utilization management (UM) within a service delivery process is much broader and more interactive than the historical utilization review (UR), quality improvement (QI) and/or quality assurance (QA) models that many CBHOs use. UM moves away from typical one dimensional “retrospective view of service delivery compliance” to provide support multiple views of compliance such as:
• **Access to Treatment View** (i.e., Timeliness into treatment, screening/triage effectiveness, eligibility, emergency services, referrals, etc.)

• **Concurrent View** (i.e., Transition times between levels of care, awareness of services being provided to high risk consumers, ongoing real time qualitative review of clinical documentation and billing processes, etc.)

• **Prospective View** (i.e., Transfer/discharge criteria/planning, new level of service access to service timeliness monitoring, estimate of duration of services at current level of care, etc.)

• **Retrospective View** (i.e., Qualitative/Quantitative Review of Charts, Coding and Claims Processes and Outcomes/Satisfaction Measures, etc.)

These UM views greatly assist staff and agents by providing much more continuous information about potential compliance concerns for all service delivery process - from first contact for help by the client to discharge planning and every activity in between. The basic operational difference between typical retrospective approaches to compliance and UM is:

• Primarily retrospective review processes (i.e., UR, QA, QI, etc.) seem to be more circular in nature in the day to day service delivery environment. This circular process is best defined within CBHOs with the following scenario:

  ➢ UR Team identifies through retrospective review of charts compliance concerns such as late documentation submission after the service was billed, unsigned treatment plans before treatment starts, qualitative concerns about progress notes, etc.

  ➢ UR Team discusses concerns and develops a recommendation to address concerns and sends finding to supervisor/staff for their attention and correction

  ➢ Some months later the UR Team discussing the same concerns about the same staff, programs or agents when the next retrospective audit occurs.

  ➢ UR Team develops another finding and develops another recommendation to address the concerns.

• UM is a continuous quality improvement (CQI) based progressive approach to compliance. Therefore, the UM process is truly horizontal in nature and moves through time tracking specific actions that need to be taken to ensure non-compliant findings are addressed.
The key sections of the typical UM Plan being used by CBHOs are:

1. Purpose/Justification for Plan: Identify the support capability of the UMP such as management of service utilization is necessary to assure optimal use of resources on behalf of clients, can provide a decision support system for managing service utilization and medical/clinical necessity criteria, levels of care, and practice standards are valid and reliable mechanisms for systems management.

2. Goals and Objectives to be achieved: Identify the specific goal(s)/objective(s) that the UMP will achieve.

3. Levels of Care/Benefit Design Support: Level of care/benefit design guidelines are an important way to support the UM Plan in that they provide a practice-based method to determine the array/types of services and intensity necessary to achieve treatment benefits. Level of care guidelines provide a framework for determining who is eligible for which services at what level of intensity and for how long. These guidelines provide the UMP a framework to support determination of Medical Necessity and importantly provide clinicians with a decision support tool to assist them in assigning clients to the appropriate level of care.

   **Core Elements of Level of Care/Benefit Design Models**
   
   o Admission Criteria (as objective as possible using Diagnostic Profiles, DLA-20 based GAF, LOCUS scores, etc.)
   o Continue Stay Criteria
   o Transition/Discharge Criteria to a lower level of care
   o Service Array and Frequency to be provided
   o Cost of Service Array for each level based on the duration of care timeline
   o Projected Service Duration within each level

4. Overview of the Organizational Structure/Support for Plan: Provide a description of the UM process and the specific members of the UM Team that will be responsible for executing the plan on a continuous basis. Also, identify where the UM Team is located within the organizational structure which should eliminate any supervision by clinical directors/managers or supervisors whose programs or staff will be reviewed by the UM Team.

5. Authority and Responsibility: Define both the responsibility and the authority of the UM Team. This is a key concept in that if the UM Team is not authorized to instruct
supervisors/staff/agents to timely correct non-compliant behavior then the process of compliance becomes circular.

6. **Sampling Procedures:** Identify the specific sampling procedures that will be used by the UM Team for clinical charts, billings, access to treatment, appropriate discharge planning, etc.

7. **Procedures for Following Up on Adverse Findings including Appeal Procedures:** Identify the specific timelines for the UM Team issuing a finding and request for corrective action plan following a adverse finding and the specific timeline the supervisor/staff/agent has to respond with a plan. These procedures should include an appeals process if the supervisor/staff/agent feels the findings are not accurate.

8. **Monitoring Procedures:** Identify the ongoing monitoring procedures that the UM Team will use to confirm if the corrective actions have been taken by supervisors/staff/agents.

9. **Sanctions:** The UM Team should be given sanctioning authority for supervisors, staff and agents that do not timely respond to the corrective action plan provided by the UM Team which includes disciplinary action, up to, and including termination.

The UM Plan is critically important to supporting a Corporate Compliance Plan and implementing levels of care/benefit designs within the CBHO is critically important to support the UM Plan. Additionally, the UM Plan is an excellent way to move staff beyond the discussion of compliance to addressing compliance concerns in a CQI process that challenges staff to move beyond the “way we have always done it”.

In an era of healthcare reform and integration of care models, CBHOs will need to move from loosely held federations of private practices to a group practice model of service delivery. The UM Plan provides the bridge between historical silos of care.

**About the author:** David Lloyd, author of *How to Deliver Accountable Care*, has successfully facilitated the development and implementation of compliance based management accountability initiatives with over 700 CBHOs, regional medical centers, and primary care practices throughout the United States. He has been a featured presenter at numerous national, regional, state and local workshops and conferences. Mr. Lloyd is Founder of MTM Services based in Raleigh, North Carolina, that specializes in providing management, training, and accountable care project management services throughout the nation. Consultation engagement scheduling and Mr. Lloyd’s publications are available at www.mtmservices.org or by contacting Marian Bradley, MTM Director of Operations at marian.bradley@mtmservices.org.