United States General Accounting Office

GAO

Fact Sheet for the Chairman, Select Committee on Aging, House of Representatives

November 1992

# UTILIZATION REVIEW

# Information on External Review Organizations



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GAO

**United States**
**General Accounting Office**
**Washington, D.C. 20548**

**Human Resources Division**

B-251272

November 24, 1992

The Honorable Edward R. Roybal
Chairman, Select Committee on Aging
House of Representatives

Dear Mr. Chairman:

Utilization review organizations [1] (URO) currently have a significant influence on the provision of and payment for health care in this country. Because recommendations made by these organizations may have an impact on what care is approved for payment, a URO might affect a patient's access to health care. As a result, there is a considerable amount of interest in the health care community about who makes utilization review decisions, the professional experience of these individuals, and the review criteria they use.

This fact sheet responds to your request that we obtain information on how UROs perform their work. In conducting this study, we inquired about (1) the size and ownership of UROs, (2) the professional qualifications of staff involved in utilization review decisions, (3) the complexity of decisions made by various types of staff, (4) appeal procedures, (5) clinical review criteria used by UROs, and (6) quality assurance procedures implemented to ensure adherence to company directives. The information was obtained through responses to a questionnaire we sent to 294 organizations—283 that were identified in Faulkner and Gray's 1991 Medical Utilization Review Directory as conducting utilization reviews and 11 that were identified by other UROs as providing utilization review services. [2] (See appendix I for a copy of the questionnaire and aggregate results for each item.) The response rate to the questionnaire was 65 percent (191 organizations), including those organizations that indicated that they do not review medical/surgical cases. Of the 191 UROs that responded, 42 percent (79 organizations) review medical/surgical cases. We did not verify the responses provided by the UROs or analyze the effectiveness of these organizations' operations.

We believe this study provides the most complete information available to date about the roles and responsibilities of staff employed by UROs, the processes employed, and types of review criteria used to make

[1]Utilization review organizations were established on behalf of health benefits purchasers to manage costs through a case-by-case assessment of the clinical justification for proposed medical services.

[2]Questionnaires initially were sent to 41 peer review organizations also listed in the Directory, but these were later excluded because of the difficulty differentiating between policies and processes implemented for Medicare reviews and those implemented for private sector medical/surgical cases.

recommendations about whether care being proposed by providers is appropriate and necessary. Sections 1 through 7, which follow, provide detailed information concerning these matters. In short, we found that

- physicians are usually employed by UROs on a part-time basis or as consultant/advisors;
- registered nurses are heavily involved in first-level review decisions, but physicians become more involved during the second-level review and appeals process;
- UROs generally use commercially developed review criteria when making their recommendations;
- most UROs have established appeal procedures;
- of the few utilization review decisions that are appealed, many are successful; and
- UROs have implemented quality assurance procedures to ensure adherence to company directives.

We are sending copies of this fact sheet to interested congressional Committees, and will make copies available to others on request. If you have any questions, please call me at (202) 512-7101. The major contributors to this fact sheet are listed in appendix III.

Sincerely yours,

David P. Baine

David P. Baine
Director, Federal Health
Care Delivery Issues

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## Abbreviations

| | |
|---|---|
| AEP | Appropriateness Evaluation Protocol |
| AMCRA | American Managed Care and Review Association |
| ART | accredited records technician |
| HCFA | Health Care Financing Administration |
| HSI/LOS | Health Systems International/Length of Stay |
| LPN | licensed practical nurse |
| NIH | National Institutes of Health |
| PAS | professional activities study |
| RN | registered nurse |
| RRA | registered records administrator |
| SMI | Standardized Medreview Instrument |
| SW | social worker |
| TMJ | temporal mandibular joint |
| URAC | Utilization Review Accreditation Committee |
| URO | utilization review organization |
| WBGH | Washington Business Group on Health |

# Utilization Review Process

Utilization review is a process increasingly used in the private sector to help contain health care costs. Prospective utilization review, commonly implemented by external utilization review organizations [1] (URO), is a process where a third party reviews the appropriateness of and/or necessity for a health care provider's proposed hospital admission or medical procedure for a particular individual. The third party reports its opinion to the insurer who then decides whether payment will, in fact, be made. This process has been promoted by health care insurers and purchasers to control and reduce the escalation of health care costs. Different techniques, staff, procedures, and criteria can be employed to make recommendations regarding the proposed care. To help protect against inappropriate recommendations, standards have been established by URO representatives and health care providers. Further, state legislation has been enacted to specify the types of people, procedures, and protocols that should be used in making utilization review decisions.

Utilization review techniques include prehospital admission certification reviews, concurrent reviews, second surgical opinions, and case management. Generally, prehospital admission certification reviews determine if the proposed inpatient hospital care is required. Concurrent reviews are conducted at the time a patient is in the hospital and are designed to determine if the hospital stay should be continued or extended. Second opinion programs refer a patient to an alternate physician for confirmation of a proposed elective surgical procedure before the procedure is performed. Case management reviews focus on providing cost-effective care for patients requiring expensive or extended care, such as stroke rehabilitation or care for AIDS patients.

In many types of review, URO staff make recommendations after comparing the provider's proposed treatment to preestablished review criteria. [2] For example, the patient's physician, a member of the physician's staff, or the patient telephones the URO and explains to a reviewer the proposed care and the relevant medical history. Based on this information and using the review organization's preestablished medical criteria as a guide, the reviewer makes a recommendation about authorizing the care. If the proposed care does not conform to the review organization's criteria, the

[1]Utilization review organizations were established on behalf of health benefits purchasers to manage costs through a case-by-case assessment of the clinical justification for proposed medical services.

[2]Review criteria are based on either a patient's diagnosis or required level of care. These criteria justify admission or continued hospital stay by comparing specific indicators that describe the type, number, and/or intensity of a combination of physician, skilled nursing, and ancillary hospital services requiring a hospital setting to the diagnoses, symptoms, or procedure being recommended by a provider for a specific patient.

case may be referred to another reviewer for a second level review. That reviewer may then make a recommendation about the care.

Recommendations range from recommending approval for the proposed care or recommending a modified care plan to not recommending the proposed care. Additionally, reviewers are sometimes given the authority by the payor to recommend a shorter length of hospital stay, convert an inpatient procedure or hospital stay to an outpatient procedure, or authorize a different health care provider to furnish the care. The reviewer generally only will make recommendations to the health care insurer based on the medical appropriateness or necessity for care. The reviewer will not actually deny payment for the care or prohibit the health care provider from delivering the care. Those decisions are left to the insurer. However, the insurer often accepts the advisory recommendation of the reviewer.

If payment for the proposed procedure or hospital admission is denied on the basis of a reviewer's recommendation, the health care provider and/or patient can usually appeal the decision. To do this, the provider or patient contacts the URO, discusses the case with review staff, and, if necessary, provides additional information. At this first level review of an appeal, utilization review staff reassess the case, make a recommendation, and notify the provider and/or the patient. If this reviewer reaffirms the initial recommendation, a second level of review may occur. Based on the information, a first or second level reviewer can overturn any prior recommendation. The amount of time necessary for the appeals process can vary considerably between organizations and range from hours to weeks. However, in emergency cases, some organizations have a procedure to expedite decisions.

## Some States Have Enacted Legislation to Regulate UROs

Twenty-eight states and the District of Columbia have passed legislation and four states are considering legislation to address issues such as reviewers' qualifications, review standards, and appeal procedures. These statutes resulted from health care providers' concerns that utilization review activities are increasing their administrative workload and preventing patients from obtaining necessary medical care.

For example, Connecticut passed legislation in 1991 following the completion of a URO study. [3] The Connecticut statute established minimum

[3]Recommendations on Standards for Utilization Review Programs in Connecticut was published by the Center for Health Systems Management at the University of Connecticut's School of Business Administration in January 1991.

standards for all UROs to follow, including requirements to (1) maintain and make available procedures for notifying the provider or enrollee about utilization review decisions; (2) maintain and make available written descriptions of appeal procedures; (3) use written clinical criteria and review procedures that are periodically evaluated and updated; (4) allow providers a reasonable time to furnish information needed to certify an admission, procedure, treatment, or stay; and (5) prohibit employees from receiving any financial incentives based on the number of certification denials they make.

Organizations such as the American Managed Care and Review Association (AMCRA) and the Washington Business Group on Health (WBGH) as well as a study group organized by the Institutes of Medicine have opposed such legislation. These organizations believe that legislation and the resulting regulations will constrict the industry's ability to improve utilization review services. They also believe that regulations will increase health care costs by adding expensive administrative requirements.

## Utilization Review Programs Are Accredited by an Independent Organization

Concerns raised by providers, health care purchasers, and insurers about the quality of utilization review services prompted the utilization review industry to establish a voluntary accreditation program for UROs. As of October 1, 1992, 42 UROs have been accredited, [4] and 44 others have applied and are awaiting accreditation. Accreditation serves as an indicator that a URO upholds certain standards.

The Utilization Review Accreditation Commission (URAC) was established in 1990 to develop quality assurance standards for UROs and to accredit organizations that seek this distinction. URAC was created by AMCRA, the American Medical Association, the American Hospital Association, and others in March 1990 to encourage efficient and effective utilization review processes and to provide a method of evaluation and voluntary accreditation of utilization review programs.

In November 1990, national utilization review standards for both prospective and concurrent hospital reviews were published. These standards include such requirements as (1) having only licensed or certified and trained staff conducting utilization reviews, (2) establishing with physician involvement written clinical criteria or protocols for determining the appropriateness of the care, (3) having clinical review criteria used for determining the appropriateness of care periodically

[4]Ten of the accredited UROs responded to our questionnaire.

evaluated and updated, and (4) having clinical review criteria used by review staff when making decisions. URAC standards also state that a physician is required to review the case if a reviewer does not recommend the proposed care. If an appeal is filed and the recommendation not to endore the care is upheld by the reviewing physician, a physician in the same or a similar specialty that typically manages the medical condition or treatment under discussion must be reasonably available to review the case. [5]

Accreditation is for a 2-year period. As of October 1, 1992, no organization had been denied accreditation. However, six organizations were in a correction phase (a period of time from 90 to 180 days) to correct a deficiency that would have resulted in denial of its application for accreditation and three applications were withdrawn from the process.

## Scope and Methodology

The data in this fact sheet were accumulated from responses to a questionnaire and discussions with experts in the utilization review field. We developed the questionnaire incorporating suggestions received during pretests at three UROs and after discussing the questions with AMCRA, the Health Insurance Association of America, WBGH, and other experts in the utilization review industry. We limited our questionnaire scope to medical/surgical utilization review activities performed in 1990 by organizations external to those providing care to the patient. [6] We asked that respondents provide information relevant to their 1990 fiscal year. On July 31, 1991, the questionnaire was sent to 294 companies—283 that were listed in Faulkner & Gray's 1991 edition of the Medical Utilization Review Directory as providing utilization review services [7] and 11 that were identified by other UROs as providing utilization review services. Both AMCRA and WBGH notified their membership to encourage a response to the questionnaire. A second mailing of the questionnaire was sent on September 16, 1991, to those firms that had not responded initially. In November 1991, telephone calls were made to 30 randomly selected utilization review companies that had not responded to the previous mailings. We determined if the organization provided medical/surgical

[5]As of November 1992, URAC has not defined what it means for a physician to be reasonably available. However, based on observations by URAC members of current utilization review practices, it appears that from 1-2 days is within reason for reviewing the appeal and making a final decision.

[6]Additionally, we excluded information pertaining to review activities required by Medicare regulations. The Medicare program requires limited prospective utilization review. In those areas where it is required, the review procedures are thoroughly identified in the regulations. Consequently, we did not include peer review organizations in our study.

[7]Medical Utilization Review Directory (New York, NY: Faulkner & Gray, 1991).

utilization review services, determined reasons for the nonresponse, and encouraged organization representatives to complete the questionnaire if their organization provided medical/surgical utilization review services. Of the 294 UROs that the questionnaire was sent to, 191 responded. Of these, 112 indicated that they did not perform medical/surgical utilization reviews. The remaining 79 indicated that they reviewed medical/surgical cases, and completed the questionnaire. We did not verify the responses provided by the UROs.

To determine if our respondents were representative of all utilization review companies that received our questionnaire, we analyzed information about the number of covered lives, [8] admissions reviewed, and the types of services provided as described in the Medical Utilization Review Directory. We found that the respondents were more likely to review inpatient medical and surgical services than nonrespondents.

The information contained in our fact sheet is the most complete published survey of UROs and the staff, process, and types of review criteria used by them to make vital decisions regarding payment for proposed health care. We believe this information can be used by states and the federal sector when making regulatory decisions and others who are interested in studying utilization review practices.

We performed our work between September 1990 and January 1992 in accordance with generally accepted government auditing standards.

[8]Covered lives include all individuals—employees and their dependents—who are covered by a specific URO.

# General Information About URO Respondents

UROs responding to our questionnaire vary widely in terms of their years of experience, ownership arrangements, number and composition of employees, revenues, and covered lives. Sixty-four of the respondents are discrete UROs while 15 are insurance-based UROs. [1] Eleven UROs (all discrete) have contracts that provide for the URO to receive additional payments if the company achieves cost savings for its clients. [2] Two respondents have incentive plans for staff if staff achieve cost savings through reviews. None of the respondents submitted a copy of their company or individual incentive plans for our review, as we requested.

The responding UROs were established between 1892 and 1989. Most were established between 1982 and 1987. (See table 2.1.) They more than doubled in number between 1982 and 1989. (See fig. 2.1.) Thirty-eight (49 percent) of the respondents are independently owned and 39 (51 percent) are subsidiaries of or are owned by another company. The parent organizations or other subsidiaries of the parent purchased services from 29 of the UROs. Twenty of the parent organizations or their subsidiaries are also health care insurers, and 9 parent or other subsidiaries provide direct care. [3] (See fig. 2.2.) Gross revenues attributable to utilization review activities range from $100,000 or less to approximately $62 million, [4] with an average of $4,888,535 and a median of $1,000,000. (See table 2.2.) The number of lives covered by individual UROs range from 25,000 or less to 10.6 million, [5] with an average of 872,929 and a median of 150,000. (See table 2.3.)

[1]Discrete UROs are free-standing organizations while insurance-based UROs are utilization review departments based within an insurance company.

[2]These 11 UROs cover 10,576,774 covered lives.

[3]Parent organizations of UROs and other subsidiaries of the parent may provide direct care, be a health care insurer, and/or purchase services from the URO. These descriptions are not mutually exclusive.

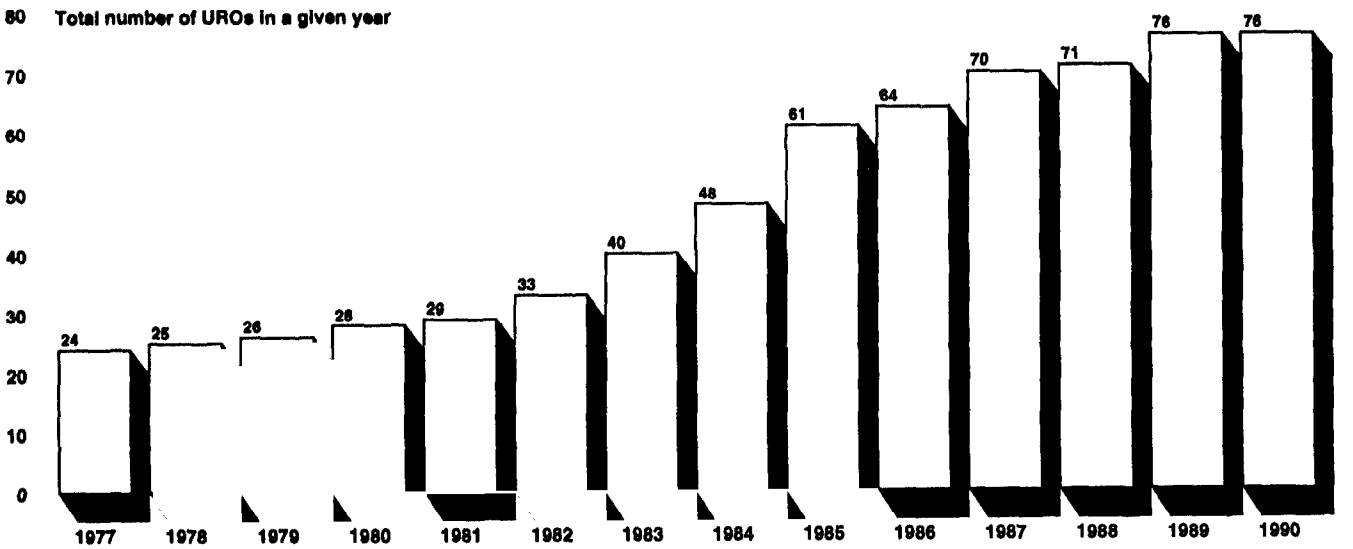
[4]Two UROs that performed medical/surgical utilization review activities responded that their company did not receive any revenues as a result of these activities.

[5]Two UROs that performed medical/surgical utilization review activities responded that their company did not cover any lives as a result of their utilization review activities.

**Table 2.1: Years in Which UROs Were Established**

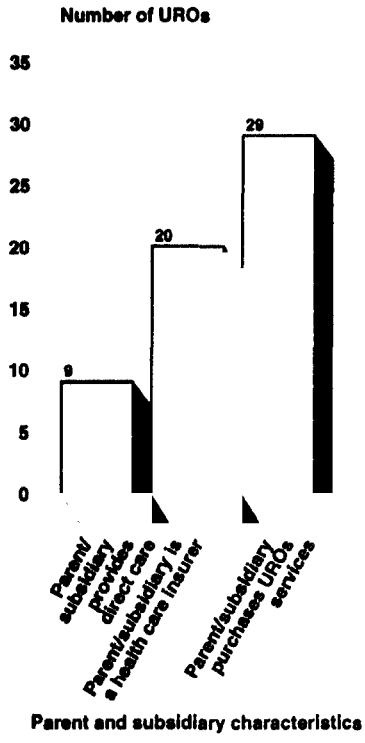
| Year | Number of UROs | Percent of respondents |
|---|---|---|
| Before 1930 | 6 | 7.8 |
| 1930-39 | 1 | 1.3 |
| 1940-49 | 3 | 3.9 |
| 1950-59 | 3 | 3.9 |
| 1960-69 | 3 | 3.9 |
| 1970-74 | 4 | 5.2 |
| 1975-79 | 7 | 9.1 |
| 1980 | 2 | 2.6 |
| 1981 | 1 | 1.3 |
| 1982 | 4 | 5.2 |
| 1983 | 7 | 9.1 |
| 1984 | 8 | 10.4 |
| 1985 | 13 | 16.9 |
| 1986 | 3 | 3.9 |
| 1987 | 6 | 7.8 |
| 1988 | 1 | 1.3 |
| 1989 | 5 | 6.5 |
| 1990 | 0 | 0 |

## Figure 2.1: Growth in Number of UROs




Note: N=77.

**Figure 2.2: Parent Organization and Subsidiary Involvement in Provision of Care or Purchase of UROs' Services**




Note: N=39. These categories are not mutually exclusive.

**Table 2.2: Respondents' Reported Gross Revenues for Utilization Review Services**

| Gross revenues | Number of UROs | Percent of respondents | Cumulative percent |
|---|---|---|---|
| $100,000 or less | 7 | 12.3 | 15.8 |
| $100,001-200,000 | 4 | 7.0 | 19.3 |
| $200,001-300,000 | 2 | 3.5 | 22.8 |
| $300,001-400,000 | 4 | 7.0 | 29.8 |
| $400,001-500,000 | 0 | 0.0 | 29.8 |
| $500,001-600,000 | 2 | 3.5 | 33.3 |
| $600,001-700,000 | 5 | 8.8 | 42.1 |
| $700,001-800,000 | 2 | 3.5 | 45.6 |
| $800,001-900,000 | 0 | 0.0 | 45.6 |
| $900,001-1,000,000 | 3 | 5.3 | 50.9 |
| $1,000,001-2,000,000 | 6 | 10.5 | 61.4 |
| $2,000,001-3,000,000 | 4 | 7.0 | 68.4 |
| $3,000,001-4,000,000 | 4 | 7.0 | 75.4 |
| $4,000,001-5,000,000 | 3 | 5.3 | 80.7 |
| $5,000,001-6,000,000 | 4 | 7.0 | 87.7 |
| $6,000,001-7,000,000 | 0 | 0.0 | 87.7 |
| $7,000,001-8,000,000 | 1 | 1.8 | 89.5 |
| $8,000,001-9,000,000 | 0 | 0.0 | 89.5 |
| $9,000,001-10,000,000 | 1 | 1.8 | 91.2 |
| $10,000,001-20,000,000 | 1 | 1.8 | 93.0 |
| $20,000,001-30,000,000 | 1 | 1.8 | 94.7 |
| $30,000,001-40,000,000 | 1 | 1.8 | 96.5 |
| $40,000,001-50,000,000 | 1 | 1.8 | 98.2 |
| $50,000,001-60,000,000 | 0 | 0.0 | 98.2 |
| $60,000,001-70,000,000 | 1 | 1.8 | 100.0 |

**Table 2.3: Lives Covered Under Contracts for Utilization Review Services**

| Covered lives | Number of UROs | Percent of respondents | Cumulative percent |
|---|---|---|---|
| 25,000 or less | 16 | 22.5 | 25.3 |
| 25,001-50,000 | 6 | 8.5 | 31.0 |
| 50,001-75,000 | 3 | 4.2 | 35.2 |
| 75,001-100,000 | 5 | 7.0 | 42.3 |
| 100,001-200,000 | 9 | 12.7 | 54.9 |
| 200,001-300,000 | 6 | 8.5 | 63.4 |
| 300,001-400,000 | 1 | 1.4 | 64.8 |
| 400,001-500,000 | 4 | 5.6 | 70.4 |
| 500,001-600,000 | 2 | 2.8 | 73.2 |
| 600,001-700,000 | 2 | 2.8 | 76.1 |
| 700,001-800,000 | 3 | 4.2 | 80.3 |
| 800,001-900,000 | 0 | 0.0 | 80.3 |
| 900,001-1,000,000 | 3 | 4.2 | 84.5 |
| 1,000,001-2,000,000 | 4 | 5.6 | 90.1 |
| 2,000,001-3,000,000 | 2 | 2.8 | 93.0 |
| 3,000,001-4,000,000 | 0 | 0.0 | 93.0 |
| 4,000,001-5,000,000 | 2 | 2.8 | 95.8 |
| 5,000,001-6,000,000 | 0 | 0.0 | 95.8 |
| 6,000,001-7,000,000 | 1 | 1.4 | 97.2 |
| 7,000,001-8,000,000 | 0 | 0.0 | 97.2 |
| 8,000,001-9,000,000 | 0 | 0.0 | 97.2 |
| 9,000,001-10,000,000 | 1 | 1.4 | 98.6 |
| 10,000,001-11,000,000 | 1 | 1.4 | 100.0 |

# Utilization Review Staff

## Employee Status and Location of Utilization Review Staff

UROs employ more physician advisors/consultants than full-time or part-time on-premises physicians (see table 3.1), the average being 84.7 advisors/consultants per URO compared to 4.4 full-time and 7.6 part-time physicians. Four of 70 UROs responded that they do not have either a full-time physician or an on-premises part-time physician. Twelve of the 70 UROs have an on-premises part-time physician but no full-time physician.

Most UROs rely on registered nurses (RN) to provide utilization review services although physicians also are involved in the decisions. (See fig. 3.1.) Many respondents report employing large numbers of on-premises full-time RNs. (See table 3.2.) Licensed practical nurses (LPN) are not employed by many UROs. (See table 3.3.) However, in those UROs where LPNs are employed, they most frequently are used in first level reviews to make decisions where no modification in the provider's proposal is required. (See figs. 3.2 and 3.3.)

Respondents reported that they generally do not use other types of health care professionals in their utilization review decisions. Thirteen UROs employ social workers (SW), 7 UROs employ accredited records technicians (ART), and 4 UROs employ registered records administrators (RRA). [1] Thirty UROs employ other types of staff to make decisions about the necessity or appropriateness of care. These staff include chiropractors, data consultants, dentists, dental assistants and hygienists, foreign medical graduates, health care administrators, and persons with expertise in paying health care claims. UROs also employ medical technologists, pharmacists, physician assistants, psychologists, prosthetics/orthotics experts, radiology technicians, other allied health professionals, and vocational specialists. These professionals are most commonly used for case management and are infrequently used in prehospital and concurrent reviews.

[1] ARTs are responsible for maintaining components of health information systems. RRAs are responsible for the management of these systems.

**Table 3.1: Reported Physician Employment Status**

| | Number of respondents | | | |
|---|---|---|---|---|
| Number of Physicians | Advisors/ consultants | Part-time staff on premises | Part-time staff off premises | Full-time staff |
| 0 | 9 | 35 | 46 | 34 |
| 1-10 | 21 | 24 | 8 | 26 |
| 11-25 | 11 | 2 | 2 | 1 |
| 26-50 | 12 | 1 | 1 | • |
| 51-75 | 2 | • | • | • |
| 76-100 | 3 | 1 | 1 | • |
| 101-250 | 5 | • | • | • |
| 251-500 | 3 | • | • | • |
| over 500 | 2 | • | • | • |

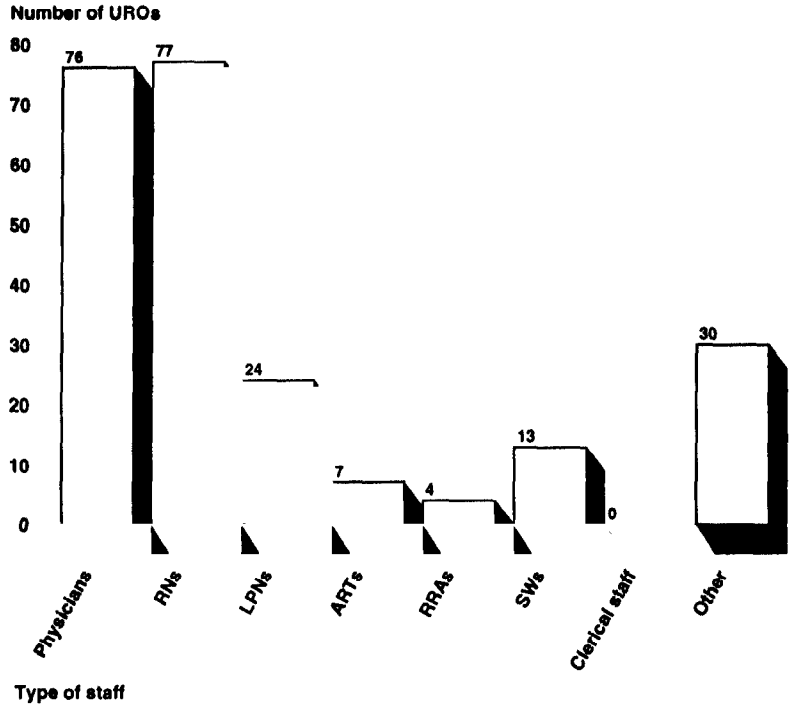
**Table 3.2: Reported RN Employment Status**

| | Number of respondents | | | |
|---|---|---|---|---|
| Number of RNs | Advisors/ consultants | Part-time staff on premises | Part-time staff off premises | Full-time staff |
| 0 | 63 | 34 | 57 | 1 |
| 1-10 | 3 | 27 | 9 | 36 |
| 11-25 | 1 | 3 | 1 | 17 |
| 26-50 | • | 3 | • | 9 |
| 51-75 | • | • | • | 2 |
| 76-100 | • | • | • | 1 |
| 101-250 | • | • | 1 | 1 |
| 251-500 | • | • | • | 2 |
| over 500 | • | • | • | 1 |

**Table 3.3: Reported LPN Employment Status**

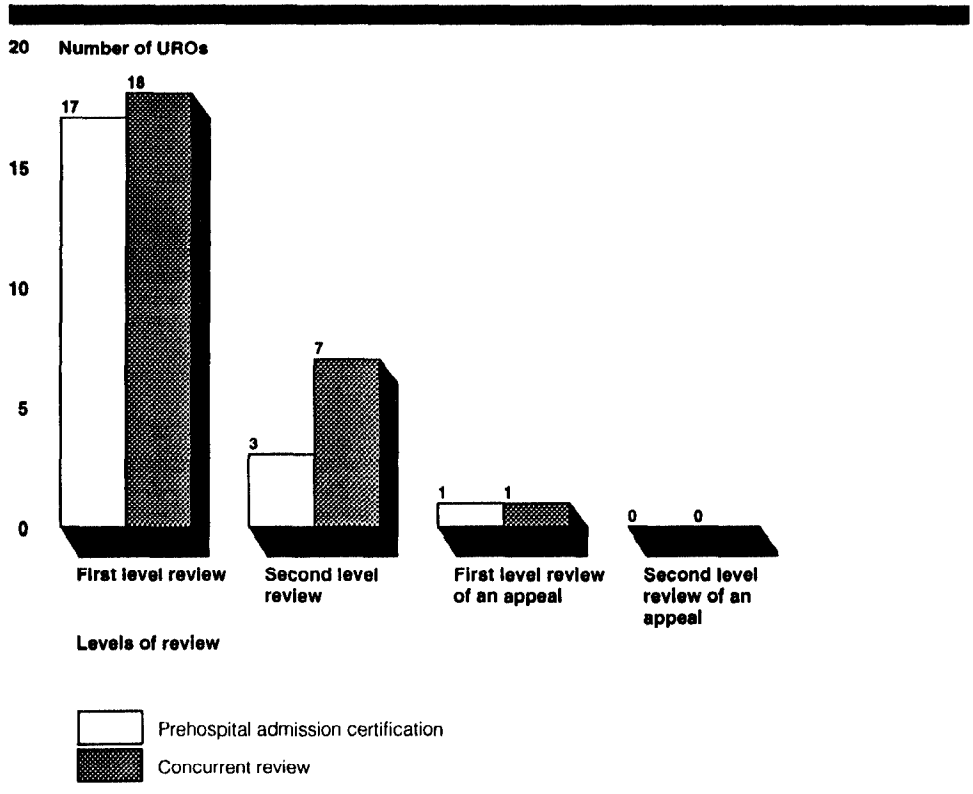
| | Number of respondents | | | |
|---|---|---|---|---|
| Number of LPNs | Advisors/ consultants | Part-time staff on premises | Part-time staff off premises | Full-time staff |
| 0 | 19 | 15 | 18 | 4 |
| 1-10 | 1 | 5 | 1 | 15 |
| 11-25 | • | • | • | 2 |
| 26-50 | • | • | • | • |
| 51-75 | • | • | 1 | • |
| over 75 | • | • | • | • |

**Figure 3.1: Staff Used to Provide Utilization Review Services**



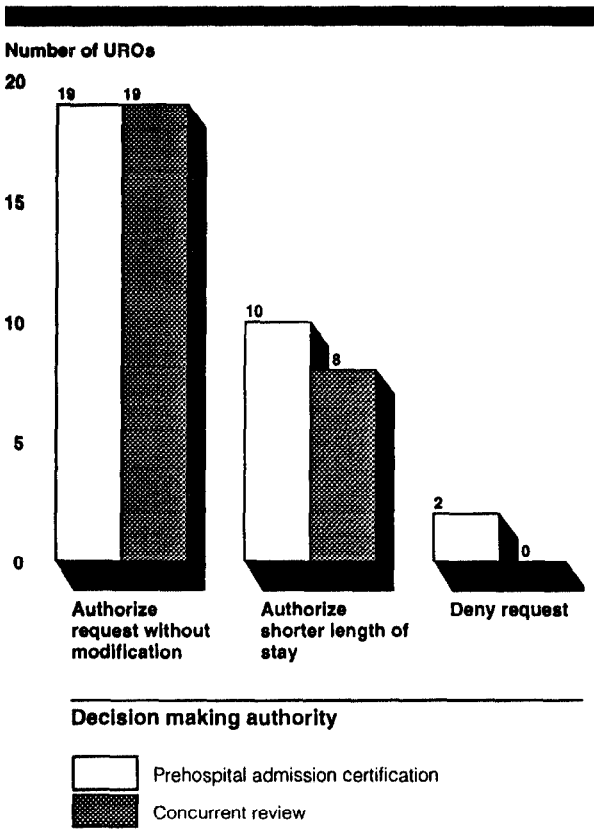

Note: N=79. Other includes chiropractors, data consultants, dental assistants and hygienists, dentists, foreign medical graduates, health care administrators, medical technologists, pharmacists, physician assistants, prosthetics/orthotics, psychologists, radiology technicians, other allied health professionals, persons with expertise in claims processing, and vocational specialists.

**Figure 3.2: Involvement of LPNs in Utilization Review Process**




Note: Only 24 of 79 respondents stated that they employed LPNs. Seventy-one of 79 respondents stated that they perform prehospital admission certification reviews; 70 of 79 respondents indicated that they perform concurrent reviews.

**Figure 3.3: Authority of LPNs in Utilization Review Process**




Note: N=24. Our survey did not determine if any staff had the authority to change an inpatient stay to an outpatient stay or authorize a different provider during the concurrent review process.

## Minimum Educational Levels and Clinical Experience

Many UROs report setting minimum qualifications regarding the educational level for their RNs and other nonphysician staff and minimum qualification levels for years of clinical experience for all staff, including physicians. (See tables 3.4 and 3.5.) The median number of years of clinical experience required by respondents is 5 years for physicians, 3 years for RNs, 3 years for LPNs, 2 years for ARTs, 1.5 years for RRAs, 3 years for SWs, and 2 years for other types of staff.

**Table 3.4: Minimum Educational Qualifications for Respondents' Utilization Review Staffs**

| Minimum educational qualifications | Number of UROs with various types of professional utilization review staff[a,b] | | | | | |
|---|---|---|---|---|---|---|
| | RNs | LPNs | ARTs | RRAs | SWs | Other[c] |
| | **73** | **23** | **6** | **5** | **9** | **10** |
| No minimum qualifications | 3 | 2 | 1 | • | 1 | • |
| High school | • | • | 1 | 1 | • | 2 |
| LPN certificate | • | 18 | • | • | • | • |
| Nursing diploma | 54 | 2 | • | • | • | 1 |
| Associate's degree | 10 | 1 | 3 | • | • | 1 |
| Bachelor's degree | 6 | • | 1 | 4 | 2 | 3 |
| Master's degree | • | • | • | • | 5 | 2 |
| Doctorate's degree | • | • | • | • | 1 | 3 |

[a]Figures in bold are the total number of UROs responding.

[b]Bullets mean that UROs did not indicate that these minimum educational qualifications were relevant.

[c]The minimum qualifications required by UROs included: high school for preadmission certification coordinators; nursing diplomas for management level nurses; associate's degrees for radiology technicians; bachelor's degrees for medical technologists, health care administrators, and physical therapists; master's degrees for vocational specialists; and education beyond a master's degree for chiropractors and foreign medical graduates.

**Table 3.5: Minimum Experience Qualifications for Respondents' Utilization Review Staffs**

| Minimum years of experience | Number of UROs with experience qualifications for professional utilization review staff[a] | | | | | | |
|---|---|---|---|---|---|---|---|
| | Physicians | RNs | LPNs | ARTs | RRAs | SWs | Other[b] |
| | **52** | **72** | **22** | **5** | **4** | **5** | **7** |
| 0 year | 1 | • | • | • | • | • | • |
| 1 year | 2 | 4 | 2 | 2 | 2 | 1 | 1 |
| 2 years | 4 | 17 | 7 | 1 | 1 | 1 | 6 |
| 3 years | 7 | 24 | 8 | 1 | • | 2 | 2 |
| 4 years | 3 | 3 | 1 | • | 1 | 1 | • |
| 5 years | 26 | 22 | 4 | 1 | • | • | 1 |
| 6-10 years | 6 | 1 | • | • | • | • | • |
| 11-15 years | 2 | 1 | • | • | • | • | • |
| 16-20 years | 1 | • | • | • | • | • | • |

[a]Figures in bold are the total number of UROs responding.

[b]This column total is greater than the total number of UROs that responded because three respondents have minimum experience qualifications for more than one type of staff categorized as "other."

## Review Criteria Training

Seventy-one UROs reported that their staff receive training on the use of review criteria. However, the number of training hours varies among UROs and between the different types of staff. For example, RNs receive significantly more training than physicians. (See table 3.6.)

**Table 3.6: Training Received by Utilization Review Staff on Use of Review Criteria**

| | Number of UROs with given number of training hours | | | | | | |
|---|---|---|---|---|---|---|---|
| Type of staff | 1-8 hours | 9-16 hours | 17-24 hours | 25-48 hours | 49-80 hours | 81-160 hours | 161 or more hours |
| **Same-specialty physicians** | | | | | | | |
| Initial | 18 | 4 | 5 | 9 | 2 | 1 | 1 |
| Additional annual | 18 | 7 | 3 | 4 | • | 1 | • |
| **Related-specialty physicians** | | | | | | | |
| Initial | 21 | 2 | 6 | 8 | 1 | 1 | 1 |
| Additional annual | 17 | 6 | 2 | 4 | • | 1 | • |
| **RNs** | | | | | | | |
| Initial | 10 | 7 | 2 | 23 | 9 | 11 | 2 |
| Additional annual | 17 | 18 | 11 | 6 | 3 | • | • |
| **LPNs** | | | | | | | |
| Initial | 6 | 1 | 1 | 9 | 1 | 2 | 2 |
| Additional annual | 7 | 5 | 3 | 5 | • | • | • |
| **SWs** | | | | | | | |
| Initial | 2 | 1 | 1 | 1 | 2 | • | • |
| Additional annual | 2 | 4 | 1 | • | • | • | • |
| **ARTs** | | | | | | | |
| Initial | 1 | • | • | 2 | 1 | • | • |
| Additional annual | 1 | 1 | 1 | 1 | • | • | • |
| **RRAs** | | | | | | | |
| Initial | 1 | • | • | 1 | 1 | • | • |
| Additional annual | 1 | • | 1 | 1 | • | • | • |
| **Other** | | | | | | | |
| Initial | 2 | • | • | 2 | • | 1 | 1 |
| Additional annual | 2 | 1 | 1 | 1 | 1 | • | • |

# Utilization Review and Appeal Procedures

Utilization review activities include prehospital admission certification reviews, concurrent reviews, second surgical opinions, and case management.

## Prehospital Admission Certification Review

Seventy-one of the 79 responding UROs reported that they performed prehospital admission certification reviews of medical/surgical cases in 1990. [1] The total number of such reviews ranged from 25 to 434,582 with an average of 37,608.7 and a median of 9,884.5. [2] Generally, UROs recommend that requests for prehospital admission certification be approved without modification. Fifty UROs responded that some of their recommendations to deny certification for medical/surgical cases are formally appealed. Further, many of these appeals were successful, and the recommended denials were overturned. (See table 4.1 and figs. 4.1 and 4.2.)

Individuals involved in prehospital admission certification recommendations to deny hospital care are often involved in the first level appeals process and are sometimes involved in the final decision on an appeal. For example, in 16 UROs, the person who first issued the denial also conducted the first review of the appeal; of these, 13 UROs provided us with further information on their appeals procedures. Six respondents indicated that the person involved in the original denial recommendation also conducted the first review in over 80 percent of the appealed cases. In addition, in 9 of the 13 UROs, reviewers overturned the initial decision 40 percent or less of the time with the remainder ranging from 41 to 80 percent. Three UROs indicated that in over 80 percent of all of their appealed prehospital admission denials the person who first issued a denial recommendation also made the final decision on the appeal (for example, participated in both the first and second level appeal). Conversely, 5 UROs indicated that the person who first issued the denial never made the final decision on an appeal. [3]

[1]Not all respondents provided answers to each of the questions. Therefore, the number of respondents varies depending upon the question.

[2]One of the 71 respondents reported they performed prehospital admission certificate reviews, but reported "0" when asked how many. That "0" is included in the mean and median computation.

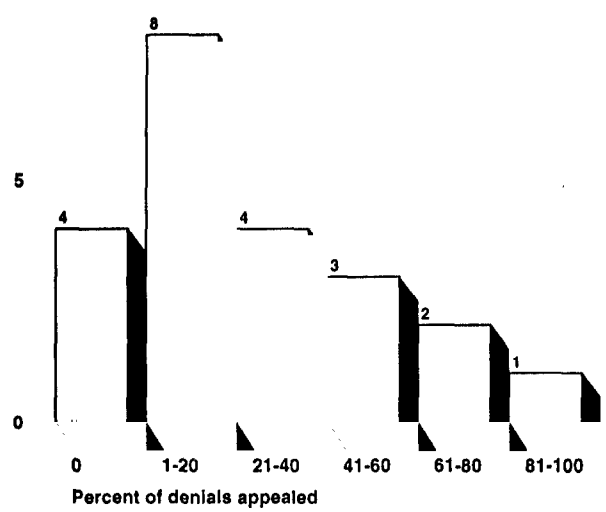
[3]Of these 5 UROs, 3 indicated that the person who first issued the denial also conducted the first review 81 to 100 percent of the time. The other 2 UROs had the person who first issued the denial conduct the first review 20 percent or less of the time.

**Table 4.1: Reported Results of Prehospital Admission Reviews[a]**

| Outcome | Average number of reviews: With each outcome | Appealed | Successfully appealed |
|---|---|---|---|
| Authorized request without modification | 13,103 | NA | NA |
| Authorized shorter length of stay | 9,835 | 258 | 157 |
| Converted setting from inpatient to outpatient care or to alternative setting | 657 | 13 | 13 |
| Recommended denial due to unsubstantiated medical need | 860 | 107 | 39 |
| Authorized a different provider than was requested | 7 | 1 | 0 |

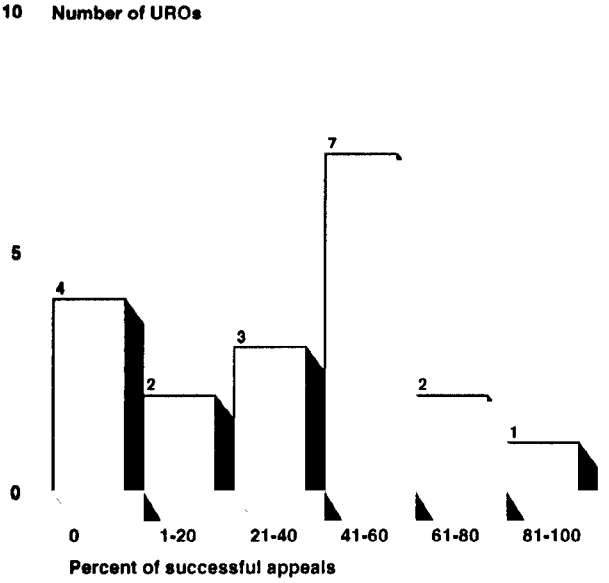
[a]The sample for each calculation varies depending upon the number of UROs that provided this information, the average being 19 UROs with a range from 1 URO (successful appeals for authorizing different providers than was requested) to 40 UROs (authorized requests without modification).

**Figure 4.1: Reported Percentage of Appeal of Denials Based on Unsubstantiated Medical Need**




Note: N=22. The firms with no denials appealed denied 2, 3, 4, and 30 cases, respectively. The portion of denials appealed in the remaining UROs ranged from 3 percent (5 of 150) to 100 percent (525 of 525).

**Figure 4.2: Reported Percentage of Successful Appeals of Denials Based on Unsubstantiated Medical Need**



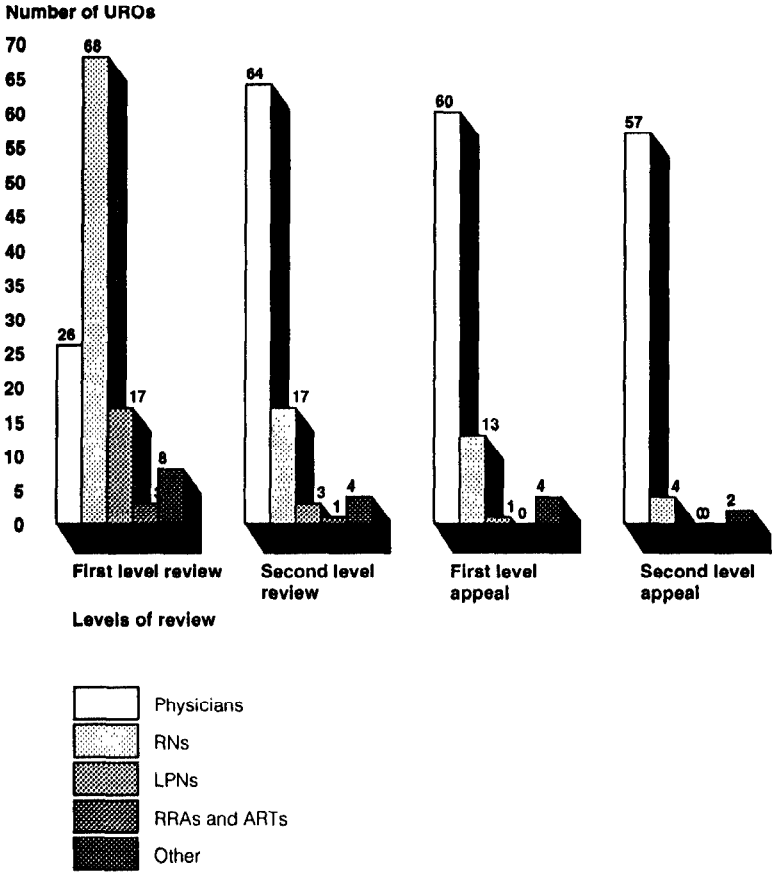

Note: N=19. The 4 UROs that had no decisions successfully appealed had 5, 20, 72, and 500 decisions appealed. The number of successful appeals in the remaining 15 UROs with decisions appealed varied from 1 of 19 to 289 of 525. One URO reported 100 percent of their appeals being successful (3 of 3).

## Staff Involved in Prehospital Admission Review

UROs usually have physicians or RNs make prehospital admission certification recommendations. Generally, authority and responsibility for these review recommendations is given to RNs for the first level of review. However, when cases require more medical knowledge or a recommendation is appealed, physicians assume more authority and responsibility. (See figs. 4.3 and 4.4.) Further, when a recommendation is appealed and requires additional review, UROs are more likely to utilize same-specialty physicians rather than related-specialty physicians for making the recommendations. [4] (See fig. 4.5.)

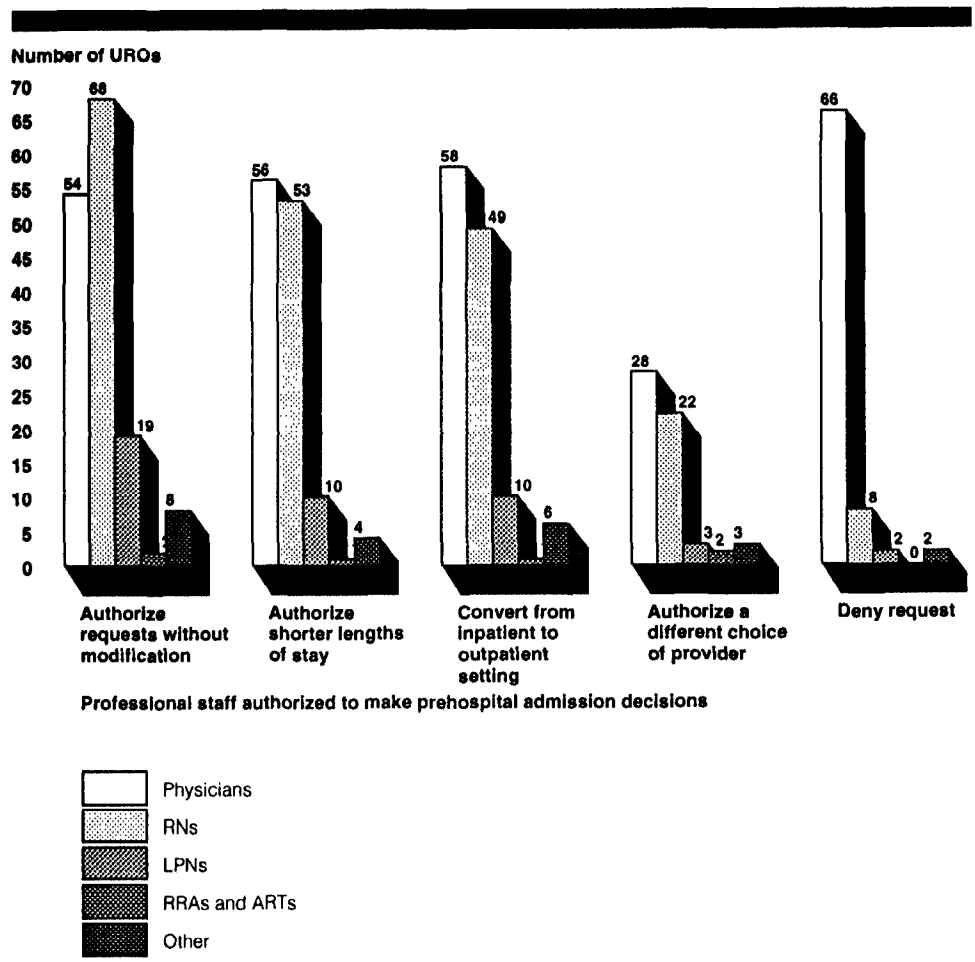
[4]Same-specialty physicians specialize in a field of medicine identical to the case under review (for example, an orthopedic surgeon who reviewed orthopedic cases). Related-specialty physicians specialize in a field of medicine similar but not the same as the case under review (that is, a general surgeon who reviewed orthopedic cases).

**Figure 4.3: Staff Involvement in Prehospital Admission Reviews**



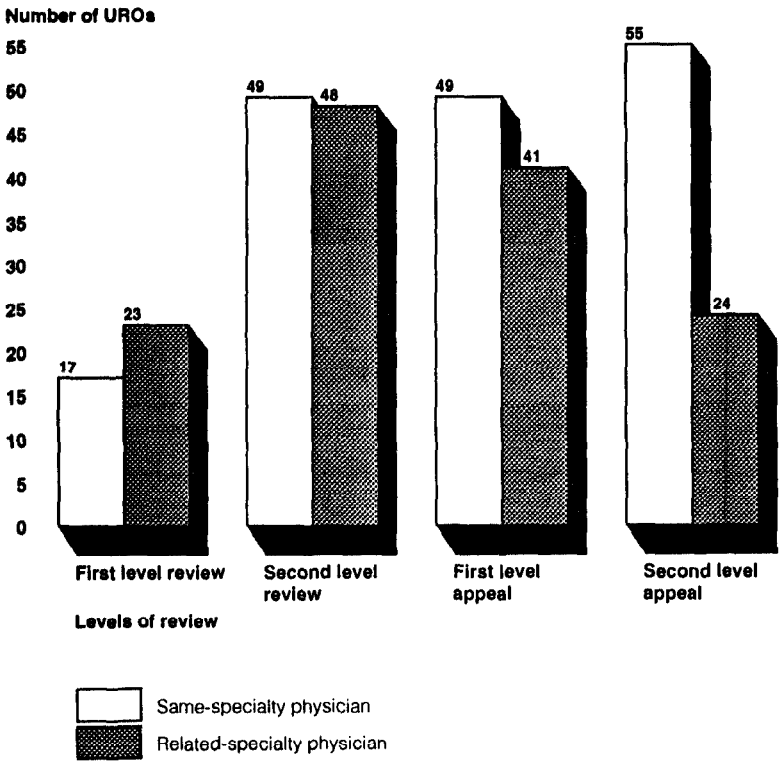

Note: N=71. Only 24 UROs stated that they employ LPNs, 7 employ ARTs, 4 employ RRAs, and 30 employ other professionals such as dentists and pharmacists.

**Figure 4.4: Staff Authority in Prehospital Admission Reviews**



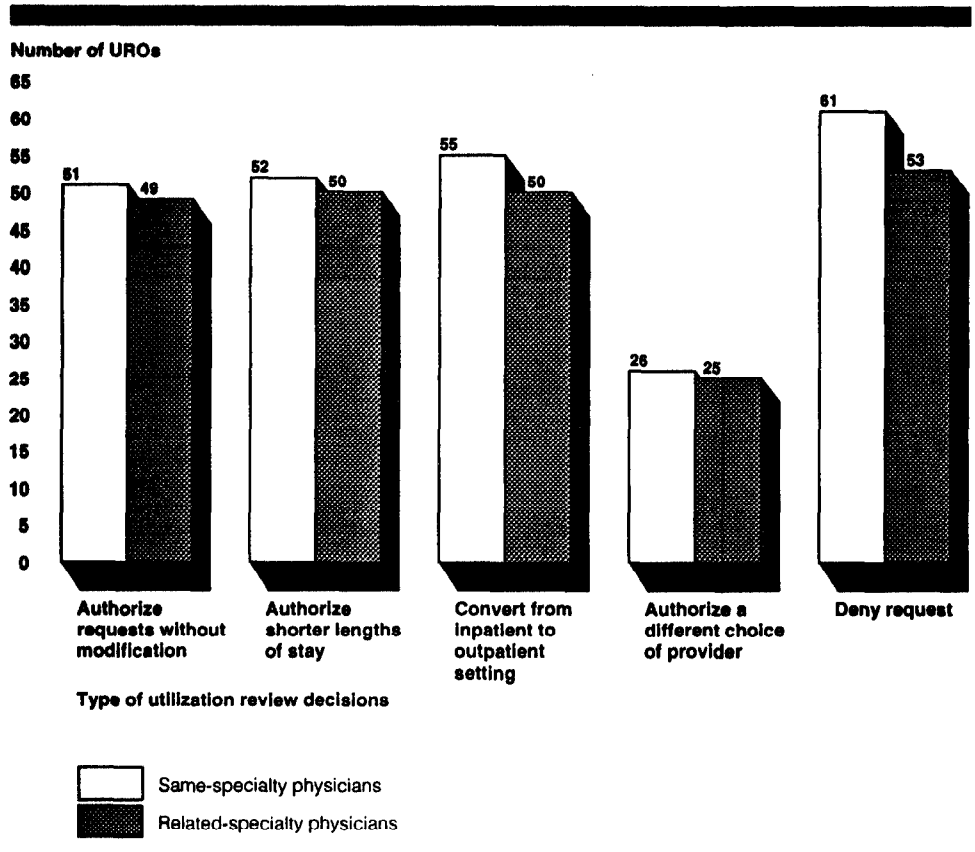

Note: N=72. Only 24 UROs stated that they employ LPNs, 7 employ ARTs, 4 employ RRAs, and 30 employ other professionals such as dentists and pharmacists.

**Figure 4.5: Specialty Physicians' Involvement in Prehospital Admission Reviews**




Note: N=71. The use of different physicians is not mutually exclusive. Some organizations use both a same-specialty and related-specialty physician at each level of review.

**Figure 4.6: Reported Authority of Specialty Physicians to Make Prehospital Admission Review Decisions**




Note: N=72.

# Concurrent Review

Seventy of the 79 responding UROs stated that they performed concurrent reviews of medical/surgical cases in 1990. [5] Many of these UROs conducted their first concurrent reviews in 1984 and 1985. The number of reviews performed by the respondents in 1990 ranged from 5 to 865,577 with an average of 49,303 and a median of 10,000. Generally, UROs recommend that requests for continued hospital stay be authorized without modification. Those UROs that provided information about the results of their recommended denials or modifications to the continued stay requests indicate that about 5 percent of their cases were appealed. However, many of these appeals were successful, and the recommended denials or modifications were overturned. (See table 4.2 and figs. 4.7 and 4.8.)

[5]Not all respondents provided detailed responses to all of the questions. Therefore, the number of respondents varies depending upon the question.

Approximately one-half of the respondents provided information about the outcome of their concurrent review. These UROs stated that 62 percent of such reviews resulted in authorizing the continuation of stay requests without modification. However, 50 of 67 UROs responded that some of their recommendations not to extend authorization for a continued hospital stay were formally appealed. Those recommendations that were appealed include recommendations for shorter stays than was requested and recommended denials of continuation of stay due to unsubstantiated medical need. Of those providing appeals data, most respondents had less than a third of their continuation of stay denial recommendations appealed. Of these, appeals usually were successful more than 40 percent of the time.

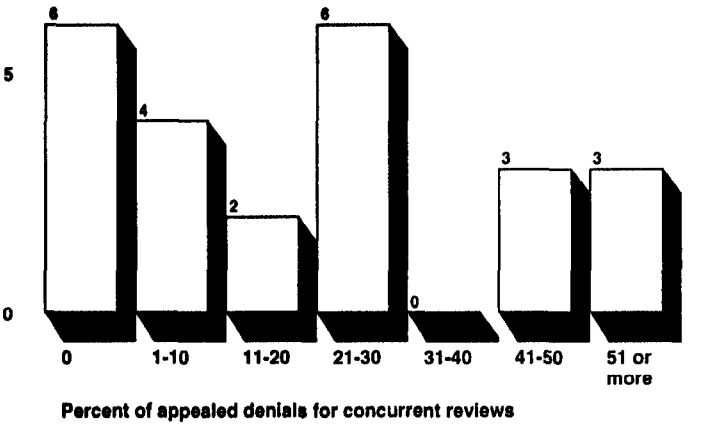
Some of the respondents allow the individual who originally made the denial recommendation to be involved in the appeals process. For example, in 18 UROs the person who first issued the denial also conducted the first review of the appeal. Three UROs indicated that in over 80 percent of these cases the person who first issued a denial also made the final decision on the appeal. Conversely, 7 UROs indicated that they had no appealed concurrent reviews in which the person who initially recommended the denial also made the final decision on an appeal.

**Table 4.2: Reported Results of Concurrent Review Decisions[a]**

| | Average number of reviews | | |
|---|---|---|---|
| Outcome | With each outcome | Appealed | Successfully appealed |
| Authorized continuation without modification | 20,822 | NA | NA |
| Authorized shorter continuation of stay than was requested | 6,826 | 128 | 59 |
| Recommended denial of continuation due to unsubstantiated medical need | 1,866 | 310 | 181 |

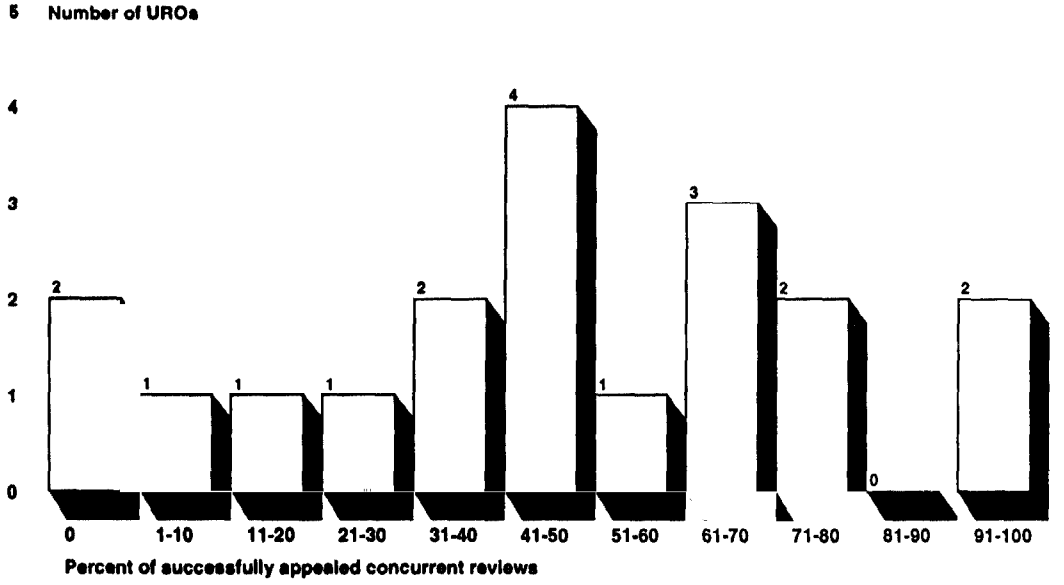
[a]The sample for each calculation varies depending upon the number of UROs that provided this information, with the average being 24 UROs and a range from 11 UROs (successful appeals for authorizing shorter continuation of stay than requested) to 34 UROs (authorized continuation without modification).

**Figure 4.7: Reported Percentage of Appeals of Concurrent Review Denials**




Note: N=24. The firms with no denials appealed denied 1, 2, 3, 10, 20, and 160 cases, respectively. The portion of denials appealed in other UROs ranged from 2 of 1,350 to 2,216 of 2,216.

**Figure 4.8: Reported Success Rates for Appeals of Concurrent Review Denials**



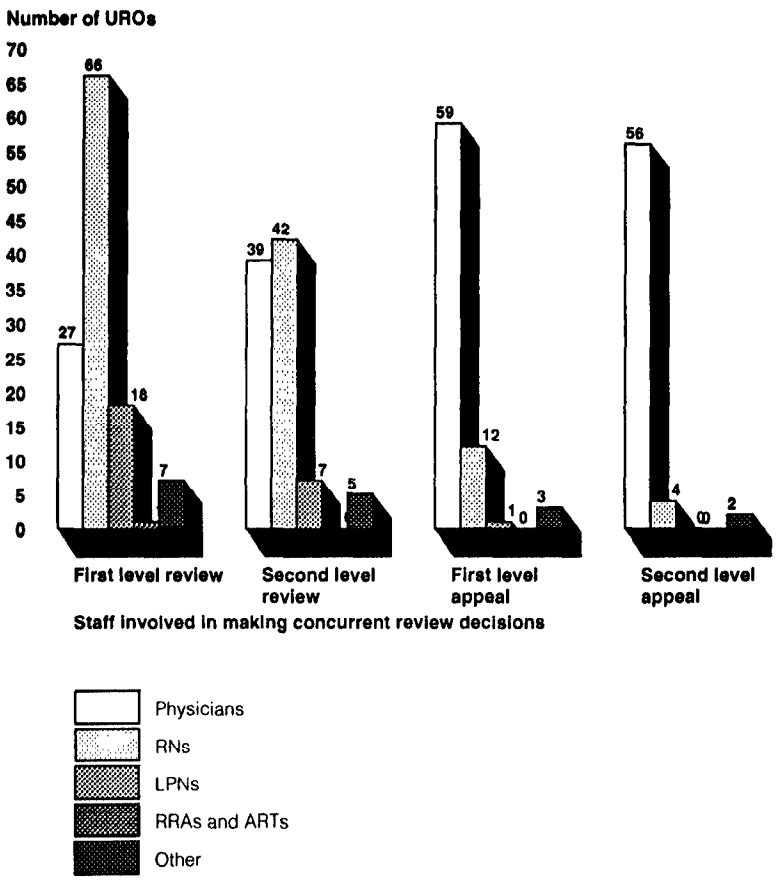

Note: N=19.

## Staff Involved in Concurrent Review

UROs employ professional staff with a variety of backgrounds and expertise to make their concurrent review decisions. Generally, they give authority and responsibility to RNs for the initial levels of review, and if a decision is appealed or if the case requires further review, physicians assume more authority and responsibility. LPNs are also involved in first level review activities. Three quarters of the UROs that employ LPNs give them the authority to make a decision to authorize requests without modification. Other health care professionals such as medical records technicians and administrators are infrequently used in a decision making capacity. (See figs. 4.9 and 4.10.)

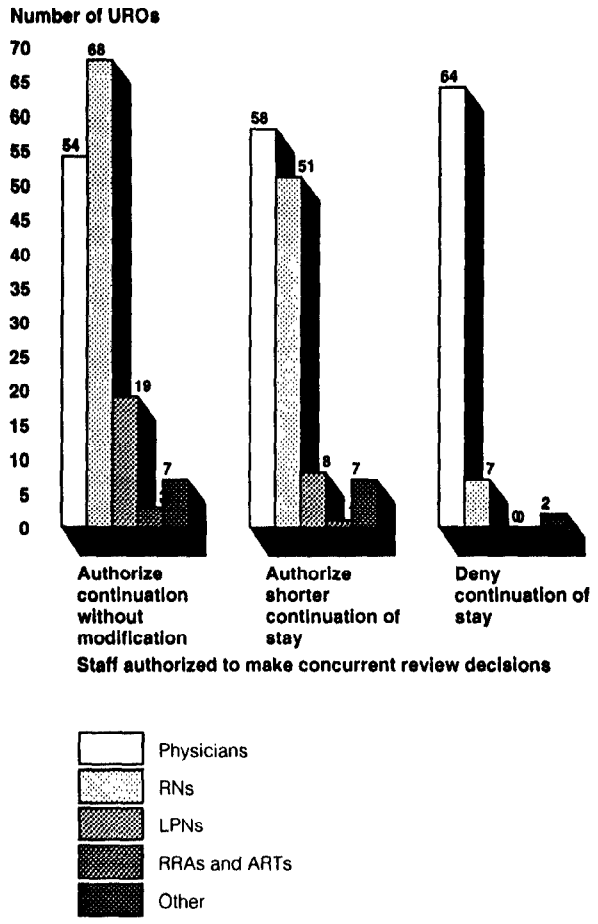
Same-specialty physicians and related-specialty physicians generally have similar authority to make decisions. However, same-specialty physicians are more likely to be involved than related-specialty physicians at the second level of appeal. (See figs. 4.11 and 4.12.)

**Figure 4.9: Staff Involvement in Concurrent Reviews**



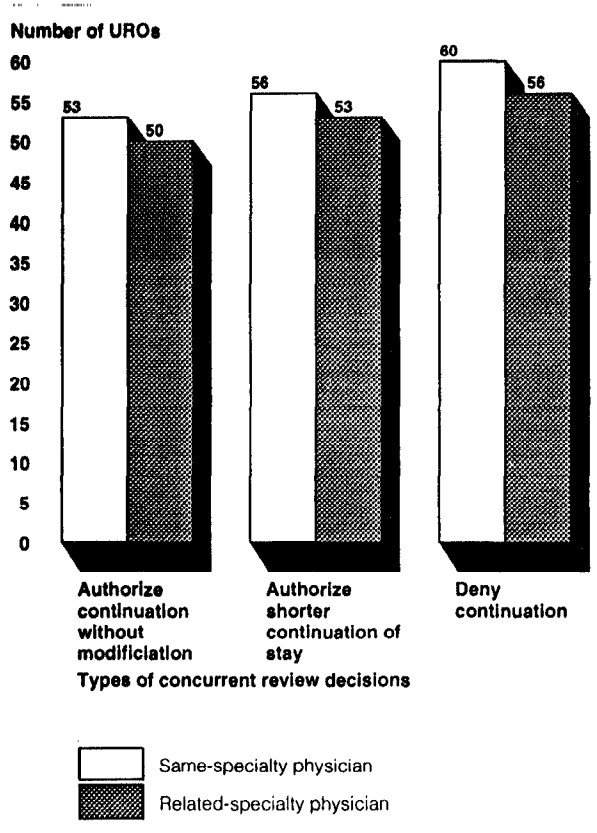

Note: N=69. Only 24 UROs stated that they employ LPNs, only 7 employ ARTs, 4 employ RRAs, and 30 employ other professionals such as dentists and pharmacists.

**Figure 4.10: Staff Authority in Concurrent Reviews**



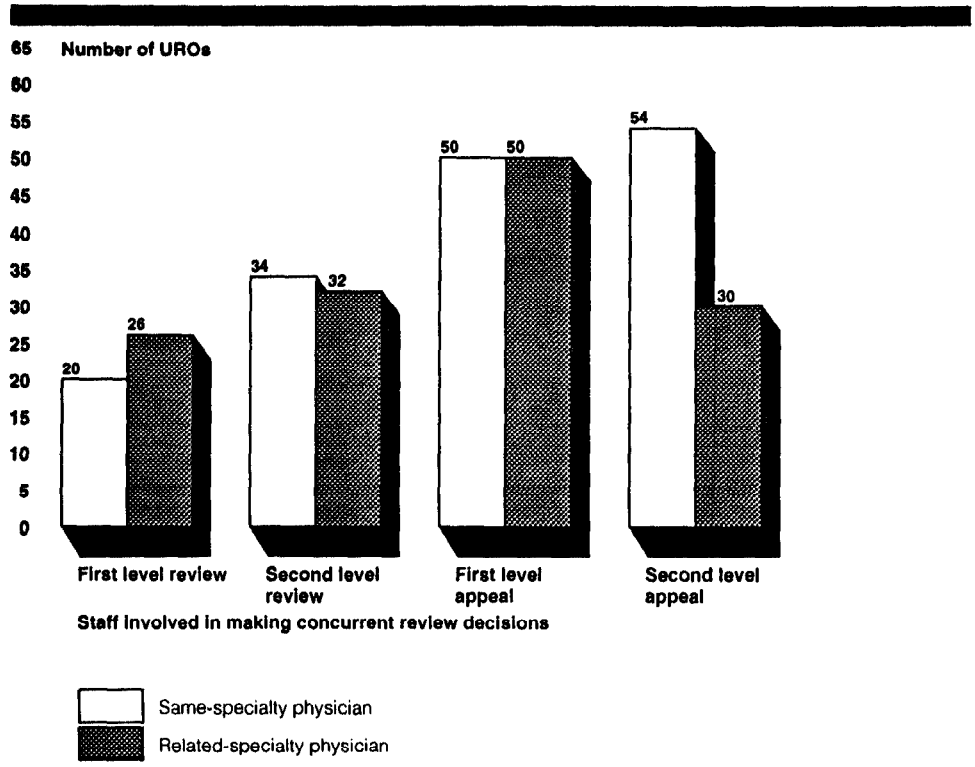

Note: N=70. Only 24 UROs stated that they employ LPNs, only 7 employ ARTs, 4 employ RRAs, and 30 employ other professionals such as dentists and pharmacists.

**Figure 4.11: Specialty Physicians' Authority to Make Concurrent Review Decisions**




Note: N=70.

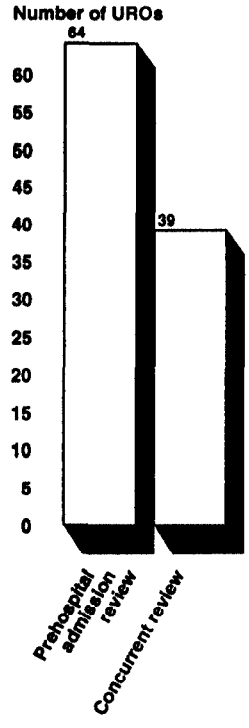
**Figure 4.12: Specialty Physicians' Involvement in Concurrent Review Decisions**




Note: N=69. The use of different physicians is not mutually exclusive. Some organizations use both same-specialty and related-specialty physicians at the same level of review.

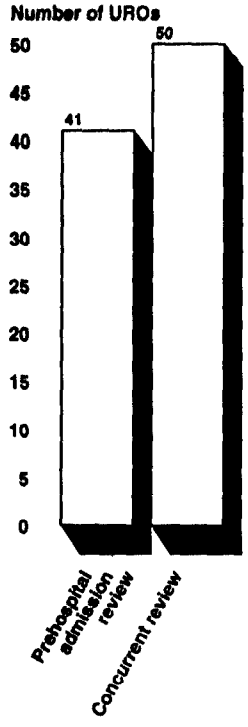
When comparing physician involvement between prehospital admission reviews and concurrent reviews, two differences are apparent. A second level prehospital admission review has greater physician involvement than a similar concurrent review, (see fig. 4.13) and related-specialty physician involvement is greater in the first level appeal of concurrent reviews than in the first-level appeal of prehospital admission review decisions. (See fig. 4.14.)

**Figure 4.13: Physicians' Involvement in Second Level Prehospital Admission and Concurrent Review Decisions**




Note: N=71 for prehospital admission reviews and 69 for concurrent reviews.

**Figure 4.14: Related-Specialty Physicians' Involvement in First Level Appeals of Prehospital Admission and Concurrent Review Decisions**




Note: N=71 for prehospital admission review and 69 for concurrent review.

## Second Surgical Opinion Reviews

Sixty-four of 79 respondents said they referred patients for a second surgical opinion; that is, referred a patient to another physician for confirmation of a proposed elective surgical procedure. Further, 19 of these UROs specify the physician a patient must consult with for the second surgical opinion. Thirty-nine UROs require that the physicians who provide second surgical opinions be located within the patient's service area. Only one URO requires the physicians who provide second surgical opinions to be located outside the patient's service area.

When referring a surgical case for a second opinion, UROs said they primarily rely on other surgeons' opinions. Twenty-seven UROs refer 100 percent of their cases requiring a second surgical opinion to a surgeon only, 8 refer 90 to 99 percent of these cases to a surgeon only, and 8 others refer from 50 to 89 percent of these cases to a surgeon only. Three UROs refer 100 percent of their second surgical opinions to both surgeons and

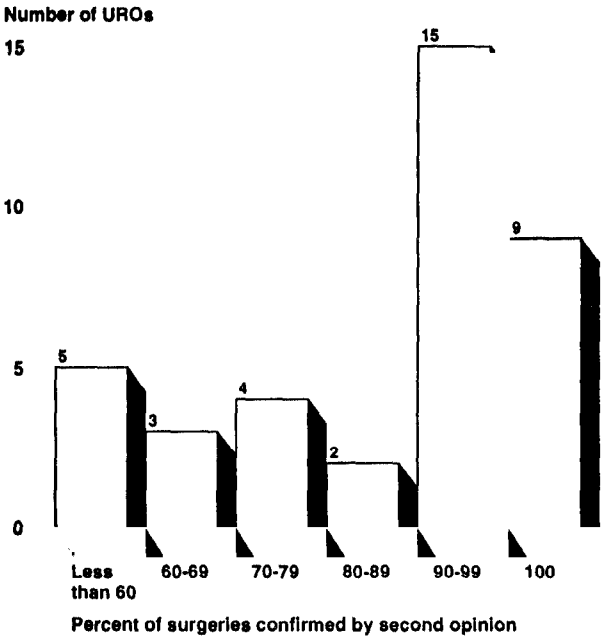
nonsurgeons. Three other UROs refer their cases requiring a second surgical opinion to either a surgeon or a nonsurgeon, but not both. One of these latter UROs responded that 70 percent of its second surgical opinion cases were sent to a non-surgeon only.

A second opinion resulted in the majority of surgeries confirmed as being necessary. (See figs. 4.15 and 4.16.) Those surgeries UROs most often recommended for denial as a result of the second opinion are (1) hysterectomies, (2) tonsillectomies and/or adenoidectomies, and (3) nasal surgery. (See table 4.3.) Only five UROs provided specific data on recommendations to deny surgery that were successfully appealed. Two had approximately two-thirds of their surgery recommendations that were not confirmed by a second opinion successfully appealed, and two others had 50 percent of such recommendations successfully appealed. The fifth URO had 17 percent of such recommendations successfully appealed. Specific information on the types of surgeries involved in these appeals was not requested.

UROs reported taking an average of 8.5 days and a median of 5.5 days from the time the URO was first notified of an appeal of the second surgical opinion to the day the patient or physician was notified of the UROs final decision. [6]

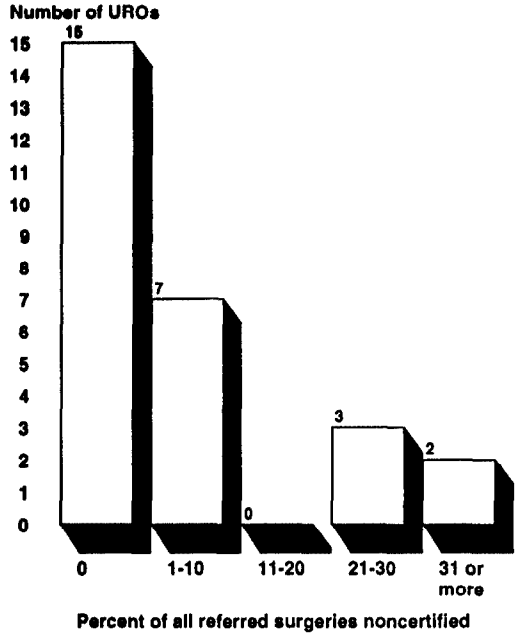
[6]UROs varied widely in their responses to this question, ranging from 0 to 30 days.

**Figure 4.15: Percentages of Recommended Surgeries Confirmed by a Second Opinion**




Note: N=38. Three of the respondents that confirmed less than 60 percent of their surgeries did not confirm any of their surgeries referred for second surgical opinion review. However, these UROs referred only 1, 3, and 10 surgeries, respectively.

**Figure 4.16: Percentages of Surgical Decisions Overruled by a Second Opinion**




Note: N=27.

**Table 4.3: Surgeries Most Often Recommended Against Due to Unsubstantiated Medical Need[a]**

| Type of surgery | Number of UROs | Type of surgery | Number of UROs |
|---|---|---|---|
| Hysterectomy | 29 | TMJ surgery | 4 |
| Tonsillectomy and/or adenoidectomy | 15 | Abdominal wall surgery | 3 |
| Nasal surgery | 13 | Cholecystectomy | 3 |
| Cosmetic surgery | 9 | Fertility surgery | 3 |
| Knee surgery | 8 | Vein stripping | 3 |
| Back surgery | 7 | Breast augmentation | 2 |
| Dilatation & curettage | 7 | Caesarian section | 2 |
| Foot surgery | 6 | Carotid endarterectomy | 2 |
| Gastric stapling | 6 | Carpal tunnel | 2 |
| Reduction mammoplasty | 5 | Gastroplasty | 2 |
| | | Penile implants | 2 |

[a]The 37 respondents to this question provided a list of their surgeries that were recommended against due to unsubstantiated medical need. The table does not include those types of surgeries that only one respondent did not recommend in fiscal year 1990. These types of surgeries include lesion removal, myelogram, ovarian surgery, and ventral hernia repair.

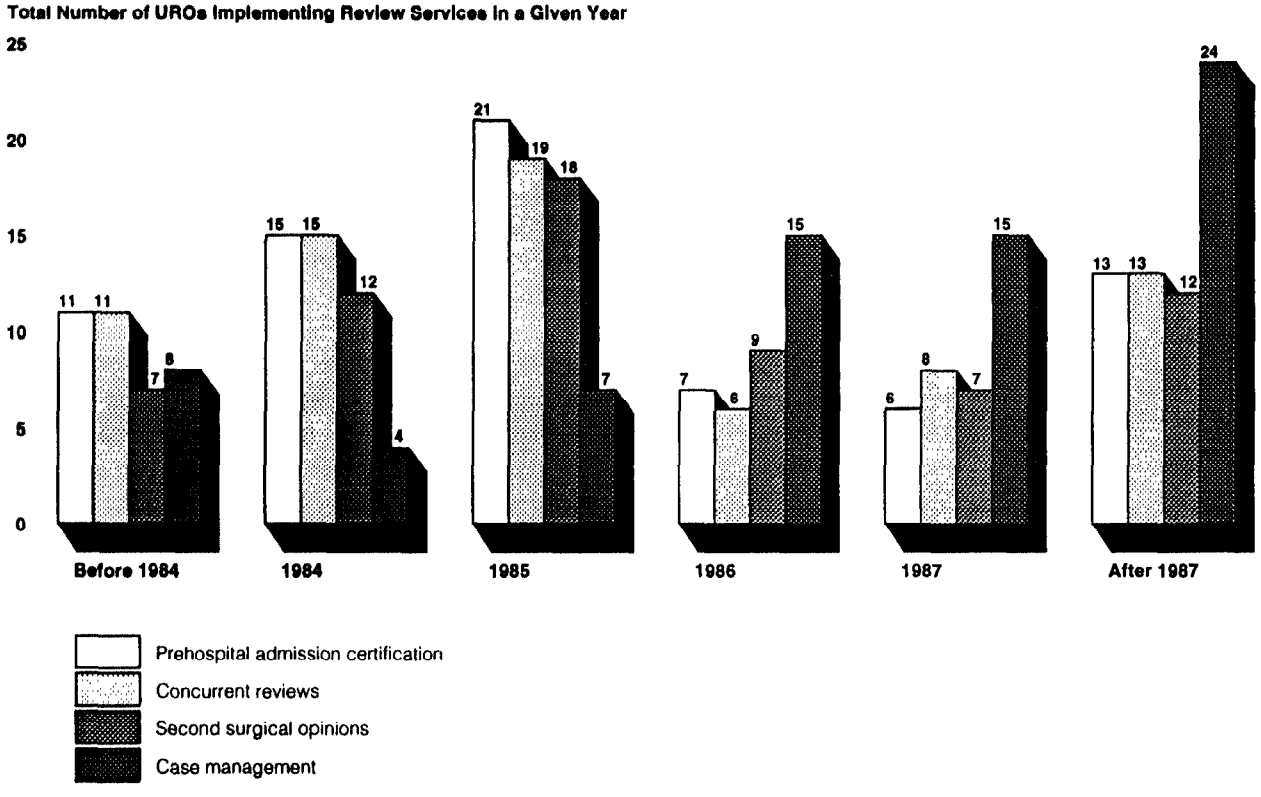
## Case Management

Since 1986, UROs have turned increasingly to case management as a component of their utilization review activities. (See fig. 4.17.) Case management reviews focus on providing cost-effective care for patients requiring expensive or extended care such as stroke or rehabilitation or care for AIDS patients. [7] Seventy respondents stated that in fiscal year 1990 they had screened patient cases to determine if they should be managed by the URO. When making a determination on whether a case should be managed, the URO may consult lists of diagnoses appropriate to receive case management or catastrophic cases that are most likely to require higher cost medical care. Most UROs reported that they consult with both the patient's primary health care provider and family members when determining a patient's case management needs.

UROs vary in the percent of cases screened that are actually recommended for case management. (See figs. 4.18 and 4.19.) Respondents to our questionnaire had an average of 349 and a median of 61 on-going case management cases at the end of fiscal year 1990. Due to the voluntary nature of case management and the fact that many UROs require that all parties—including the patient—agree to the approach before a case is managed, very few medical/surgical case management cases are appealed.

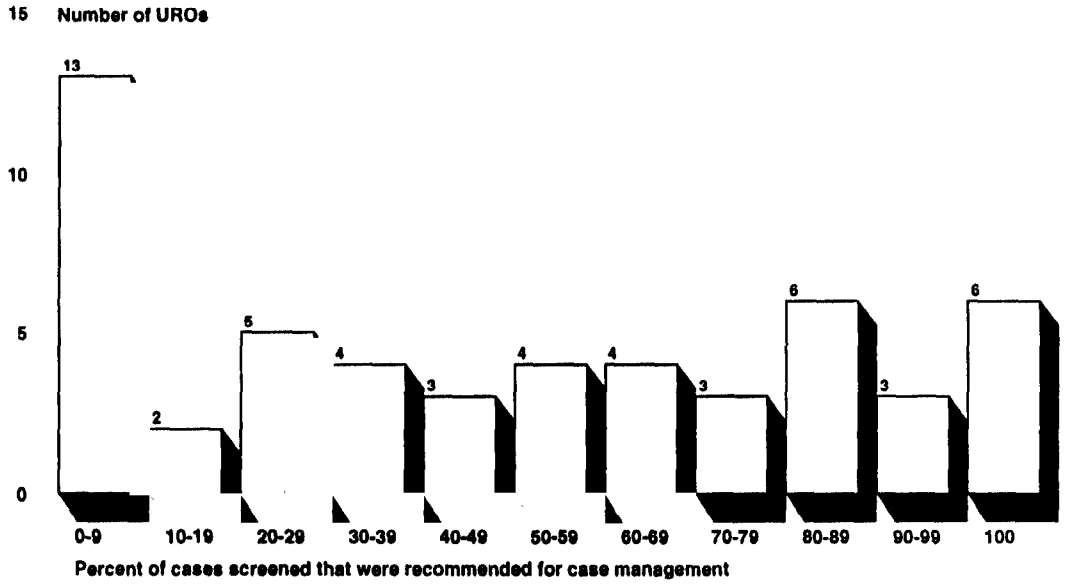
[7]Case management as it relates to utilization review generally involves (1) identification of potential cases, (2) evaluation of cases, (3) care plan development, and (4) case review and monitoring. Activities may include negotiating (1) length of stay, (2) place of service, (3) type of service, and (4) choice of provider.

**Figure 4.17: Years in Which UROs Introduced Case Management Services**



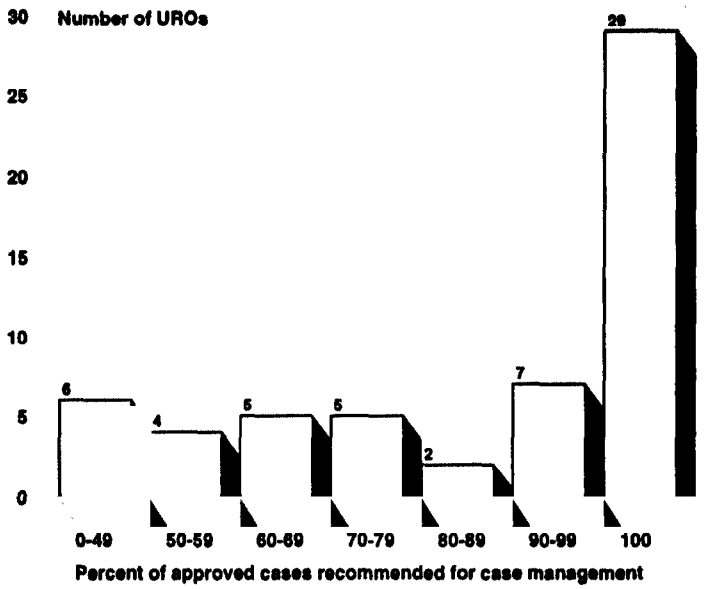

Note: N=73, 72, 65, and 73, respectively.

**Figure 4.18: Reported Percentages of Screened Cases Recommended for Case Management**




Note: N=53.

**Figure 4.19: Reported Approvals of Cases Recommended for Case Management**

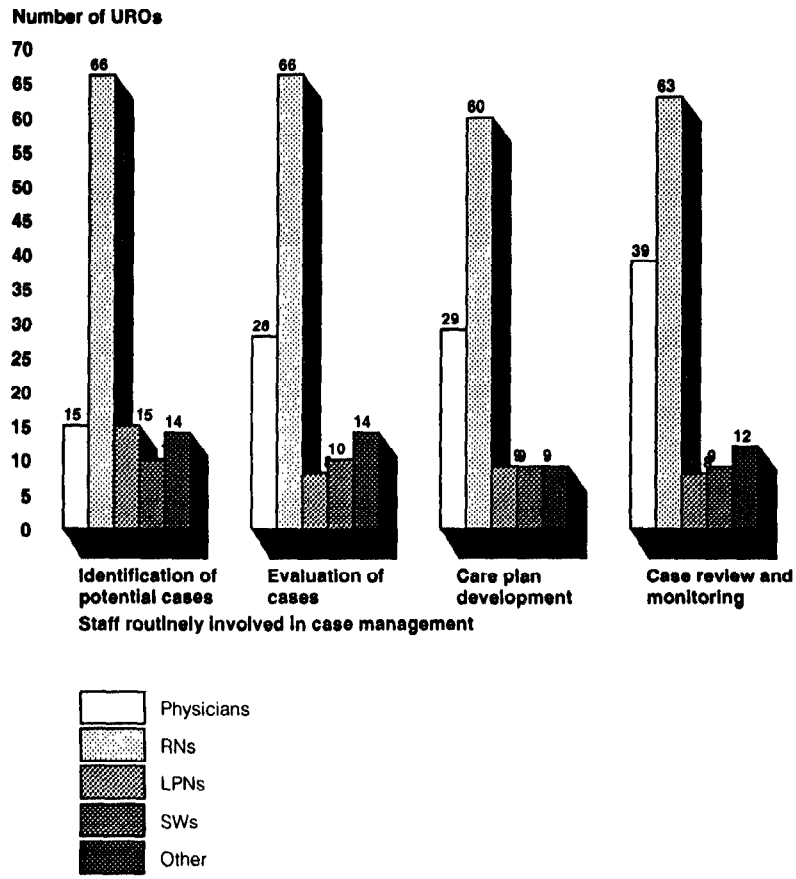



Note: N=58.

## Staff Involved in Case Management Recommendations

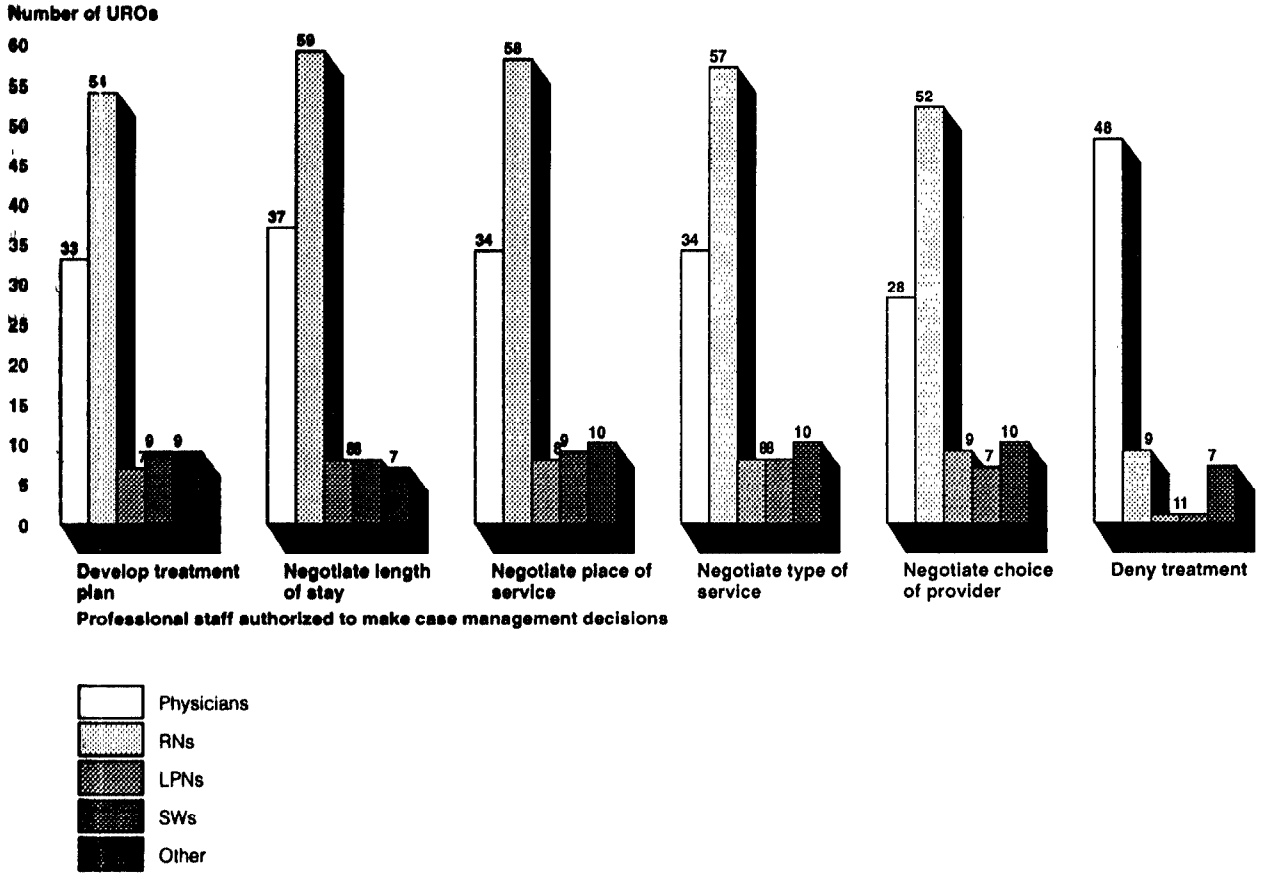
RNs were more involved with case management decisions than any other type of professional. (See figs. 4.20 and 4.21.) Except for the authority to deny treatment plans, same-specialty and related-specialty physicians have similar levels of involvement and authority in the process. (See figs. 4.22 and 4.23.) As is the case in prehospital admission review, a same-specialty physician has more authority than a related-specialty physician to recommend denials.

**Figure 4.20: Staff Involvement in Case Management Decisions**



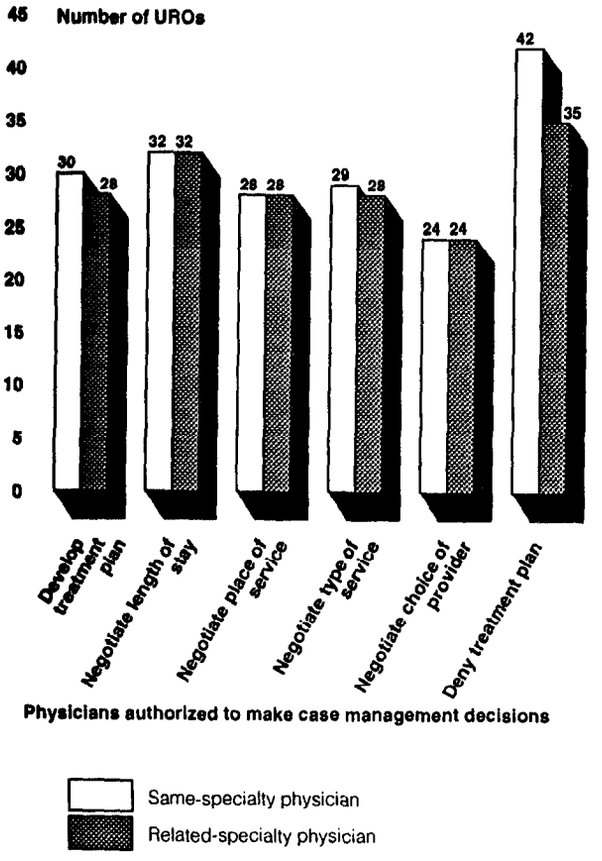

Note: N=70. "Other" includes ARTs, RRAs, a benefits specialist, claims manager, physician assistant, psychologist, and rehabilitation counselor.

**Figure 4.21: Staff Authority in Case Management Decisions**



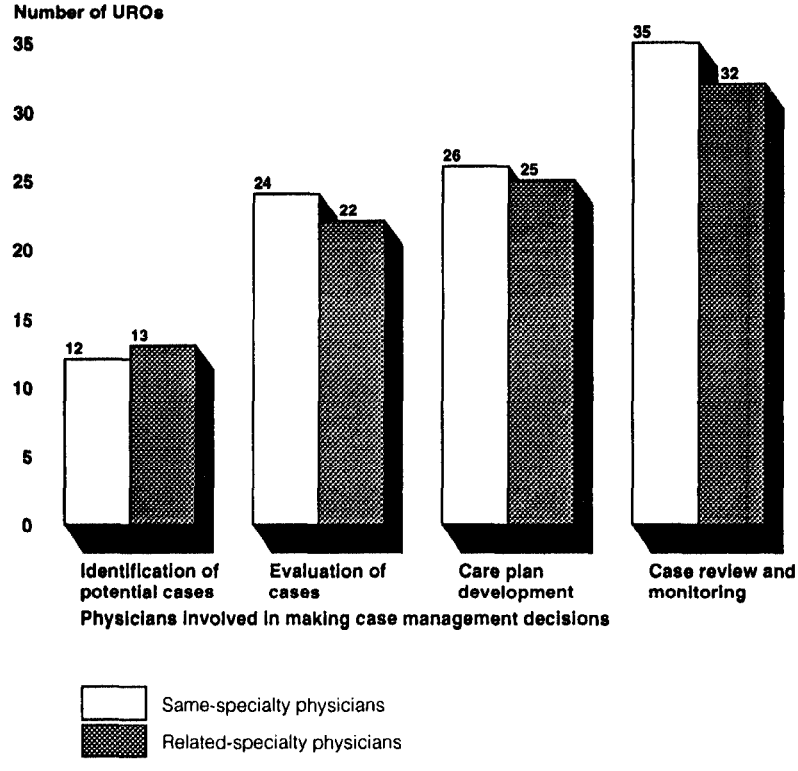

Note: N=70. "Other" includes ARTs, RRAs, benefits specialist, claims manager, physician assistant, psychologist, and rehabilitation counselor.

**Figure 4.22: Specialty Physicians' Authority in Case Management Decisions**




Note: N=70.

**Figure 4.23: Specialty Physicians' Involvement in Case Management Decisions**




Note: N=70.

# The Appeals Process

Utilization review organizations have established an appeals process for patients and providers to request a reconsideration of recommendations not to authorize an admission, extension of hospital stay, or surgery. A majority of respondents said they use a physician in the same specialty—one that typically manages the medical conditions, procedures, or treatments being reviewed—to examine most or all of the utilization review decisions being appealed. However, many respondents also use panels of two or more people to review appeals. When this occurs, most of the panels include a physician who practices in the same specialty area as the case under review. Approximately one-fourth of respondents have review panels with nonphysician staff. The majority of respondents (60) do not require the persons who review appeals to be located within the patient's service area.

A majority of 69 respondents stated that most or all of the decisions that were appealed were reviewed by a physician who is in the same specialty as the case being reviewed. However, 5 stated that none of the appealed decisions were reviewed by a physician who was in the same specialty as the cases under review; 14 stated that most or all of the appealed decisions were reviewed by a physician who was in a related specialty to the case under review. Sixty UROs indicated that they expedite the appeals of cases that are considered urgent. However, we did not request any further information on expediting appeals.

Some respondents reported using nonphysician specialists to review appeals and to make final decisions. Specifically, 10 UROs use nonphysician specialists to review appeals, and 4 of these UROs use them to make a final decision. In addition, some respondents use nonphysician nonspecialists to review appeals or make the final decision on appeals. Specifically, 6 UROs use nonphysician nonspecialists to review appeals, and 2 UROs use them to make a final decision.

Thirty-nine respondents have used a panel of two or more people to review appeals of utilization review decisions. In 21 of these UROs, all of the review panels included a physician who was in the same specialty as the case being reviewed. In 5 of the 39 UROs, every panel included physicians who were in a related specialty to the case being reviewed. [1] However, in one URO the panels never included any physician.

[1]All of these UROs also had same-specialty physicians review their appealed utilization review decisions.

Some respondents include nonphysician specialists on panels to review appeals, but few are included in panels making final decisions on appeals. Specifically, 9 UROs use nonphysician specialists on a panel to review appeals, but only 2 of these UROs use them on panels making final decisions on appeals. Further, only a few UROs include nonphysician nonspecialists on panels to review appeals or to make final decisions: Five UROs use nonphysician nonspecialists on panels to review appeals, but only 2 of these UROs use them to make a final decision on appeals.

# Review Criteria

URO staff have specific criteria that they use to evaluate a case and make recommendations about the appropriateness or necessity for proposed care. [1] Many UROs develop their own criteria while others purchase criteria from companies specializing in this area. Some UROs also purchase criteria and then modify it to suit their needs. Often, UROs consider the review criteria they use as proprietary information and restrict access to it.

In conducting first level reviews, RNs and other health care professionals collect information about patients and the medical services to be provided and compare it to specific criteria established for these services. If the proposed medical care meets the criteria, a recommendation for approval is made. If it does not, the case is sent for a second level review. Explicit preestablished criteria are less likely to be used at the second level of review than at the first level of review. [2]

Review criteria can be used to evaluate either a diagnosis or a required level of care. [3] Diagnosis-specific criteria focus on the services medical experts consider appropriate for particular diagnoses, symptoms, or procedures. For example, criteria may be developed for reviewing a patient being admitted to or staying in a hospital with diabetes (a diagnosis), a patient experiencing chest pain (a symptom), or a patient requiring a carotid endarterectomy (a procedure). In each case, the criteria indicate which medical services are appropriate for patients in each of these categories. Level-of-care criteria are not specific to particular diagnoses or medical problems. These criteria justify admission or continued stay by applying specific indicators that describe the type, number, and/or intensity of a combination of physician, skilled nursing, and ancillary hospital services requiring a hospital setting, regardless of which diagnoses, symptoms, or procedure the patient has. Sixty-eight of 74 respondents use criteria that address appropriateness of care.

Experts agree that criteria development should begin with a review of the medical literature and identification of relevant clinical indicators. [4] On the

[1]Review criteria are based on clinical indicators that relate to either a specific diagnosis, the intensity of care required, or a combination of the two.

[2]After the first level of review, physicians' judgments usually serve as the basis for the recommendation rather than the preestablished criteria.

[3]We cannot determine the number of respondents that use a diagnosis based review criteria because some UROs reported using proprietary or internally developed criteria that may or may not be diagnosis based. Sixty-eight UROs indicated that their review criteria address the appropriateness of care in addition to or instead of where or how long prescribed care would be provided.

[4]For example, a clinical indicator for an appendectomy (procedure) would be acute or early appendicitis or gangrenous or perforated appendix.

basis of the literature review and their clinical judgment, a panel of expert physicians rate each indicator on a scale of appropriateness. Using this information and physician input, the company formulates draft criteria. These criteria are revised one or more times as further physician input is obtained. Companies may then test the criteria's reliability and validity among reviewers. This entire process requires approximately one year per criteria. Fifty of 76 respondents develop their own criteria for making utilization review decisions about medical/surgical cases. GAO did not determine if they followed this process, a more stringent process, or a less reliable one. However, most of the respondents involve physicians in the development process.

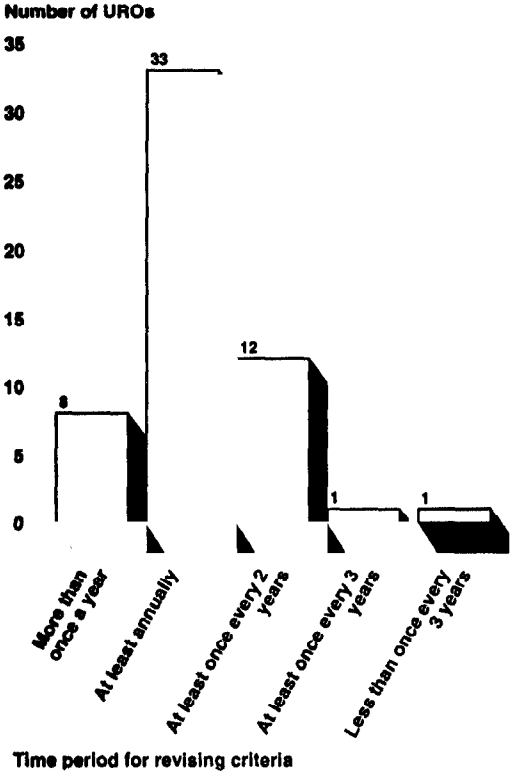
Many UROs said they revise their review criteria periodically. (See fig. 6.1.) Thirty-three UROs most recently revised one or more of their criteria in 1991, and 22 last revised one or more of their criteria in 1990.

UROs usually consider the review criteria they use in the decision making process to be proprietary information and restrict the amount of information they provide to physicians, hospitals, customers, or patients. These limitations are in place in order to limit the ability of others to "game" the system or circumvent the criteria. (See fig. 6.2)

Most UROs use two or more sets of review criteria to make their decisions about medical/surgical care being proposed. (See fig. 6.3.) The most commonly used is commercially developed by a company called InterQual. (See table 6.1.) Their ISD-A criteria is based on the intensity of service required by the patient and patient's severity of illness rather than the patient's diagnosis.

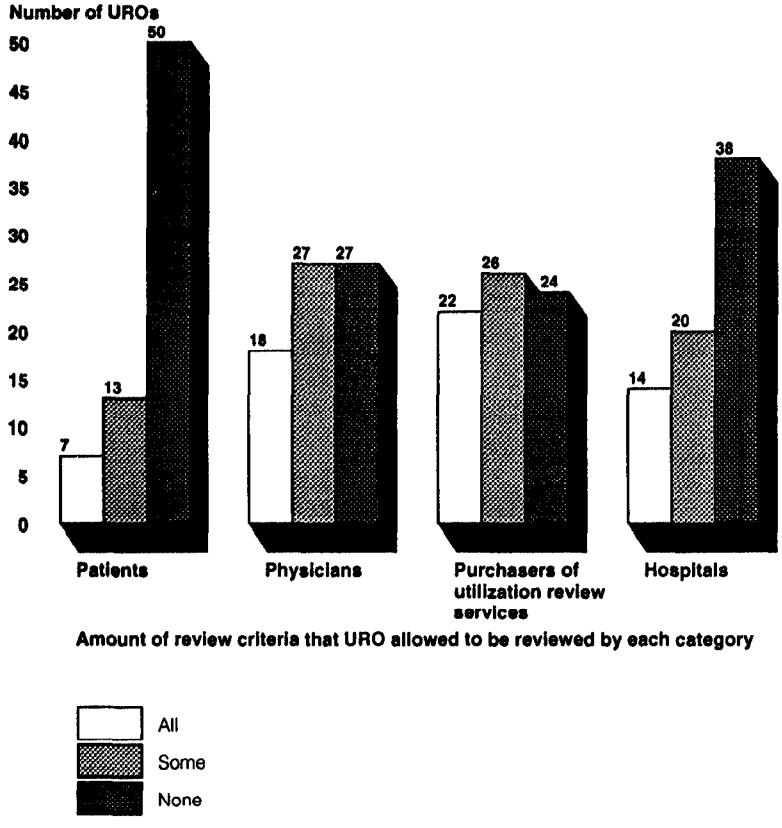
The publication Professional Activities' Study (PAS) Length of Stay by Diagnosis and Operation provides baseline regional data that UROs use to determine length of stay recommendations for patients' hospitalizations. The data are categorized by age, sex, single diagnosis (surgical and nonsurgical), and multiple diagnoses (surgical and nonsurgical). The length of stay data vary by region with the Western region having the shorter lengths of stay than other regions of the country. Fifty-six UROs indicated that they use this resource data as criteria when conducting utilization reviews.

**Figure 6.1: Frequency of Revisions to URO Review Criteria**



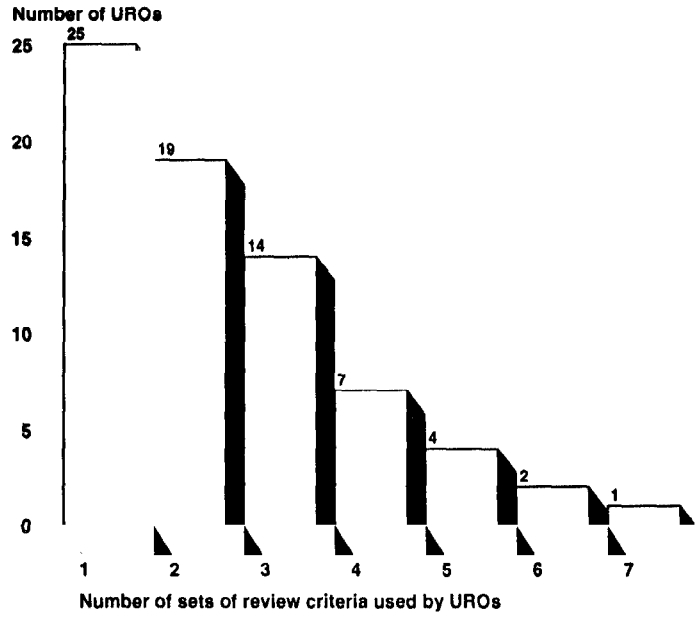

Note: N=55.

**Figure 6.2: Reported URO Authorization to Examine Review Criteria**




Note: N=70 for patient data and 72 for the other three categories.

**Figure 6.3: Number of Different Criteria Sets Used to Review Medical/Surgical Cases**




Note: N=75.

**Table 6.1: Types of Review Criteria Used to Make Decisions About Medical/Surgical Cases[a]**

| Review criteria | Number of UROs |
|---|---|
| InterQual[b] | 34 |
| Intensity of Service, Severity of Illness and Discharge Screens-Appropriateness (ISD-A) | 23 |
| American Medical Association (AMA) | 18 |
| Appropriateness Evaluation Protocol (AEP) | 17 |
| Client/payer | 17 |
| Proprietary/internally developed | 21 |
| Standardized Medreview Instrument (SMI) | 14 |
| Blue Cross/Blue Shield | 3 |
| Value Health Sciences | 3 |
| National Health Services | 3 |
| Milliman & Robertson | 3 |
| Governmental agencies (for example, HCFA-modified, NIH) | 2 |
| National Medical Audit | 2 |
| Pace Company/Pace Healthplan Management | 2 |
| Other[c] | 11 |

[a]Many UROs use more than one set of criteria in their utilization review decisions.

[b]The questionnaire listed InterQual and ISD-A as two different types of criteria that UROs might use to make recommendations. However, ISD-A is a name for one set of review criteria developed by InterQual.

[c]"Other" includes those sets of review criteria listed by only one URO, such as PAR clinical criteria and HSI/LOS criteria.

# Quality Assurance Monitoring Mechanisms

Sixty-three of the UROs responding to our questionnaire stated that they have quality assurance monitoring processes in place to ensure that their case managers and other professional staff make appropriate decisions. Twenty-nine of these UROs provided us with specific information about the mechanisms they use. The monitoring processes vary considerably with respect to (1) the decisions reviewed; (2) the methods to select cases for review; (3) the time periods in which the review is generally conducted; (4) whether they establish thresholds [1] for action; and (5) the types of personnel used to review the decisions. [2] Other quality assurance actions which are implemented if URO staff identify poor quality care may include discussing care with the patient's primary physician or hospital where the patient is being treated. (See table 7.1.)

Six of the 29 respondents said they review only certain types of decisions. For example, 2 UROs review all appeal decisions, and another URO randomly reviews a certain number of admission decisions every month. Methods to select cases for review also vary. For example, 1 URO reviews all new employees' review decisions, 9 review a percent of all cases, ranging from 10 to 25 percent, while 9 UROs review a percent of an individual reviewer's decisions, ranging from 3 to 100 percent. In addition, UROs' quality assurance reviews vary by the time period in which they are conducted. Three of the 29 respondents perform quality assurance monitoring on a daily basis, 11 perform monitoring activities on a monthly basis, and 3 perform monitoring activities on a quarterly basis.

Only 3 of the 29 respondents stated that they have established a threshold for action based on the case manager's accuracy rate. One of these UROs uses an evaluation tool to identify the case manager's accuracy level for coding the patients' conditions and other information. If the case manager's accuracy level falls below 95 percent, an action plan to correct the deficiencies is written.

UROs also vary in the extent to which they use RNs, physicians, audit teams, or quality assurance department staff to monitor their reviewers' decisions. For example, one URO requires supervisors to evaluate 100 percent of reviewers' decisions on a daily basis. In this URO, program managers also review a random selection of decisions and the accuracy of

[1] A threshold is that preestablished point in the collection of data when an intensive evaluation of the indicator is initiated.

[2] These categories are not necessarily mutually exclusive. One URO monitors a sample of review decisions and also monitors 100 percent of a nurse reviewer's decisions during the first 3 months of employment. Another URO reviews a percent of decisions and all appeals.

data entered into its computer system. Another URO evaluates on a monthly basis a sample of review decisions made by both nurses (generally approvals and referrals) and physicians (generally approval and denials). This URO has a policy of reviewing 100 percent of (1) each nurse's reviews during the first three months of employment and (2) each physician's first 20 reviews. If concerns are identified, the URO intensifies its review of the individual's work and corrective action is taken.

UROs generally discuss the care provided with a patient's primary physician when a URO's quality assurance procedures indicate that a patient has received poor health care. Other steps taken when a URO determines that a patient received poor quality health care include discussing that care with the hospital where the patient was treated, other physicians who were treating the patient, or the patient's insurer. Sixty of 72 respondents had a mechanism for intervening in or reporting cases where a patient was receiving poor health care.

**Table 7.1: Extent to Which UROs Notify Others of Cases of Poor Health Care[a]**

| Action | Percent of UROs responding "Yes" |
|---|---|
| Discussed care with patient's primary physician | 91 percent (63 of 69) |
| Discussed care with hospital where patient was being treated | 75 percent (50 of 67) |
| Discussed care with other physicians who were treating patient | 64 percent (43 of 67) |
| Discussed care with patient's insurer | 65 percent (42 of 65) |
| Discussed care with client who contracted for review | 58 percent (38 of 66) |
| Recommended that patient consult another physician | 52 percent (34 of 66) |
| Discussed care with state medical board | 47 percent (30 of 64) |
| Discussed care with health care provider's employer | 41 percent (26 of 64) |
| Discussed care with local medical board | 35 percent (23 of 65) |

[a]Twelve respondents took actions beyond those listed in the table. These actions include (1) referring cases to the medical director and quality assurance committee; (2) utilizing a consulting physician to discuss the care with the primary physician; (3) referring the case to the staff responsible for network contract compliance; or (4) referring the case to the Attorney General of the states' medical fraud unit.

# Questionnaire Survey of Utilization Review Companies

United States General Accounting Office

GAO

Questionnaire

## Survey of Utilization Review Companies

U.S. General Accounting Office

Survey of Utilization Review Companies

***This appendix includes a summary of the data collected on our survey instrument. Text or numbers in bold, italic print either are the data or refer to sections of the report where the data are displayed.***

At the request of the House Select Committee on Aging, the U.S. General Accounting Office (GAO) is conducting a study of utilization review companies. As part of this study, we are conducting a national survey of all utilization review companies to obtain information on the types of reviews that they conduct, criteria that they use for these reviews, and the professional backgrounds of the individuals who conduct their reviews. Accordingly, we ask your assistance with this survey by completing this questionnaire.

Your assistance in providing this information is necessary for us to have a complete understanding of the range of processes that are used to conduct utilization review. Your responses to this questionnaire are confidential. No one outside of GAO will know how you, individually, answered any of the questions. We will report your responses only in summary with those of everyone else who answers this questionnaire.

Please complete and return this questionnaire in the next two weeks. Also, please retain a copy of the completed questionnaire in the event that we have any follow-up questions. A pre-addressed business reply envelope is provided for your convenience. We will provide a copy of our report to all companies who participate in our survey. If you have any questions about this questionnaire or our study, please call Sandi Isaacson on (202) 708-4228.

In the event that the business reply envelope is misplaced, please return this questionnaire to:

U.S. General Accounting Office
Attn: Sandra K. Isaacson
441 G Street, NW
Reporters' Bldg., Rm. 414
Washington, DC 20548

1. Please enter the name, title, and telephone number of the individual who completes this questionnaire.

   Name: _____

   Title: _____

   Telephone: (_____) _____ - _____

**I. Background Information**

2. Excluding psychiatric cases, during your fiscal year (FY) 1990, did your company ever conduct utilization reviews of medical or surgical cases?

   1. [*79*] Yes **(Please answer the remaining questions relative only to your FY 1990 reviews of non-psychiatric medical and surgical cases.)**

   2. [*112*] No (STOP! Please return this questionnaire in the pre-addressed business reply envelope. It is not necessary that you complete this questionnaire.)

3. During your FY 1990, was your company independently owned or was it a subsidiary of or owned by another company?

   1. [*38*] Independently owned (SKIP TO QUESTION 7.)

   2. [*39*] A subsidiary of or owned by another company

4. During your FY 1990, did your parent company or any of its subsidiaries provide direct patient care?

   1. [ *9*] Yes

   2. [*30*] No

5. During your FY 1990, was your parent company or any of its subsidiaries a health insurer?

   1. [*20*] Yes

   2. [*19*] No

6. During your FY 1990, did your parent company or any of its subsidiaries ever purchase any of your utilization review services?

   1. [*29*] Yes

   2. [*10*] No

7. In what year was your company established?

   *See table 2.1.*

   19 |__|__|

8. Please list the states in which you are certified to conduct utilization reviews? Also, enter the year in which each of these states first certified you?

   *Information determined to be unreliable*

   1._____ 19|__|__|
   2._____ 19|__|__|
   3._____ 19|__|__|
   4._____ 19|__|__|
   5._____ 19|__|__|
   6._____ 19|__|__|
   7._____ 19|__|__|
   8._____ 19|__|__|
   9._____ 19|__|__|
   10._____ 19|__|__|

9. During your FY 1990, what were your company's gross revenues from utilization review sources?

   *$1,000,000 (median); $4,888,535 (mean)*
   *See table 2.2.*

10. During your FY 1990, how many contracts did your company have to provide utilization review services for non-psychiatric medical and surgical cases?

    *85 (median); 19,698.7 (mean)* contracts

11. During your FY 1990, how many lives did your company cover under these contracts for these services?

    *150,000 (median); 872, 930 (mean)* lives

**II. Personnel Who Conduct Reviews**

12. Listed below are types of health care staff. (A) For each type, please indicate if, at any phase of the utilization review process, any of that staff type made decisions about the necessity or the appropriateness of requested medical or surgical care for your company during your FY 1990. (B) If "Yes," please enter the total number of staff of each type that made these decisions, and the number of these staff that were full-time employees of your company, part-time employees of your company who worked on the premises of your company, part-time employees of your company who worked off the premises of your company, and consultants/advisors to your company. (IF NONE, ENTER "0.")

*See tables 3.1, 3.2, and 3.3.*

| | (A) During FY 1990, did staff type make necessity/appropriateness decisions? (CHECK ONE.) | | (B) For each type of staff who made necessity or appropriateness decisions, please enter the number of... (ENTER A NUMBER FOR EACH.) | | | | |
|---|---|---|---|---|---|---|---|
| | No (1) | Yes --> (2) | Employees, in total | Full-time employees | Part-time employees, on-premises | Part-time employees, off-premises | Consultants/advisors to company |
| 1. Physicians | | | | | | | |
| 2. Registered nurses | | | | | | | |
| 3. Licensed practical nurses | | | | | | | |
| 4. Accredited records technicians | | | | | | | |
| 5. Registered records administrators | | | | | | | |
| 6. Social workers | | | | | | | |
| 7. Clerical staff | | | | | | | |
| 8. Other (PLEASE SPECIFY.) | | | | | | | |
| 9. Other (PLEASE SPECIFY.) | | | | | | | |

13. How many of the physicians that you entered in question 12 above were board certified and how many were board eligible but not board certified? (IF NONE, ENTER "0.")

a. Board certified *14 (median); 59 (mean)*
b. Board eligible, but not board certified *0 (median); 7 (mean)*

14. During your FY 1990, did your company ever use consultants to make decisions about the necessity or appropriateness of requested medical or surgical care?

1. [*70*] Yes
2. [ *7*] No (SKIP TO QUESTION 16.)

15. Listed in the table below are types of health care **consultants** or **advisers**. For each type,

(A) indicate if your company ever used a **consultant** or **adviser** of that type to make decisions about the necessity or the appropriateness of requested medical or surgical care during your FY 1990.

If "Yes," please enter the percentage of all FY 1990 medical and surgical case reviews in which each type of consultant or adviser made necessity or appropriateness decisions about

(B) requested medical or surgical care, and

(C) requested medical or surgical care for a case in his or her same exact specialty, for example, an orthopedic surgeon who reviewed orthopedic cases OR

for a case in his or her related specialty, for example, a general surgeon who reviewed orthopedic cases.

***Information determined to be unreliable.***

| Consultant/adviser | (A) During your FY 1990, did **consultants** or **advisers** of this type make necessity or appropriateness decisions? (CHECK ONE.) No (1) | (A) Yes --> (2) | (B) Percentage of all FY 1990 medical and surgical cases for which each type of **consultant** or **adviser** made necessity or appropriateness decisions? (ENTER PERCENTAGES FOR EACH.) | (C) Percentage of all FY 1990 medical and surgical cases for which each type of **consultant** or **adviser** made necessity or appropriateness decisions about cases in... (ENTER PERCENTAGES.) The same specialty? | A related specialty? |
|---|---|---|---|---|---|
| 1. Physician | | | ____% | ____% | ____% |
| 2. Registered nurse | | | ____% | ____% | ____% |
| 3. Licensed practical nurse | | | ____% | ____% | ____% |
| 4. Accredited records technician | | | ____% | ____% | ____% |
| 5. Registered records administrator | | | ____% | ____% | ____% |
| 6. Social worker | | | ____% | ____% | ____% |
| 7. Clerical | | | ____% | ____% | ____% |
| 8. Other (PLEASE SPECIFY.) | | | ____% | ____% | ____% |
| 9. Other (PLEASE SPECIFY.) | | | ____% | ____% | ____% |

16. **Please indicate whether or not the nurses and physicians, who conducted utilization reviews for your company during your FY 1990, were required to have active licenses. If any of these staff did not conduct utilization reviews for your company, check the not applicable "N/A" box. (CHECK ONE FOR EACH.)**

| | Yes (1) | No (2) | N/A (3) |
|---|---|---|---|
| 1. Practical nurses | [21] | [ 3] | [45] |
| 2. Graduate nurses | [55] | [ 4] | [17] |
| 3. Physicians | [74] | [ 0] | [ 2] |

17. (A) For each type of staff listed below, please indicate whether or not, during your FY 1990, your company had any minimum requirements on what educational level was needed to conduct utilization reviews for your company. (If any of these staff did not conduct utilization reviews for your company, check the not applicable "N/A" box.) (B) If "Yes," please indicate the **minimum** education level that was required. (CHECK ONE FOR EACH.)

*See table 3.3.*

| | (A) During FY 1990, did you have minimum educational requirements? (CHECK ONE.) | | | (B) What **minimum** educational level was required? (CHECK ONE.) | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | N/A, staff did not conduct reviews (1) | No minimum requirements for staff (2) | Yes --> (3) | High school diploma/ GED (4) | Practical nurse certificate (5) | Nursing diploma (6) | Associate's degree (7) | Bachelor's degree (8) | Master's degree (9) | Doctoral degree (10) |
| 1. Registered nurses | | | | | | | | | | |
| 2. Licensed practical nurses | | | | | | | | | | |
| 3. Accredited records technicians | | | | | | | | | | |
| 4. Registered records administrators | | | | | | | | | | |
| 5. Social workers | | | | | | | | | | |
| 6. Clericals | | | | | | | | | | |
| 7. Other (PLEASE SPECIFY.) | | | | | | | | | | |
| 8. Other (PLEASE SPECIFY.) | | | | | | | | | | |

18. (A) For each type of staff listed below, please indicate whether or not your company had any minimum requirements for experience needed in a clinical setting in order to conduct utilization reviews for your company during your FY 1990. (If any of these staff did not conduct utilization reviews for your company during your FY 1990, check the not applicable "N/A" box.) (B) If "Yes," please enter the minimum number of years of experience that was required.

*See table 3.4.*

| | (A) During FY 1990, did you have minimum experience requirements? (CHECK ONE.) | | | (B) What was the minimum, number of years of experience in a clinical setting that was required? (ENTER NUMBER.) |
|---|---|---|---|---|
| | N/A staff did not conduct reviews (1) | No (2) | Yes --> (3) | |
| 1. Physicians | | | | |
| 2. Registered nurses | | | | |
| 3. Licensed practical nurses | | | | |
| 4. Accredited records technicians | | | | |
| 5. Registered records administrators | | | | |
| 6. Social workers | | | | |
| 7. Clericals | | | | |
| 8. Other (PLEASE SPECIFY.) | | | | |
| 9. Other (PLEASE SPECIFY.) | | | | |

19. During your FY 1990, did the physicians who conducted utilization reviews for your company also have to be practicing medicine at the same time?

1. [*48*] Yes

2. [*24*] No

**III. Types of Reviews**

**Please note that in this section, we ask for separate information about pre-hospital admission certification reviews, concurrent reviews, second surgical opinions and case-management.**

PRE-HOSPITAL ADMISSION CERTIFICATION REVIEWS

20. Has your company ever conducted pre-hospital admission certification reviews of **medical** or **surgical** cases -- that is, reviews to determine if inpatient hospital care is required and what the length of stay should be?

    1. [*73*] Yes

    2. [ *5*] No (SKIP TO QUESTION 37.)

21. In what year did your company first conduct these types of reviews?

    *1968-90 range*

    19 |___|___|

22. During your FY 1990, did your company conduct any pre-hospital admission certification reviews of medical or surgical cases?

    1. [*71*] Yes

    2. [ *1*] No (SKIP TO QUESTION 37.)

23. In total, how many pre-hospital admission certification reviews of medical and surgical cases did you conduct during your FY 1990?

    *2,884 (median); 37,609 (mean)* reviews

24. Listed below are various outcomes of a pre-hospital admission certification review. Of the pre-hospital admission certification reviews of medical and surgical cases that you conducted during your FY 1990,

    (A) how many reviews had each outcome?

    Also, how many of each review outcome were (B) appealed, (C) successfully appealed -- the decision was reversed and (D) grieved or arbitrated by a third party? (IF NONE, ENTER "0.")

*See table 4.1.*

| Outcome | (A) How many FY 1990 reviews had each outcome? (ENTER NUMBER.) | (B) How many FY 1990 outcomes were appealed? (ENTER NUMBER.) | (C) How many FY 1990 outcomes were successfully appealed? (ENTER NUMBER.) | (D) How many FY 1990 outcomes were grieved or arbitrated by a third party? (ENTER NUMBER.) |
|---|---|---|---|---|
| 1. Authorized request without modification | _____ | | | |
| 2. Authorized a shorter length of stay | _____ | _____ | _____ | _____ |
| 3. Converted from in- to out-patient care or to an alternative setting | _____ | _____ | _____ | _____ |
| 4. Authorized a different provider than was requested | _____ | _____ | _____ | _____ |
| 5. Denied request because of unsubstantiated medical need | _____ | _____ | _____ | _____ |

25. For the pre-hospital admission certification reviews of medical and surgical cases that your company conducted during your FY 1990, in total, how many days of hospital care were requested? Including those cases that were initially approved and cases that were approved after appeal, in total, how many days of hospital care were authorized? (IF NONE, ENTER "0.")

    a. Days requested *52,800 (median); 202,399 (mean)*

    b. Days authorized *48,180 (median); 159,176 (mean)*

26. Were any pre-hospital admission denials of medical or surgical cases formally appealed during your FY 1990?

    1. [*50*] Yes

    2. [*20*] No (SKIP TO QUESTION 31.)

27. For any of these appeals, did the person who first issued the denial also conduct the first review of the appeal?

    1. [*16*] Yes

    2. [*34*] No (SKIP TO QUESTION 31.)

28. In about what proportion of these appealed cases did the person who first issued the denial also conduct the first review of the appeal? (CHECK ONE.)

    1. [ *6*] 81 - 100%

    2. [ *2*] 61 - 80%

    3. [ *1*] 41 - 60%

    4. [ *0*] 21 - 40%

    5. [ *4*] 20% or less

29. Consider those pre-hospital admission denials where the person who first issued the denial also conducted the first review of the appeal. In about what proportion of these cases did the reviewer overturn his or her initial decision? (CHECK ONE.)

    1. [ *0*] 100%

    2. [ *0*] 81 - 99%

    3. [ *2*] 61 - 80%

    4 [ 2] 41 - 60%

    5. [ *4*] 21 - 40%

    6. [ *4*] 1 - 20%

    7. [ *1*] 0%

30. In about what proportion of all appealed pre-hospital admission denials did the person who first issued a denial also make the final decision on the appeal? (CHECK ONE.)

    1. [ *1*] 100%

    2. [ *2*] 81 - 99%

    3. [ *0*] 61 - 80%

    4. [ *1*] 41 - 60%

    5. [ *2*] 21 - 40%

    6. [ *2*] 1 - 20%

    7. [ *5*] 0%

31. Consider the staff, both your employees and consultants or advisers, who conducted pre-hospital admission certification reviews of medical or surgical cases for your company during your FY 1990. In what phases of a pre-hospital admission certification review did these types of staff routinely make decisions about the necessity or the appropriateness of requested medical or surgical care? (CHECK ALL THAT APPLY FOR EACH.)

*See figure 4.3.*

| | First level review (1) | Second level review (2) | First level review of an appeal (3) | Second level review of an appeal (4) | Grievance or third party arbitration of an appeal (5) |
|---|---|---|---|---|---|
| 1. A physician who reviewed cases in their same specialty, for example, an orthopedic surgeon who reviewed orthopedic cases | | | | | |
| 2. A physician who reviewed cases in a related specialty, for example, a general surgeon who reviewed orthopedic cases | | | | | |
| 3. Registered nurse | | | | | |
| 4. Licensed practical nurse | | | | | |
| 5. Accredited records technician | | | | | |
| 6. Registered records administrator | | | | | |
| 7. Clerical | | | | | |
| 8. Other (PLEASE SPECIFY.) | | | | | |

32. For each type of staff who conducted pre-hospital admission certification reviews for your company during your FY 1990, what kinds of decisions did the type of staff have authority to make during pre-hospital admission certification reviews of medical or surgical cases? (CHECK ALL THAT APPLY FOR EACH.)

*See figure 4.4.*

| | Authorize requests without modification (1) | Authorize shorter lengths of stay (2) | Convert from in-to out- patient care or to alternative settings (3) | Authorize a different choice of provider (4) | Deny request (5) |
|---|---|---|---|---|---|
| 1. A physician who reviewed cases in their same specialty | | | | | |
| 2. A physician who reviewed cases in a related specialty | | | | | |
| 3. Registered nurse | | | | | |
| 4. Licensed practical nurse | | | | | |
| 5. Accredited records technician | | | | | |
| 6. Registered records administrator | | | | | |
| 7. Clerical | | | | | |
| 8. Other (PLEASE SPECIFY.) | | | | | |

33. During your FY 1990, did your company ever review the appropriateness of a proposed procedure prior to authorizing hospital admission?

    1. [*58*] Yes

    2. [*14*] No (SKIP TO QUESTION 36.)

34. During your FY 1990, in how many medical and surgical case reviews did your company review the appropriateness of a proposed procedure prior to authorizing admission?

    *3,200 (median); 25,126 (mean)* cases

35. Did your company use formal criteria when making these reviews?

    1. [*54*] Yes

    2. [ *4*] No

36. During your FY 1990, from the date your company was first notified of an appeal of a pre-hospital admission certification, about how many days usually elapsed before your company notified the patient or physician of its decision?

    *5 (median); 11 (mean)* days

CONCURRENT REVIEWS

37. Has your company ever conducted concurrent reviews of **medical** or **surgical** cases -- that is, reviews, while a patient is admitted to a hospital, to determine if their hospital stay should be continued or extended?

    1. [*72*] Yes

    2. [ *6*] No (SKIP TO QUESTION 52.)

38. In what year did your company first conduct these reviews?

    ***Range from 1968-90.***

    19 |___|___|

39. During your FY 1990, did your company conduct any concurrent reviews of medical or surgical cases?

    1. [*70*] Yes

    2. [ *1*] No (SKIP TO QUESTION 52.)

40. In total, how many concurrent reviews of medical or surgical cases did you conduct during your FY 1990?

    ***10,000 (median); 49,303 (mean)*** concurrent reviews

41. Of the concurrent reviews that you conducted during your FY 1990, in about what proportion did you conduct the review in response to a request for continued or extended stay and in what proportion did you conduct the review without ever receiving a request for continued or extended stay? (ENTER A PERCENTAGE FOR EACH.)

    Reviews conducted...

    a. in response to a request ***10% (median); 28% (mean)***

    b. without ever receiving a request ***90% (median); 82% (mean)***

42. Listed below are various outcomes of a concurrent review. Of the concurrent reviews of medical and surgical cases that you conducted during your FY 1990,

    (A) how many reviews had each outcome?

    Also, how many of each review outcome were (B) appealed, (C) successfully appealed -- the decision was reversed and (D) grieved or arbitrated by a third party? (IF NONE, ENTER "0.")

***See table 4.2.***

| Outcome | (A) How many FY 1990 reviews had each outcome? (ENTER NUMBER.) | (B) How many FY 1990 outcomes were appealed? (ENTER NUMBER.) | (C) How many FY 1990 outcomes were successfully appealed? (ENTER NUMBER.) | (D) How many FY 1990 outcomes were grieved or arbitrated by a third party? (ENTER NUMBER.) |
|---|---|---|---|---|
| 1. Authorized continuation without modification | _____ | | | |
| 2. Authorized a shorter continuation of stay than was requested | _____ | _____ | _____ | _____ |
| 3. Denied continuation because of unsubstantiated medical need | _____ | _____ | _____ | _____ |

43. Of the concurrent reviews of medical and surgical cases that your company conducted during your FY 1990, in how many of these reviews did you grant additional days of hospital care? Also, how many days of care did you grant? (IF NONE, ENTER "0.")

    a. Reviews: *2,800 (median); 20,109 (mean)*

    b. Days granted: *12,625 (median); 94,539 (mean)*

44. Were any concurrent reviews of medical or surgical cases formally appealed during your FY 1990?

    1. [*50*] Yes

    2. [*17*] No (SKIP TO QUESTION 49.)

45. For any of these appeals, did the person who first issued the denial also conduct the first review of the appeal?

    1. [*18*] Yes

    2. [*32*] No (SKIP TO QUESTION 49.)

46. In about what proportion of these appealed cases did the person who first issued the denial also conduct the first review of the appeal? (CHECK ONE.)

    1. [ *9*] 81 - 100%

    2. [ *2*] 61 - 80%

    3. [ *1*] 41 - 60%

    4. [ *0*] 21 - 40%

    5. [ *4*] 20% or less

47. Consider those concurrent reviews where the person who first issued the denial also conducted the first review of the appeal. In about what proportion of these cases did the reviewer overturn his or her initial decision? (CHECK ONE.)

    1. [ *2*] 100%

    2. [ *0*] 81 - 99%

    3. [ *3*] 61 - 80%

    4. [ *2*] 41 - 60%

    5. [ *2*] 21 - 40%

    6. [ *6*] 1 - 20%

    7. [ *1*] 0%

48. In about what proportion of all appealed concurrent reviews did the person who first issued a denial also make the final decision on the appeal? (CHECK ONE.)

    1. [ *1*] 100%

    2. [ *2*] 81 - 99%

    3. [ *0*] 61 - 80%

    4. [ *3*] 41 - 60%

    5. [ *0*] 21 - 40%

    6. [ *3*] 1 - 20%

    7. [ *7*] 0%

49. Consider the staff, both your employees and consultants or advisers, who conducted concurrent reviews of medical or surgical cases for your company during your FY 1990. In what phases of a concurrent review did the types of staff routinely make decisions about the necessity or the appropriateness of requested medical or surgical care? (CHECK ALL THAT APPLY FOR EACH.)

*See figure 4.9.*

| | First request for continued length of stay (1) | Second request for continued length of stay (2) | First level review of an appeal (3) | Second level review of an appeal (4) | Grievance or third party arbitration of an appeal (5) |
|---|---|---|---|---|---|
| 1. A physician who reviewed cases in their same specialty for example, an orthopedic surgeon who reviewed orthopedic cases | | | | | |
| 2. A physician who reviewed cases in a related specialty for example, a general surgeon who reviewed orthopedic cases | | | | | |
| 3. Registered nurse | | | | | |
| 4. Licensed practical nurse | | | | | |
| 5. Accredited records technician | | | | | |
| 6. Registered records administrator | | | | | |
| 7. Clerical | | | | | |
| 8. Other (PLEASE SPECIFY.) | | | | | |

50. For each type of staff who conducted concurrent reviews for your company during your FY 1990, what kinds of decisions did the type of staff have authority to make during concurrent reviews of medical or surgical cases? (CHECK ALL THAT APPLY FOR EACH.)

*See figure 4.10.*

| | Authorize continuation without modification (1) | Authorize a shorter continuation of stay than was requested (2) | Deny continuation (3) |
|---|---|---|---|
| 1. A physician who reviewed cases in their same specialty | | | |
| 2. A physician who reviewed cases in a related specialty | | | |
| 3. Registered nurse | | | |
| 4. Licensed practical nurse | | | |
| 5. Accredited records technician | | | |
| 6. Registered records administrator | | | |
| 7. Clerical | | | |
| 8. Other (PLEASE SPECIFY.) | | | |

51. During your FY 1990, from the date your company was first notified of an appeal of a concurrent review, about how many days usually elapsed before your company notified the patient or physician of its decision?

*2.0 (median); 6.8 (mean)* days

SECOND SURGICAL OPINIONS

52. Has your company ever referred patients for a second surgical opinion; that is, refer a patient to a physician for confirmation of a proposed elective surgical procedure?

1. [*67*] Yes

2. [*11*] No (SKIP TO QUESTION 72.)

53. In what year did your company first refer a patient for a second surgical opinion?

*1961-90 range.*

19 |___|___|

54. During your FY 1990, did your company refer any patients for a second surgical opinion?

1. [*64*] Yes

2. [ *3*] No (SKIP TO QUESTION 72.)

55. During your FY 1990, how many surgeries did you refer for a second surgical opinion?

*120 (median); 1,216 (mean)* surgeries

56. How many of these surgeries were confirmed by the second opinion?

*90 (median); 871 (mean)* confirmed surgeries

57. How many of these surgeries were not confirmed by the second opinion?

*10 (median); 76 (mean)* non-confirmed surgeries

58. How many of these non-confirmed surgeries were appealed?

*0 (median); 6.7 (mean)* appealed surgeries

59. How many of these non-confirmed surgeries were successfully appealed?

*0 (median); 1.5 (mean)* successfully appealed surgeries

60. Including both surgeries that were appealed as well as those that were not appealed, how many of all referred surgeries were not certified because of unsubstantiated medical need?

*0 (median); 65 (mean)* non-certified surgeries

61. Of the surgeries that were referred for a second opinion during your FY 1990, about what percentage were referred to both a surgeon and non-surgeon, to a surgeon only, and to a non-surgeon only? (ENTER A PERCENTAGE FOR EACH. IF NONE, ENTER "0."

| Surgeries referred to... | Percentage |
|---|---|
| 1. Both a surgeon and non-surgeon | *0 (median)* *15% (mean)* |
| 2. A surgeon only | *100 (median)* *87% (mean)* |
| 3. A non-surgeon only | *1 (median)* *11% (mean)* |
| Total | *100%* |

62. Were any second surgical opinions formally appealed during your FY 1990?

1. [*10*] Yes
2. [*47*] No (SKIP TO QUESTION 67.)

63. For any of these appeals, did the person who first issued the denial also conduct the first review of the appeal?

1. [ *3*] Yes
2. [ *9*] No (SKIP TO QUESTION 67.)

64. In about what proportion of these appealed cases did the person who first issued the denial also conduct the first review of the appeal? (CHECK ONE.)

1. [ *1*] 81 - 100%
2. [ *0*] 61 - 80%
3. [ *1*] 41 - 60%
4. [ *0*] 21 - 40%
5. [ *1*] 20% or less

65. Consider those second surgical opinions where the person who first issued the denial also conducted the first review of the appeal. In about what proportion of these cases did the reviewer overturn his or her initial decision? (CHECK ONE.)

1. [ *0*] 100%
2. [ *0*] 81 - 99%
3. [ *0*] 61 - 80%
4. [ *0*] 41 - 60%
5. [ *0*] 21 - 40%
6. [ *3*] 1 - 20%
7. [ *0*] 0%

66. In about what proportion of all appealed second surgical opinions did the person who first issued a denial also make the final decision on the appeal? (CHECK ONE.)

1. [ *0*] 100%
2. [ *0*] 81 - 99%
3. [ *0*] 61 - 80%
4. [ *0*] 41 - 60%
5. [ *0*] 21 - 40%
6. [ *1*] 1 - 20%
7. [ *2*] 0%

67. During your FY 1990, did your company specify the physician a patient must consult for a second surgical opinion?

    1. [*19*] Yes

    2. [*42*] No

68. During your FY 1990, did your company require the physicians who provided second surgical opinions to be located within the patient's service area?

    1. [*39*] Yes (SKIP TO QUESTION 70.)

    2. [22] No

69. During your FY 1990, did your company require the physicians who provided second surgical opinions to be located outside the patient's service area?

    1. [ *1*] Yes

    2. [*20*] No

70. During your FY 1990, from the date your company was first notified of an appeal of a second surgical opinion, about how many days usually elapsed before your company notified the patient or physician of its decision?

    *5.5 (median); 8.5 (mean)* days

71. Please list the five surgeries that your company most often did not authorize during your FY 1990 because of unsubstantiated medical need.

*See table 4.3.*

1. _____

2. _____

3. _____

4. _____

5. _____

CASE MANAGEMENT

72. Has your company ever reviewed any catastrophic medical or surgical cases to determine the need for case management services; that is, determine the need for coordinated care for patients requiring expensive or extended care?

    1. [*74*] Yes

    2. [ *4*] No (SKIP TO QUESTION 84.)

73. In what year did your company first conduct these reviews?

    *1980-91 range*

    19 |___|___|

74. During your FY 1990, did your company review any catastrophic medical or surgical cases to determine the need for case management services?

    1. [*70*] Yes

    2. [ *2*] No (SKIP TO QUESTION 84.)

75. During your FY 1990, how many contracts for catastrophic case-management services did your company have?

    *40 (median); 16,753 (mean)* contracts

76. During your FY 1990, in total, how many catastrophic medical and surgical cases did you screen for case-management? (IF NONE, ENTER "0.")

    *1,300 (median); 13,066 (mean)* cases screened

77. How many of these cases were recommended for case-management? (IF NONE, ENTER "0.")

    *318 (median); 1,354 (mean)* cases recommended

78. How many of these recommended cases were ultimately case-managed? (IF NONE, ENTER "0.")

    *300 (median); 1,125 (mean)* cases managed

79. How many case-management cases were ongoing at the close of your FY 1990? (IF NONE, ENTER "0.")

    *61 (median); 349 (mean)* ongoing cases

80. How many case-management cases did you close during your FY 1990? (IF NONE, ENTER "0.")

    *225 (median); 1,057 (mean)* cases closed

81. During your FY 1990, when determining a patient's case-management needs, did your company usually consult the patient's primary health care provider?

    1. [*67*] Yes

    2. [ *2*] No

82. When determining a patient's case-management needs, did your company usually consult the patient's family members?

    1. [*60*] Yes

    2. [ *8*] No

83. Listed below are types of staff who might be involved in case-management. Also arrayed are (A) various phases of case-management and (B) types of involvement that staff might have in case-management. During your FY 1990, for catastrophic medical and surgical cases, (A) in what phases of case-management was each type of staff routinely involved and (B) what kinds of involvement were they authorized to have?

*See figures 4.20 and 4.21.*

| | (A) In what phases was each type of staff routinely involved? (CHECK ALL THAT APPLY.) | | | | (B) What kinds of involvement were each type of staff authorized to have? (CHECK ALL THAT APPLY.) | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Identification of potential cases (1) | Evaluation of cases (2) | Care plan development (3) | Case review and monitoring (4) | Develop treatment plan (1) | Negotiate length of stay (2) | Negotiate place of service (3) | Negotiate type of service (4) | Negotiate choice of provider (5) | Deny treatment plan (6) |
| 1. A physician who reviewed cases in their same specialty, for example, an orthopedic surgeon who reviewed orthopedic cases | | | | | | | | | | |
| 2. A physician who reviewed cases in a related specialty for example, a general surgeon who reviewed orthopedic cases | | | | | | | | | | |

83. (Continued.)

*See figures 4.20 and 4.21.*

| | Identification of potential cases (1) | Evaluation of cases (2) | Care plan development (3) | Case review and monitoring (4) | Develop treatment plan (1) | Negotiate length of stay (2) | Negotiate place of service (3) | Negotiate type of service (4) | Negotiate choice of provider (5) | Deny treatment plan (6) |
|---|---|---|---|---|---|---|---|---|---|---|
| 3. Registered nurse | | | | | | | | | | |
| 4. Licensed practical nurse | | | | | | | | | | |
| 5. Social worker | | | | | | | | | | |
| 6. Accredited records technician | | | | | | | | | | |
| 7. Registered records administrator | | | | | | | | | | |
| 8. Clerical | | | | | | | | | | |
| 9. Other (PLEASE SPECIFY.) | | | | | | | | | | |

**IV. Appeals**

84. During your FY 1990, did your company require the people who reviewed appeals of your company's utilization review decisions to be located **within** the patient's service area?

    1. [*11*] Yes (SKIP TO QUESTION 86.)

    2. [*60*] No

85. During your FY 1990, did your company require the people who reviewed appeals of your company's utilization review decisions to be located **outside** the patient's service area?

    1. [ *5*] Yes

    2. [*50*] No

86. Of your FY 1990 utilization review decisions that were appealed, about what proportion were reviewed by a physician who was in the **same** specialty as the case being reviewed? (CHECK ONE.)

    1. [ *5*] None

    2. [*10*] Some

    3. [ *9*] About half

    4. [*24*] Most

    5. [*21*] All (SKIP TO QUESTION 88.)

87. Of your FY 1990 utilization review decisions that were appealed, about what proportion were reviewed by a physician who was in a related specialty to the case being reviewed? (CHECK ONE.)

    1. [ *3*] None

    2. [*22*] Some

    3. [ *8*] About half

    4. [ *8*] Most

    5. [ *6*] All

88. During your FY 1990, did any **non**-physician staff, who **specialized** in the area under review, ever review appeals of utilization review decisions for your company?

    1. [*10*] Yes

    2. [*62*] No (SKIP TO QUESTION 90.)

89. Did any of these **non**-physician **specialists** ever make the final decision on an appeal?

    1. [ *4*] Yes

    2. [ *6*] No

90. During your FY 1990, did any **non**-physician staff, who did **not** specialize in the area under review, ever review appeals of utilization review decisions for your company?

    1. [ *6*] Yes

    2. [*64*] No (SKIP TO QUESTION 92.)

91. Did any of these **non**-physician staff, who were **not** specialists, ever make the final decision on an appeal?

    1. [ *2*] Yes

    2. [ *4*] No

92. During your FY 1990, did your company ever **use a panel** of two or more people to review appeals of utilization review decisions?

    1. [*39*] Yes

    2. [*34*] No (SKIP TO QUESTION 99.)

93. Consider your FY 1990 utilization review decisions that were appealed and reviewed by a panel. In about what proportion of these cases was a physician on the panel who was in the **same** specialty as the case being reviewed?

    1. [ *1*] None

    2. [ *2*] Some

    3. [ *2*] About half

    4. [*13*] Most

    5. [*21*] All (SKIP TO QUESTION 95.)

94. In about what proportion of these cases was a physician on the panel who was in a related specialty to the case being reviewed?

    1. [ *1*] None

    2. [ *8*] Some

    3. [ *2*] About half

    4. [ *2*] Most

    5. [ *5*] All

95. During your FY 1990, did these panels ever include any **non**-physician staff who **specialized** in the area under review?

    1. [ *9*] Yes

    2. [*30*] No (SKIP TO QUESTION 97.)

96. Did any of these **non**-physician **specialists** ever have responsibility for the final decision on an appeal?

    1. [ *2*] Yes

    2. [ *7*] No

97. During your FY 1990, did these panels ever include any **non**-physician staff, who did **not** specialize in the area under review?

    1. [ *5*] Yes

    2. [*34*] No (SKIP TO QUESTION 99.)

98. Did any of these **non**-physician staff, who were **not** specialists, ever have responsibility for the final decision on an appeal?

    1. [ *2*] Yes

    2. [ *3*] No

99. During your FY 1990, did your company expedite appeals of cases that were considered urgent?

    1. [*60*] Yes

    2. [ *7*] No

**V. Review Criteria**

100. Please indicate whether or not, during your FY 1990, your company used any of the following criteria for making utilization review decisions about medical or surgical cases. (CHECK ONE FOR EACH.)

| | Yes (1) | No (2) |
|---|---|---|
| 1. INTERQUAL | [34] | [28] |
| 2. ISDA | [23] | [28] |
| 3. AEP | [17] | [31] |
| 4. AMA | [18] | [31] |
| 5. SMI | [14] | [33] |
| 6. Client/Payor | [17] | [31] |
| 7. Value Health Sciences | [ 3] | [37] |
| 8. Other (PLEASE SPECIFY.) | [43] | [ 6] |

_____

_____

101. As of your FY 1990, had your company developed its own criteria for making utilization review decisions about medical or surgical cases?

1. [50] Yes
2. [26] No (SKIP TO QUESTION 104.)

102. Were any physicians involved in developing your criteria?

1. [49] Yes
2. [30] No

103. In what year did/will you first implement your criteria?

*1974-91 range.*

19 |___|___|

104. Have you ever revised any of the criteria that you use for medical or surgical cases?

1. [59] Yes
2. [17] No (SKIP TO QUESTION 108.)

105. Have you periodically revised any of these criteria?

1. [57] Yes
2. [ 1] No (SKIP TO QUESTION 107.)

106. Consider the criteria that you have most often revised. How often have you periodically revised these criteria? (CHECK ONE.)

1. [ 8] More than once a year
2. [33] At least once a year
3. [12] At least once every two years
4. [ 1] At least once every three years
5. [ 1] Less often than once every three years

107. In what year did you most recently revise any of your criteria?

| *Year* | *Respondents* |
|---|---|
| *1989* | *2* |
| *1990* | *22* |
| *1991* | *33* |

108. During your FY 1990, when conducting reviews, did your company ever use the book "PAS Length of Stay by Diagnosis and Operation?"

1. [56] Yes

2. [20] No (SKIP TO QUESTION 110.)

109. Please indicate whether or not your company used this book's criteria for each of the following regions. (CHECK ONE FOR EACH.)

| | Yes (1) | No (2) |
|---|---|---|
| 1. Northeast | [18] | [19] |
| 2. North central | [23] | [20] |
| 3. South | [18] | [19] |
| 4. West | [34] | [12] |
| 5. U.S. | [26] | [14] |

110. Consider all of the criteria that your company used for utilization reviews of medical or surgical cases during your FY 1990. Did any of these criteria address the appropriateness of care, in addition to or instead of where or how long prescribed care would be provided?

1. [68] Yes

2. [ 6] No

111. Please indicate if, during your FY 1990, your company allowed patients, physicians, purchasers, or hospitals to review all, some or none of the criteria that you used for utilization reviews. (CHECK ONE FOR EACH.)

| | All (1) | Some (2) | None (3) |
|---|---|---|---|
| 1. Patients | [ 7] | [13] | [50] |
| 2. Physicians | [18] | [27] | [27] |
| 3. Purchasers of utilization review services | [22] | [26] | [24] |
| 4. Hospitals | [14] | [20] | [38] |

112. Did the staff, who conducted utilization reviews for your company during your FY 1990, ever receive any formal training; that is, classroom, in-service, tutorial, etc.; in how to apply your review criteria?

1. [71] Yes

2. [ 4] No (SKIP TO QUESTION 114.)

113. **Please answer the following questions about each type of staff who conducted utilization reviews for your company during your FY 1990.**

(A) Once they began employment with your company, did the staff initially receive formal training on how to apply your review criteria? (If a type of staff did not conduct reviews for your company during your FY 1990, check the "N/A" Column.)

(B) If "Yes," about how many hours of formal training on the criteria did each type of staff initially receive?

(C) Did each type of staff annually receive additional or supplementary training on the application of your criteria?

(D) If "Yes," on average, about how many hours of training did each type of staff annually receive?

*See table 3.5.*

| | (A) Did staff initially receive training on your criteria? (CHECK ONE.) | | | | (B) Initially, how many hours of training on the criteria were received? | (C) Did staff annually receive additional or supplementary training? (CHECK ONE.) | | | (D) On average, how many additional training hours were annually received? |
|---|---|---|---|---|---|---|---|---|---|
| | N/A (1) | No (2) | Yes (3) | | | No (1) | Yes (2) | | |
| 1. Physicians who reviewed cases in their same exact specialty | | | | If yes---> | _____ | | | If yes---> | _____ |
| 2. Physicians who reviewed cases in a related specialty | | | | If yes---> | _____ | | | If yes---> | _____ |
| 3. Registered nurses | | | | If yes---> | _____ | | | If yes---> | _____ |
| 4. Licensed practical nurses | | | | If yes---> | _____ | | | If yes---> | _____ |
| 5. Social Workers | | | | If yes---> | _____ | | | If yes---> | _____ |
| 6. Accredited records technicians | | | | If yes---> | _____ | | | If yes---> | _____ |
| 7. Registered records administrators | | | | If yes---> | _____ | | | If yes---> | _____ |
| 8. Clericals | | | | If yes---> | _____ | | | If yes---> | _____ |
| 9. Other (PLEASE SPECIFY.) | | | | If yes---> | _____ | | | If yes---> | _____ |

**VI. Other**

114. During your FY 1990, did your company have any contracts which included an incentive plan to achieve cost-savings through your reviews of medical or surgical cases?

1. [*11*] Yes

2. [*61*] No

115. During your FY 1990, did your company have an incentive plan for reviewers to achieve cost-savings through their reviews of medical or surgical cases?

1. [ *2*] Yes

2. [*71*] No (SKIP TO QUESTION 117.)

116. In the space below, please describe your incentive plan for reviewers or attach a copy of it to this questionnaire.

*See section 2.*

117. During your FY 1990, did your company have an internal quality assurance monitoring process to improve or maintain the quality of your review decisions?

1. [*63*] Yes

2. [*10*] No (SKIP TO QUESTION 119.)

118. In the space below, please describe this process or attach a description of this process to the questionnaire.

*See section 7.*

119. During your FY 1990, did your company have any mechanisms for intervening in or reporting cases where a patient was receiving poor health care?

1. [60] Yes

2. [12] No

120. During your FY 1990, if your company determined that a patient was receiving poor health care, would you have ever taken any of the following actions? (CHECK ONE FOR EACH.)

| | Yes (1) | No (2) |
|---|---|---|
| 1. Discussed the care with the patient's primary physician | [63] | [ 6] |
| 2. Discussed the care with other physicians who were treating the patient | [43] | [24] |
| 3. Discussed the care with the hospital where the patient was being treated | [50] | [17] |
| 4. Discussed the care with the health care provider's employer | [26] | [38] |
| 5. Discussed the care with the local medical board | [23] | [42] |
| 6. Discussed the care with the state medical board | [30] | [34] |
| 7. Discussed the care with the client who contracted for the review | [38] | [28] |
| 8. Discussed the care with the patient's insurer | [42] | [23] |
| 9. Recommended that the patient consult another physician | [34] | [32] |
| 10. Other (PLEASE SPECIFY.) _____ | [12] | [ 6] |

121. Please enter any other comments you might have about utilization review, our study, or this questionnaire.

Thank you!

# Data Supporting Figures in Report Sections

**Table II.1: Data for Figure 4.3**

| Levels of review/staff involved | Number of UROs |
|---|---|
| First level review | |
| Physicians | 26 |
| RNs | 68 |
| LPNs | 17 |
| RRAs and ARTs | 3 |
| Other | 8 |
| Second level review | |
| Physicians | 64 |
| RNs | 17 |
| LPNs | 3 |
| RRAs and ARTs | 1 |
| Other | 4 |
| First level appeal | |
| Physicians | 60 |
| RNs | 13 |
| LPNs | 1 |
| RRAs and ARTs | 0 |
| Other | 4 |
| Second level appeal | |
| Physicians | 57 |
| RNs | 4 |
| LPNs | 0 |
| RRAs and ARTs | 0 |
| Other | 2 |

**Table II.2: Data for Figure 4.4**

| Prehospital admission decisions/staff involved | Number of UROs |
|---|---|
| Authorize request without modification | |
| Physicians | 54 |
| RNs | 68 |
| LPNs | 19 |
| RRAs and ARTs | 2 |
| Other | 8 |
| Authorize shorter lengths of stay | |
| Physicians | 56 |
| RNs | 53 |
| LPNs | 10 |
| RRAs and ARTs | 1 |
| Other | 4 |
| Convert from inpatient to outpatient setting | |
| Physicians | 56 |
| RNs | 49 |
| LPNs | 10 |
| RRAs and ARTs | 1 |
| Other | 6 |
| Authorize a different choice of provider | |
| Physicians | 28 |
| RNs | 22 |
| LPNs | 3 |
| RRAs and ARTs | 2 |
| Other | 3 |
| Deny Request | |
| Physicians | 66 |
| RNs | 8 |
| LPNs | 2 |
| RRAs and ARTs | 0 |
| Other | 2 |

**Table II.3: Data for Figure 4.9**

| Levels of review/staff involved | Number of UROs |
|---|---|
| First level review | |
| Physicians | 27 |
| RNs | 66 |
| LPNs | 18 |
| RRAs and ARTs | 1 |
| Other | 7 |
| Second level review | |
| Physicians | 39 |
| RNs | 42 |
| LPNs | 7 |
| RRAs and ARTs | 0 |
| Other | 5 |
| First level appeal | |
| Physicians | 59 |
| RNs | 12 |
| LPNs | 1 |
| RRAs and ARTs | 0 |
| Other | 3 |
| Second level appeal | |
| Physicians | 56 |
| RNs | 4 |
| LPNs | 0 |
| RRAs and ARTs | 0 |
| Other | 2 |

**Table II.4: Data for Figure 4.10**

| Concurrent review decisions/staff involved | Number of UROs |
|---|---|
| Authorize continuation without modification | |
| Physicians | 54 |
| RNs | 68 |
| LPNs | 19 |
| RRAs and ARTs | 3 |
| Other | 7 |
| Authorize shorter continuation of stay | |
| Physicians | 58 |
| RNs | 51 |
| LPNs | 8 |
| RRAs and ARTs | 1 |
| Other | 7 |
| Deny continuation of stay | |
| Physicians | 64 |
| RNs | 7 |
| LPNs | 0 |
| RRAs and ARTs | 0 |
| Other | 2 |

**Table II.5: Data for Figure 4.20**

| Levels of review/staff involved | Number of UROs |
|---|---|
| Identification of potential cases | |
| Physicians | 15 |
| RNs | 66 |
| LPNs | 15 |
| SWs | 10 |
| Other | 14 |
| Evaluation of cases | |
| Physicians | 28 |
| RNs | 66 |
| LPNs | 8 |
| SWs | 10 |
| Other | 14 |
| Care plan development | |
| Physicians | 29 |
| RNs | 60 |
| LPNs | 9 |
| SWs | 9 |
| Other | 9 |
| Case review and monitoring | |
| Physicians | 39 |
| RNs | 63 |
| LPNs | 8 |
| SWs | 9 |
| Other | 12 |

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