CORPORATE POLICY

Manual/Library Name: Case Management	**No**: CMT.104
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Policy Title: Hospital Case Management Utilization Review Process	**Effective Date:** 09/15/22
	Previous Versions: 06/30/19, 01/25/18, 05/12/16, 03/19/15, 01/30/14, 02/07/13
	Approved By: Executive Leadership Team
	Approval Date: 09/14/22

I. Scope:

This policy applies to Tenet Healthcare Corporation and its subsidiaries and affiliates other than Conifer Holdings Inc. and its direct and indirect subsidiaries (each, an "Affiliate"), any other entity or organization in which Tenet or an Affiliate owns a direct or indirect equity interest of greater than 50%, and any entity in which an Affiliate either manages or controls the day-to-day operations of the entity (each, a "Tenet Entity") (collectively, "Tenet").

II. Purpose:

To ensure Hospitals conduct standardized utilization review processes in accordance with regulatory requirements, accreditation standards and payer contracts for patients admitted to Inpatient or placed in Outpatient status.

III. Definitions:

Authorization: A process by which the hospital contacts the payer to seek authorization/preauthorization/precertification for the patient status and treatment ordered by the Admitting Physician.

Case Management: A collaborative process of assessment, planning, facilitation, care coordination, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

Hospital: A facility operated or managed by a Tenet Entity which is primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services or rehabilitation services and licensed as a hospital by the state in which it operates.

Hospital Case Management (HCM) Staff: Hospital staff members of the case management department including Registered Nurse Case Manager, Licensed Vocational Nurse Case Manager, Social Work Case Manager, Case Management Support Staff such as discharge planner, authorization coordinator, or case management extender.

Qualified Hospital Case Management Staff: Case Management staff (Registered Nurse, Licensed Vocational Nurse) who have successfully completed Tenet InterQual® or other Tenet approved clinical screening criteria annual education and passed the exam with a minimum passing score of 85% or above.

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IV. Policy:

Qualified Case Management Staff will seek to conduct an admission review for patients within 24 hours of admission, as soon as adequate clinical information is available for accurate medical necessity review. To the extent that the Centers for Medicare and Medicaid Services has issued a blanket waiver of any of the requirements of this policy during times of national emergency (e.g., COVID-19 pandemic), the requirements of this policy are waived during the effective period of the waiver.

Hospital Case Management Staff cannot abdicate their utilization review responsibilities but must collaborate with Accountable Care Organizations (ACOs), physician groups, and health plan staff to coordinate patient care in our hospitals.

V. Procedure:

A. Qualified Case Management Staff will conduct and document medical necessity reviews using Tenet-approved clinical screening criteria.

B. For patients whose payers have an Authorization process, Hospitals will have documented clinical review request to payer in the case management system and document the match between physician order and authorization by the payer for patient status, level of care and/or length of stay.

C. For patients whose payers have an Authorization process and there is not a match between the physician ordered status, level of care and/or length of stay, Qualified Case Management Staff will document the denial/dispute notification, medical necessity criteria, Physician Advisor secondary review determination, efforts to resolve the concurrent denial/dispute, and outcome in the case management system.

D. For patients whose payers do not have an Authorization process, Hospitals will have documented Tenet-approved clinical screening criteria.

VI. Enforcement:

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

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VII. Reference:

CMT.104.PR.01 Clinical Screening Criteria

Payer Request to Change Form