# Policy

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| **DEPARTMENT:** Utilization Management | **POLICY #: UM- 013** |
| **TITLE:** Inter-Rater Reliability Policy UM staff | **VERSION:** 1.0 |
| **APPROVED BY: Heidi Wold** | **DATE**: 7/26/2022 |
| **DEPENDENCIES:** N/A | |

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## Policy

It shall be the policy of Longevity Health plan to provide an annual measurement of the consistency of application of medical necessity criteria among the Utilization Management (UM) review staff, physician advisor, or consultants and Chief Clinical Officer.

## Purpose

The purpose of this policy is to provide guidelines on the monitoring and evaluation of details of the application of medical necessity criteria while and to confirm quality and consistent application of the criteria that UM reviewer personnel, providers, and contractors while using the utilization management and behavioral health guidelines. These protocols address the requirements for achieving effective and efficient UM services. The outcomes of the IRR will be evaluated for opportunities to improve consistency in decision making and quality improvement.

## Definitions, Abbreviations, and Acronyms

| Acronym | Meaning |
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| **LCD** | Local Coverage Determinations |
| **NCD** | National Coverage Determinations |
| **InterQual Criteria** | Evidence-based medicine's best practice and care plan tools which provide clinical decision support and documentation which enables efficient transitions between care settings. |
| **Episode of Care** | CMS defines an episode of care as the set of services provided to treat a clinical condition or procedure, such as a heart bypass surgery or a hip replacement. |

## Standards

A. All UM professionals who are performing and involve with UM functions are required to have education and an assessment completed as part of the UM process to ensure consistent application while the review criteria in making medically necessary decisions to include: pre-service (prior authorization), concurrent, and post-service (retrospective) review.

B. The goals of the Inter-Rater Reliability and LHP UM reviews include but not limited to:
   a. Consistent in the application of clinical guidelines
   b. Ensure that the services delivered to members are medically necessary, appropriate and consistent with the diagnosis and involve an appropriate level of care.
   c. Provide access to quality and efficient health care services.
   d. Monitor utilization, avoidable cost of care, continuity, and coordination of high-quality healthcare services.
   e. Provide continuity of care and transition of care to members when they are new members, or when transitioning or when benefits end.
   f. Provide ongoing monitoring, tracking, and trending of health care rendered to members to ensure quality health care.

g. Monitor and assist in the promotion and maintenance of high-quality care in all areas through prospective, concurrent, and retrospective review, and the application of quality indicators to identify possible quality of care concerns related to the UM program.
h. Reduce overall unnecessary healthcare expenditures by promoting wellness and preventive care to members and providers.
i. Identify members with potential and/or high-risk disease states, high resource utilization or high-cost diagnosis and intervene with measures to maximize appropriate utilization and delivery of high-cost services.
j. Continually assess and improve as necessary, member access to care as well as the quality of care available to members.
k. Providers are not inhibited from advocating for their patients by the ability to request appeals.
l. Minimize variation in the application of clinical guidelines.
m. Evaluate should UM professionals are identifying quality of care issues on their review of cases.
n. Target and Identify areas of improvement; and
o. Identify opportunities for UM professionals' education and/or training improvement

C. An NCQA systematic system to ensure Inter-Rater Reliability (IRR) may be use as well as to member file comparisons of different UM reviewers working same cases, regular scheduled case consultations attended by UM reviewers and physicians to evaluate determinations and problem cases, or periodic audits of determinations against criteria.
    a. LHP will pull a sample of UM determinations files and audit utilizing the following method:
        i. Use a sample of 5 percent or 50 of its UM determination files, whichever is fewer
D. In Annual basis all UM professionals (clinical and non-clinical staff) that perform reviews and decisions utilizing medical necessity criteria should be assess utilizing InterQual's Inter-Rater Reliability Module. Assessment will include clinician-written scenarios to which UM professionals must find the appropriate guideline sections and apply them appropriately. LHP UM Director or his/her designee selects the most common scenarios or creates one that represent typical determination decisions that may be found system wide. Delegated and/or Screening entities will receive case studies that test on the clinical indications for admission. Those groups authorizing continued stay reviews, will receive and review case studies that pertain to the total *episode of care*.
E. Inter-Rater Reliability case review assessments for new hires should be done within three months of hire and then annually thereafter. New hires must complete the Utilization Management training course within Relias (**Course Code:** REL-ACU-0-60162) within 90 days of hire.
F. LHP utilizes Relias Learning Center which is an online training center that contains learning modules that each staff member is required to complete. Each year LHP staff will be required to complete Behavioral Health and Older Adults course (**Course Code:** REL-PAC-0-BHOA).
G. LHP Director or Manager of Utilization Management or their designee will assign IRR case studies on an annual basis and determine testing parameters, such as passing rates, number of case study attempts, and due dates. An email with instructions will be generated from the

Manager of UM and sent to staff and copied to their supervisor with timeframe for completion.

H. LHP requires that all UM reviewers meet or exceed a score of 90% on each case study. A score of 89% or less requires re-testing.

I. One additional re-test is allowed within thirty (30) days of the original testing and also requires a score of 90% or higher on each case study.

J. If after reassessment, a staff person does not meet the threshold with a score of 90% or above, a corrective action plan will be required. Corrective action plans can involve such activities as face-to-face supervision, coaching and/or education and re-training as well as supervision of all decisions or a random sample of case reviews audited during the timeframe the corrective action is in place.

K. If any reviewers fail to complete the corrective action plan, he/she could be subject to being placed on probation, combined with supervision of all UM decisions, and/or transfer to a role that does not involve UM decision making, or termination.

L. The results of the Inter-Rater Reliability testing will be used to identify areas of variation among decision makers and/or types of decisions. The results will also assist in identifying opportunities for improvement as for further training needs.

M. The results of the Inter-Rater Reliability case review testing including opportunities for improvement and interventions will be summarized and presented to the Utilization Management Committee (UMC), and the Quality Improvement Committee (QIC) annually, and included in the annual QIC report.

# Change Log

| Document Version | Major or Minor Revision? | Date | Name | Comments |
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| 1.0 | New | 7/26/2022 | Kiomaris Caldana | Initial creation |