



Audit Brief

University Medical Center Case Management Audit

Coordinated Internal and External Efforts May Help Improve Hospital Processes

Why we did this audit

An independent risk assessment was performed by an outside consulting firm which identified Case Management as one of the areas that UMC should consider reviewing. This audit was performed to determine whether procedures over observation activity are sufficient and in compliance with payer terms, whether observation to admittance transactions are adequately justified and documented, and whether re-admitted patient activity is reasonable.

Background

Case Management/Utilization Review (CM/UR) is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual's health and social needs through appropriate utilization of hospital resources. It is located on the 1st floor of the University Medical Center Patient Placement Center, 1800 West Charleston Boulevard, Las Vegas, Nevada 89102. The department is comprised of approximately 30 case managers, a department manager and an office assistant.

Audit Period

Our procedures covered the period from July 1, 2008, to June 30, 2009.

Summary of Significant Findings

As a result of the audit, we noted several processes needing improvement as follows:

- The utilization review process at UMC is manual in nature, and there is no formal utilization review committee.
- Claims continue to be written off due to untimely follow-up, no prior authorizations being obtained and charges being deemed medically unnecessary.
- We encountered numerous issues relating to patient charts. We found several cases where gaps existed in physician orders and notes to Case Manager, Social Services and nurse logs. In addition, we found charts where a patient's status was changed from "inpatient" to "observation" after the patient had been discharged. This practice may result in the denial of payment.
- We noted patient processing delays relating to hospice evaluations, Legal 2000 renewals, and discharge summary dictation. We also encountered patient transfer delays to skilled nursing (SNF) and mental health (MHF) facilities.
- We noted several instances of repeat, undocumented, uninsured patients presenting at UMC for periodic and related visits (such as kidney dialysis treatments).

We Recommend

- UMC should consider automating the utilization review process and establishing a formal utilization review committee.
- All ancillary departments should review and amend its current processes to help ensure that charges, coding and billing are being input, reviewed and processed in a timely and appropriate manner.
- UMC should reassess its patient charting procedures for physicians, nurses, case managers and social services personnel to help ensure that information is recorded timely and in accordance with hospital administrative and insurance carrier guidelines.
- Coordinated efforts internally and externally should be improved to help the timely progression of patient care and the efficient transfer of patients to MHFs and SNFs as applicable.
- UMC administration should address, either legislatively or with industry coordination, the issue of repeat, undocumented, uninsured patients.