Government Business Division
Policies and Procedures

Section (Primary Department) **Utilization Management**		**SUBJECT (Document Title)** **Non-physician Review Audits - Process, Inter-Rater, and Focused - CA**	
Effective Date 05/01/1996	**Date of Last Review** 04/09/2024	**Date of Last Revision** 03/30/2023	**Dept. Approval Date** 04/09/2024
Department Approval/Signature:			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☒ California	☐ Kentucky	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☐ Louisiana	☐ New York	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ West Virginia
	☐ Georgia	☐ Missouri	☐ Ohio	☐ Wisconsin
	☐ Indiana	☐ Nebraska	☐ South Carolina	

POLICY:

Anthem is committed to members receiving benefits for appropriate medically necessary covered services. As part of Anthem's efforts to meet this standard, a structured Quality Review Program is in place, including inter-rater reliability, process and focused audits. This program is in place to review, measure and evaluate the consistent application of utilization criteria and the consistency of the decision-making process used by the qualified (clinically experienced and licensed) nursing staff involved in Medical Review, Utilization Management (UM) and Case Management (CM). In addition, the Quality Review Program evaluates and measures compliance with policy, standards, regulations and applicable laws. Focused audits are conducted on specific areas of the UM process.

Findings from the quality review process are analyzed and assessed for training needs, patterns, trends requiring corrective action(s), and for individual evaluation of technical expertise.

Quarterly reports of process and focused findings and an annual report of the Inter-Rater reliability findings with associated action plans are submitted to the Clinical Services Committee (CSC) and to the Quality Management Committee (QMC).

DEFINITIONS:

None

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PROCEDURE:

I. Quality Review Guidelines

Clinical Staff are audited, as applicable to their role, for:

A. Process Audit - Accuracy and consistency of documentation in the UM system with an established quality benchmark of 95% on a quarterly basis.

B. Inter-rater-Consistency of application of UM criteria, adherence to Anthem adopted policies and guidelines with an established quality benchmark of 90% on an annual basis. The Nurse Inter-Rater Reliability Assessment (IRRA) threshold for passing is 90%. If a Nurse scores below the 90%, it does require a corrective action plan in the form of documented re-education prior to re-testing.

C. Focused-Specific area of UM process when a need is identified.

D. The CM quality case review is designed to assess the case manager's ability to consistently implement and document the care management process (i.e. case initiation, assessment, planning, coordination, monitoring and evaluation) with an established quality benchmark of 95% on a quarterly basis.

II. Utilization Management/Case Management Review

A. Quality Review is carried out by randomly selecting nurse specific files.

B. The audit team evaluates:
   1. Pre-service reviews
   2. Post-service reviews
   3. Continued Stay reviews
   4. Case Management
   5. Non-authorized services

C. New clinical staff may be placed on 100% audit during orientation until an established quality benchmark (as applicable) of 95% for UM process 90% for inter-rater audits, and 95% for CM process are met.

D. Clinical staff may be placed on 100% audit with the same established benchmarks for evaluation of performance issues at the supervisor's request.

III. Monitoring

A. Review of findings is completed with the Medical Management Manager(s) and Director(s). The manager(s) provide individual feedback.

B. Managers are responsible for coordinating identified training needs.

C. Quality Review reports are presented to the Clinical Services Committee (CSC) and to the Quality Management Committee (QMC).

D. The Quality Review process and associated results are evaluated annually as a part of the annual UM evaluation.

E. Managers provide individual feedback with the nurses, including education on the criteria requiring review.

F. Associates are notified of all Medical Policy & Technology Assessment Committee (MPTAC) policy updates.

G. Associates are notified of all Anthem Care Management Platform (ACMP))/ MCG™ Guidelines updates and receive ACMP/ MCG™ Guidelines refresher classes as needed.

REFERENCES:

- National Committee for Quality Assurance (NCQA)

RESPONSIBLE DEPARTMENTS:

Primary Department:
Utilization Management (UM)

Secondary Department(s):
Case Management

EXCEPTIONS:

None

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REVISION HISTORY:

Review Date	Changes
04/09/24	• Annual Review, no changes
03/30/23	• Annual Review • Updated Primary department from "Medical Management: Utilization Management (UM) & Case Management (CM)" to "Utilization Management (UM)" • Added "Secondary Department(s)" sub-header under Responsible Departments section to match template; added "Case Management (CM)"
03/24/22	• Annual Review • Updated UMC to CSC within the policy and procedure • Updated References
03/10/21	• Annual Review, no changes
03/11/20	• Annual Review • Changed WMDS to ACMP
03/06/19	• Annual Review, No Changes
03/20/18	• Annual Review. • No Changes
03/31/17	• Updated passing score to 90% for IRR • Updated references
04/29/16	• Annual Review. • Updated audit benchmark from 93% to 95%
03/02/15	• Created document specific to California from business wide document