MercyCare Health Plans
Standard Operating Procedure

Title: Inter-rater Reliability Audit Policy
SOP: MS-048.25

Revision History

Date	Issue	Author	Description of Change
1/18/2022	25	Joan C. Fisher, RN, CCM	Review

Approved By _____ 3/10/22
Department Director Date

I. Purpose

The purpose of this standard operating procedure (SOP) is to define both the format and content used to assess inter-rater reliability and timeliness of decisions implemented for Medical, Behavioral Health, and Pharmacy utilization management decisions at MercyCare Health Plans (MCHP) in Janesville, WI. Inter-rater reliability audits are done for all clinical staff to determine if MCHP policy and procedure and member benefits are being interpreted appropriately and consistently. This review process is conducted prospectively, concurrently, and/or retrospectively.

II. Scope

This SOP is applicable to all inter-rater reliability audits conducted at MCHP.

III. Reference Documents

A. NCQA Standards, UM Standard 2 and UM Standard 5

IV. Policy Interrater Reliability Medical Records

A. The inter-rater reliability review will be conducted at least annually.
B. Additional individual reviews may be conducted if the individual's annual review score is less than 90%.
C. The Senior RN Review Coordinator will randomly select cases for each utilization management staff member to be cross-reviewed.
D. The cases are selected as follows:
1. Inpatient Utilization Review (both Medical and Behavioral Health)
   a. MCHP will use the "8/30 Methodology"
   b. The eligible records shall come from the Inpatient Logs

E. "8/30 Methodology
   1. random selection of 8 files for each health care professional involved in applying UM Criteria
   2. the eight files shall be scored using the appropriate Inter rater Review Form
   3. If the individual health care professional scores 90 % or greater on the first 8 file review, their review is finished
   4. If the individual health care professional scores less than 90 %, than an additional sample of 22 files are reviewed for the individual staff member's score.

F. Medical necessity reviews will be reviewed for consistency in applying criteria appropriate to the reviewed determination.

G. Turn around Times shall be measured and monitored at least annually via:
   1. Concurrent Review and Urgent Concurrent Review: Inpatient Review as described in IV. D. 1
   2. Pre Service, Non Urgent and Post Service Requests: Referral data as described in VI.

H. At the request of the Medical Director or Medical Director of Behavioral Health, reviews may also be performed on the following cases as they occur:
   1. Extended Hospital LOS (Over 7 Days)
   2. Nursing Home (Over 14 Days)
   3. Home Health (Over 20 Visits)
   4. Durable Medical Equipment Requests (Over $10,000)

I. Utilization management meetings with the Medical Director and the Utilization Review nurses to evaluate request determinations and the appropriateness and consistency of the decisions.
   a. The Medical Director or his designated representative will refer any cases to the Complex Case Management or Disease Management programs.
   b. The Medical Director or the designated representative will further review and if indicated refer the cases to the Complex Case Management staff
   c. The UR nurse will send the referral via EPIC®/ Tapestry/ Case Referral Record with appropriate accompanying documentation cases to the Complex or Disease Management staff.

J. The Medical Director of Behavioral Health, the Medical Director and the Manager of Utilization Review are a part of the weekly case management meetings (Complex and Disease Management).
K. The Medical Director of Behavioral Health or Medical Director or Senior Review Physician will make the determination for all behavioral health denials.

V. Procedure for Inter rater Review: Medical Record Review and Denial Files

A. Reviews are coordinated by the either the Team Lead Utilization Review Coordinator for Medical and Behavioral Health Determinations or the Director of Pharmacy (or his designated clinical peer) for pharmacy determinations.
- **1.** Medical and Behavioral Health Inpatient admissions that occurred within 6 months before the review date (both medical and behavior health)
  - a. Reviews shall be for consistency in applying criteria and timeliness of decisions, and required documentation fields, including documentation of Advance Care Planning.
- **2.** Denial Files
  - a. Timeliness of decisions and criteria documentation
  - b. Review of notices for required documentation
- **3.** Pharmacy determinations based on criteria approved the Pharmacy and Therapeutics Committee.
- **4.** Physician decisions based on Change Healthcare McKesson InterQual Care Planning Criteria

B. The summary of the review is distributed and reviewed with the staff members involved in applying the criteria in decision-making.
C. A written summary of the review is submitted to the Medical Director and the UR CM Manager.
D. A written summary is presented annually as part of the UM Plan Review
E. The summary is presented to the Utilization Review nurses at their bi monthly UR Nurses meetings
F. Individual reports will be shared with each staff member if inconsistencies are noted to ensure that future reviews are conducted in a consistent manner and appropriate determinations are made.
- **1.** Education may consist of individual one to one education
- **2.** Written education and instruction to individual member
- **3.** Written education and instruction to all staff members involved in the type of file review

G. All inter rater reviews will be kept in a confidential file.

VI. Timeliness of Decision Making

A. Monitors annually at least 6 months of Referral data;
B. Data includes all (approved, denied) determinations of requests including benefit or medical necessity determinations
C. Categories of Data Monitored for timeliness of decision and notification:
1. Non-behavioral UM decision making.
2. Notification of non-behavioral UM decisions.
3. Behavioral UM decision making.
4. Notification of behavioral UM decisions.
5. Pharmacy UM decision making.
6. Notification of pharmacy UM decisions.

D. Each category in V1. C further broke down into Subcategories of
1. Urgent concurrent
2. Urgent preservice
3. Non Urgent Preservice
4. Post Service

E. Measuring Data: for each category and subcategory the report will be a percentage rate that is measured:
1. Numerator: number of records that met standard
Denominator: total number of records reviewed

F. The results of this report shall be reported to:
1. Any regulatory agency as required by contract
2. The QUM Committee as part of the annual review of the UM Plan
3. Audited staff
   a. line item in the Utilization RN annual reviews
4. Director of Pharmacy