UTILIZATION MANAGEMENT PLAN
2026

I. Introduction

A. The Utilization Management Plan for Moore County Hospital District under the direction and support of the Governing Board, Chief of Medical Staff, the Chief Executive Officer, Medical Staff, and Administration is developed with the goal of providing timely, high-quality, medically necessary, and efficient treatment promoting optimal health care outcomes, regardless of payor source, age, religion, sex, national origin, or race, in accordance with all legal mandates, while supporting the ethical and moral directives of the patient, facility and physician. This is accomplished by ensuring that patients receive the right care at the right time in the right setting.

B. Collaboration among the physician, the patient/family and other hospital staff, utilization of patient and family teaching, interdisciplinary meetings, discharge planning, and timely interventions in the plan of care that meets the individual health care needs of the patient across the care continuum shall be employed as the processes that will monitor and assure appropriate allocation of resources within Moore County Hospital District and the community to which patients are discharged.

II. Purpose of the Utilization Management Plan (§482.30)

A. The Utilization Management Plan describes the organization's establishment and implementation of case management and utilization review to ensure the quality, appropriateness and efficiency of care and resources furnished by the facility and Medical Staff in accordance with established facility protocols and current evidence-based practices, as well as, standards of care and state and federal regulatory guidelines. Under this plan, Moore County Hospital District:

- Defines the scope of services included in the case management process;
- Delineates the composition of the Utilization Review Committee;
- Delineates the responsibilities and authority for those involved in the performance of internal and external case management and utilization review;
- Establishes the protocols for review for medical necessity of admissions, extended stays, professional services, and appropriateness of setting;
- Oversees the review of over-utilization, under-utilization and inefficient utilization of resources;
- Specifies the procedures for denials, appeals and peer review within the organization (§482.30 (d)); and

- Establishes the reporting, corrective action and documentation requirements for the case management and utilization review processes (§482.30 (e)(3)).

III. Scope of Services

A. The scope of case management encompasses those important processes necessary to provide a system of healthcare delivery that leads to optimal wellness for each patient, at the highest level of achievable function. These processes are both direct and indirect and are divided into three specific activities:

- Case Management
- Utilization Review
- Discharge Planning

B. To perform the specific activities within the scope of services related to case management, necessary functions are identified and will be conducted in order to meet the overall goals of the department. These functions include:

1. Case Management is an inter-disciplinary function that includes:
   - Ongoing Patient Assessment and Evaluation – Reviewing patients to ensure that the clinical needs of the patient (severity of illness) matches the level of care (intensity of services) requested or currently being provided. This function is critical and must be ongoing throughout the hospital stay.
   - Facilitation of the Development of the Collaborative Plan of Care – Assists in insuring that the health care goals of the patient and family coincide with that of the physician and the rest of the health care team.
   - Process Facilitation (Patient Throughput) – An ongoing function that monitors, identifies, and attempts to correct any lapses or omissions in the care flow of the patient. Tracking events that cause delays in care of the patient. This function also requires assisting with the initial development of the plan of care, ongoing evaluation of the established plan of care, and recommending appropriate modifications leading to improved outcomes, shorter lengths of stay, and lower cost of care.
   - Alignment of Appropriate Resources – Insuring the necessary resources are made available to the patient in order to achieve the optimal state of health, achievable for the patient, during and after the acute phase of care.

2. Utilization Review is a system of prospective, concurrent, and may include retrospective review of medically necessity and appropriateness of services provided to the patient.

3. Discharge Planning is initiated upon admission and, whenever possible, is tailored to the preferences of the patient and family. Discharge Planning requires the meshing of the patient's needs with resources available to the patient in order to reach the optimal health care outcome, achievable for the patient, following acute care delivery. The process includes:
    - Identification and Integration of Resources – The function of networking with the community to ensure, as much as is possible, that resources needed by patients are available when required. This function also assists in assuring strong communication and cooperation among different professional involved in the care delivery to the patient.
    - Transfer Coordination – The specific process of moving the patient from one level of care to another without harm or interruption of the care giving process.
    - Understand and Implement Regulations to Assure Compliance with Discharge Issues – The function of maintaining a sufficient level of expertise to act as a resource for the facility regarding issues of discharge regulation compliance.

IV. Composition of the Physician Utilization Review Committee

A. The Utilization Review Committee (UR) includes three (3) voting members of the Medical Staff. The members are appointed by the Chief of Medical Staff. The members for 2026 are: The Chief of Medicine or designee, The Chief of Surgery or designee, and The Hospitalist Medical Director or designee. The Chairman for the UR Committee is the Hospitalist Medical Director. This committee will review cases as needed.

B. If any of the voting members need to excuse themselves, due to a conflict of interest in the case to be reviewed, (i.e. physician involved in the case) the Chairman of the committee will appoint a different member to review the case.

C. Non-voting members for the committee are the Chief Nursing Officer, the Director of Case Management/Utilization Review, and the Chief Financial Officer. Ad hoc guests may be called upon if their areas of supervision are involved in the meeting's discussion.

V. Delineation of Responsibilities, Duties, and Authority

A. Governing Board

1. Establishes the organization Utilization Management Plan.
2. Provides an annual review and approval of the Utilization Management Plan.

3. Delegates to the Medical Staff and Chief Executive Officer the responsibility for the implementation of the plan.
4. Requires the hospital and Medical Staff to implement and report on utilization management activities throughout the organization.

B. Chief of Medical Staff, Chief Executive Officer and/or Designee

1. Coordinates communication from Physician UR committee to Medical Staff.
2. Assures that admissions and continued stays are medically necessary and that medical and hospital resources are appropriately used.
3. Evaluates the effectiveness of utilization management activities.
4. Reports evaluation results to the Governing Board.

C. Medical Staff

1. Criteria Development
   - Develops and/or approves general admission criteria which may be through utilization of MCG or similar guidelines.
   - Develops and/or approves specific admission criteria for specialty patient groups, such as associated with new procedures or services.

2. Resource Utilization
   - Ensures the provision of health care that meets professionally recognized quality standards.
   - Ensures consistently appropriate and medically necessary treatment for patients.
   - Ensures the most efficient use of hospital health care services and facilities.
   - Ensures the maintenance of consistently valid, accurate and complete medical record information to justify diagnoses, admissions, treatment, and continued care.
   - Receives, analyzes and acts on utilization management findings.

3. Utilization Review Process
   - Ensures that only medically necessary care is delivered.
   - Makes medical necessity and appropriateness of care determinations independent of external utilization review decision makers, such as managed care entities.
   - Recruits physician advisors as needed when specialty expertise is required for medical and professional peer review.
   - Reviews all extended stay (greater than 96 hours) or outlier cases.
   - Tracks, trends and analyzes outlier cases to identify patterns.

- Documents in meeting minutes all extended stay reviews, including approvals, disapprovals and reasons, and actions taken to resolve identified problems.
- Hears appeals presented by providers for denials related to medical necessity of admissions, continued stays and professional services.
- Physician will not make review decisions on patients with whom he/she has issued orders or has seen in consultation during the current hospitalization or has direct financial interest and no non-physician may review a case in which he/she has provided direct care.

D. Utilization Review Committee

1. Provides clinical consultation to nurses in utilization review department.

2. Provides education to Medical Staff regarding utilization review.

3. Reviews a minimum of 6 charts, including any case referred by a non-physician utilization reviewer or case managers.

4. Consults with the attending physician regarding mitigating circumstances regarding inappropriate admission, extended lengths of stay, or professional services furnished including drugs and biological.

5. Review of admission may be performed before, during, or after hospital admission.

6. Reviews will include all extended stays beyond 96 hours and cases that do not meet criteria based on MCG guidelines.

7. Professional service must only be reviewed on cases that are reasonably assumed to be outlier based on extraordinary high cost of care.

8. The determination that an admission or continued stay did not meet utilization criteria based on MCG guidelines may be made if 2 of the 3 committee members vote to make that determination.

9. When an admission is questioned for continued stay without utilization criteria and/or for inappropriate utilization of resources, the practitioner is notified via letter by the committee chair in the following sequence:

    a. Every 3 cases – the practitioner will receive a letter that includes the charts in question.
    b. After 2 letters (6 cases), the charts will be forwarded to Practitioner Excellence Committee (PEC).

10. Once a provider has received 2 letters, their cases will all be submitted to the PEC committee with an opportunity for the practitioner to present their rebuttals. If PEC committee makes a determination that the admissions followed appropriate guidelines per MCG criteria, and appropriately utilized resources, those cases will be removed from the practitioner's running total of cases deemed out of compliance for utilization of services.

E. UR/Case Management

1. Scope of Services
    - Establishes and maintains collaborative relationships with the Medical Staff
    - Establishes and maintains collaborative relationships with the Nursing and other professional staff involved in patient care.
    - Assure compliance with prospective payment regulations (Medicare, Medicaid) and to monitor, report, and review activities and recommendations
    - Recognizes and prioritizes case management activities.
    - Reviews medical record documentation thoroughly to obtain information necessary to make case management determinations.
    - Uses ONLY documentation provided in the medical record to make determinations.
    - Applies utilization review criteria objectively for inpatient admissions, continued stay, level of care, and discharge readiness using MCG Guidelines.
    - Provides guidance to the medical and hospital staff regarding medical necessity criteria as outlined in MCG.
    - Assures case management to all med/surg and ICU inpatient stays.
    - Provides utilization review to all inpatient admission and continued stays regardless of payor, including private and no-pay categories and cases that have been pre-authorized or certified by third-party payors.
    - Reviews all continued stays at a scheduled frequency, but not less than every 3 days.
    - Collects and aggregates utilization data for tracking and trending reports.

2. Denials / Appeals
    - Assist in appeals process as requested by Patient Financial Services
    - Identifies patients who do not meet admission or continued stay criteria based upon documentation available within the medical record.
    - Collaborates with the attending physician
    - Addresses opportunities with the attending physician regarding the lack of documentation associated with admission, continues stay or proposed treatments.

- Refers patients who do not meet criteria for acute care admission, continued stay or inappropriate treatment to the UR Committee for review.

3. External Review
    - Established effective working relationships with third party payor reviewers.
    - Provides clinical information as required by and to third party payor sources in a timely fashion.
    - Facilitates medical record access and supervision for external insurance reviewers coming to the hospital for utilization review.
    - Communicates external UR determination to physicians, patient and/or family.

4. Discharge Planning
    - Maintains current, accurate information regarding community resources to facilitate discharge planning. Offer the patients a list of resources.
    - Provides focused discharge planning, initiated as early as possible after admission, to facilitate timely and appropriate discharges.
    - Identifies patients with complex discharge planning needs arising from diagnoses, therapies, or psychosocial or other relevant circumstances
    - Documents discharge planning activities in the medical record
    - Prior to the identified discharge date, reassesses discharge needs and document in medical record.
    - Includes alternative care facility placement, DME, family involvement, and community resources referral in discharge planning activities.

Approval of Plan

The Utilization Review Plan has been reviewed, evaluated, and approved by the hospital's Medical Staff, UR Committee, and Governing Board and constitutes the official plan, policy, and procedure for conduction of Utilization Management of its services.

Director of Utilization Review — Date: 1/27/26

Chief of Medical Staff — Date: 2/4/26

Chief Executive Officer — Date: 2/10/2026

Chairman of the Board of Directors — Date

Approved:

- ✓ Utilization Committee
- _____ Medical Staff
- _____ Board of Directors