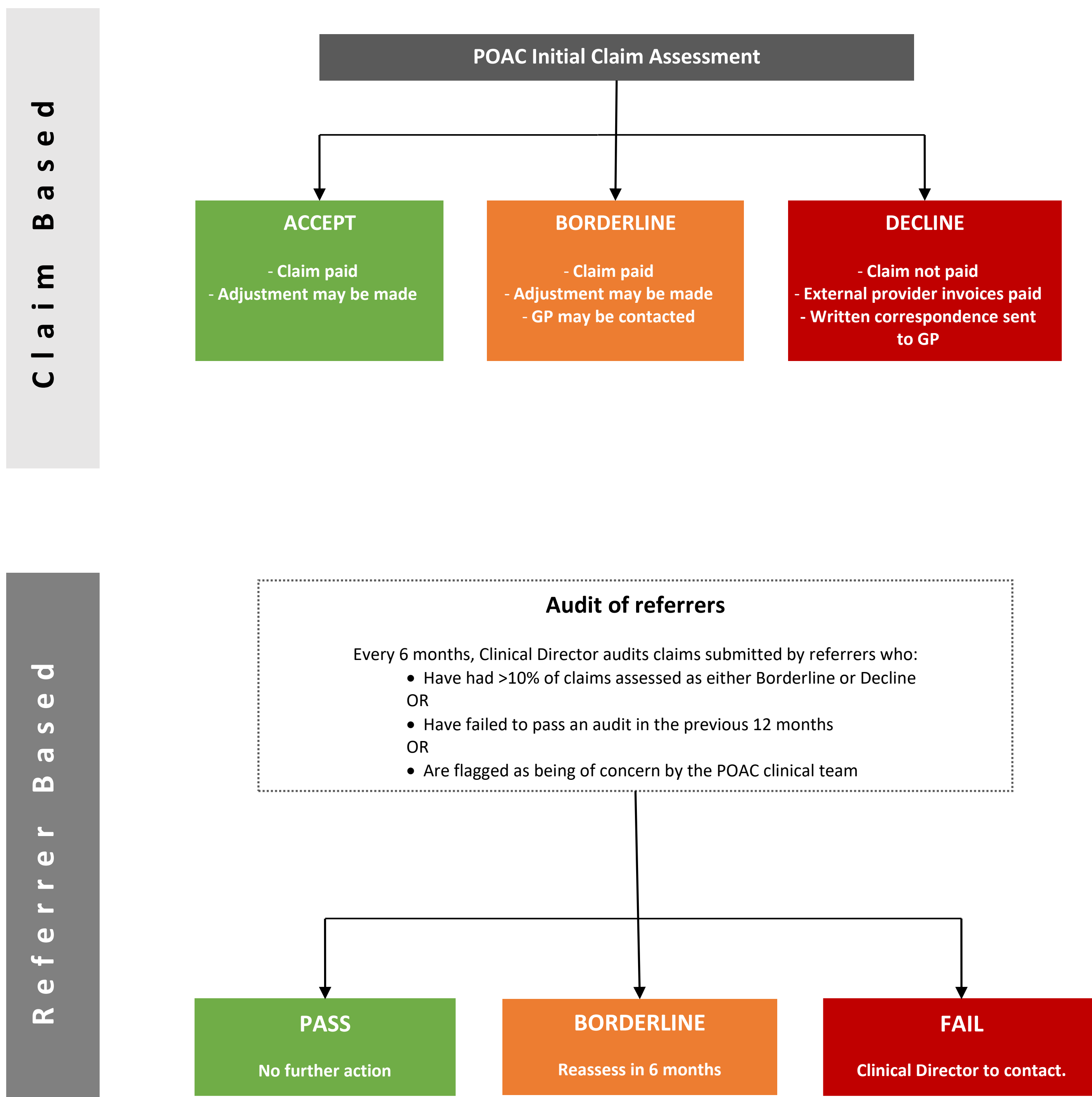
POAC Clinical Governance Process

Primary Options for Acute Care

POAC Claim Review Process



POAC Clinical Review Process Guidance

Claim Assessments

Accepted:

POAC team members may ‘accept’ claims that clearly adhere to POAC principles and any guidelines, clinical policies or the Auckland Regional HealthPathways. Claim may be adjusted if is claimed incorrectly, is clearly inconsistent with the stated work undertaken, or is outside of an existing POAC claiming fee schedule.

Specific conditions may be set to ‘auto accept’ as received. These will be checked prior to payment run processing and may then be reviewed, and adjusted, where indicated. Claims which are auto accepted will be subjected to periodic randomised audit.

Borderline:

A claim may be assessed as Borderline where it does not fit with best practice or POAC principles or policies. Communication to referrer and education may be required. Claim is paid on this occasion. Claim may be adjusted, as per above.

Declined:

The Clinical Director may decline a claim clearly outside of POAC policy and/or potentially unsafe practice, or risk of significant adverse outcome.

Claims may also be declined where an alternative funding stream is more appropriate (e.g. ACC, maternity, PHO). Claims submitted by external providers may on occasion be approved for payment. Any claim submitted by the referring clinician will not be paid and will be informed in writing. The referrer will be provided with opportunity to dispute any declined claim.

Clinical Director Review

The POAC Clinical Director will:

- Assess claims that have been escalated by the POAC team members.
- Undertake random audit of cases to review appropriateness of assessments.
- Review users that have been identified as outliers
- Complete regular clinical audits as per the POAC audit review schedule, or as requirement is prompted by an identified trend or behaviour.

Claims assessed by the Clinical Director as Borderline will be paid, and consideration given to communication with the referrer, either by phone or in writing. The decision whether to communicate is based on the nature of the concern over the claim. As a rule, where the cause for concern relates to patient safety or clinical quality of care, contact will be made.

Declined claims (on clinical grounds) should always trigger a written communication with the referrer, notifying of the assessment outcome and offering a right of reply.

Review of a Claim Assessment decision will be undertaken based on a written response being received from the referrer.

Clinical Director Referrer Assessments

When a referrer fails to pass an audit, or is repeatedly assessed as Borderline, the Clinical Director should make direct contact to discuss concerns and develop a remediation plan. This may include:

- Direct conversation with clinician (phone call/visit)
- Discussion/liaison with PHO or Urgent Care Clinical Director

A further audit should be undertaken 6 months later. Actions available to manage referrers who repeatedly fail to pass claim audits may include:

- Referral to PHO or Urgent Care Clinical Director
- Controlled access to POAC funding such as requiring pre-approval by the POAC Clinical Director
- Suspension of access to POAC funding

If the POAC Clinical Team identifies that referral to the New Zealand Medical Council may be appropriate, the Clinical Director will discuss with the appropriate PHO, Urgent Care and/or Te Whatu Ora Clinical Lead.

POAC Clinical Reporting

Quarterly reporting to POAC Clinical Governance Group and Clinical Assessments Limited Board on:

- Audit outcomes (user and service audits)
- Number of referrers being actively monitored.
- Number of referrers with action taken, including the reason for action and nature of the action taken
- Number and results of Serious Adverse Events investigated.
- Risks identified.

POAC Clinical Governance Group

The POAC Clinical Director will assemble a Clinical Governance Group (refer Terms of Reference)