

UTILIZATION MANAGEMENT PROGRAM

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive establishes policy for VHA's Utilization Management (UM) Program, an integral component of VHA's integrated framework to ensure quality, safety, and value across the care continuum.

2. SUMMARY OF MAJOR CHANGES:

a. This revision includes the requirement for review of observation stays which were previously not documented in the National Utilization Management Integration (NUMI) application and the use of NUMI for the documentation of Physician Advisor secondary review. The requirement for the review of all days of acute care has been decreased to 75 percent. This revision also defines a mechanism for sustained high performing facilities to move from daily reviews of all acute bed days of care to a sampling so that other review activities can be performed such as review of high-cost imaging procedures, nursing home care, procedures and durable medical equipment.

b. The amendment to this directive adds clarity to the responsibility section of the Medical Facility Director, 5.d.(15) by establishing a PUMA target and an expectation for PUMA review outcomes to be documented in NUMI.

(1) Previous responsibility, 5.d.(15) read as follows: Ensuring the Physician Utilization Management Advisor (PUMA) collaborates with the facility UM and medical staff and timely provides medical recommendations on cases not meeting criteria referred by those conducting UM reviews. Local policy may specify cases not meeting criteria that do not require referral to the PUMA and must be approved by the Medical Executive Committee.

(2) Amended responsibility 5.d.(15) reads as follows: Ensuring the PUMA collaborates with facility UM and medical staff on referred cases not meeting criteria and documents their secondary review outcomes exclusively in the NUMI application within 15 days from the expected review date, completing at least 75 percent of the PUMA referrals. Local policy may specify cases not meeting criteria that do not require referral to the PUMA and must be approved by the Medical Executive Committee.

c. The amendment to this directive includes a Table of Contents.

3. RELATED ISSUES: None.

4. RESPONSIBLE OFFICE: The Office of Quality, Safety and Value (10E2B) is responsible for the content of this directive. Questions may be addressed to (202) 461-1994.

July 9, 2014

VHA DIRECTIVE 1117(1)

5. RESCISSIONS: VHA Directive 2010-021, dated May 14, 2010, is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of July, 2019. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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UTILIZATION MANAGEMENT PROGRAM

1. PURPOSE

This Veterans Health Administration (VHA) directive establishes policy for VHA's Utilization Management (UM) Program, an integral component of VHA's integrated framework to ensure quality, safety, and value across the care continuum.

AUTHORITY: 38 United State Code (U.S.C.) 7301(b).

2. BACKGROUND

The UM Program, a key component of VHA's Quality Management System, provides vital tools for managing quality and resource utilization. It strives to ensure the right care, in the right setting, at the right time, for the right reason utilizing evidence-based practice and continuous measurement and improvement.

a. UM strategies, which provide guidance and do not supersede decisions made by providers, include the forward-looking evaluation of the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria. They are applied to all patients without regard to patient payment source. This proactive approach provides just-in-time information to guide evidence-based decision making and establishes the expectation of ongoing collaboration with other patient management services such as case and care management, nursing, social work services, mental health, and discharge planning.

b. As a key tool in managing the daily patient flow activities, UM:

(1) Identifies the appropriateness of level of care and services,

(2) Provides information to assist with decision making related to patient care management and discharge coordination processes, and

(3) Identifies delays in treatment and services.

c. The substantive data generated through UM reviews are integrated into quality improvement initiatives and support continuous improvement, redesign, systems engineering and efficiency management. The overall result is improved operational efficiencies, such as decreased length-of-stay and enhanced access, while sustaining or improving clinical quality.

d. The UM program addresses admission and continued-stay review of all acute inpatient care, as defined in paragraph 3.a, as well as any Veterans Integrated Service Network (VISN) or facility-specific priorities. Although the UM software application, National Utilization Management Integration (NUMI), supports collection of inpatient acute care review results, VHA has a license to utilize additional proprietary evidence-based appropriateness criteria sets, all of which are available electronically for use by VHA facilities or program offices.

3. DEFINITIONS

a. **Acute Inpatient Care Review.** Acute inpatient care includes admission and daily continued stay reviews of all patients in the following inpatient bed services: Medicine, Surgery, Neurology, Psychiatry, Intermediate Medicine in Acute Care (i.e., refers to the few facilities that use Intermediate Medicine in Acute Care for post-acute patients), High Intensity General Intermediate Psychiatry in Acute Care, Intermediate Substance Abuse in Acute Care and Hospice in Acute Care. Additionally, observation status in a dedicated unit, the Emergency Department or on beds in existing units and wards will be reviewed and entered into NUMI. Acute care and observation reviews are required unless a waiver has been granted.

(1) The following treating specialties are not included in the acute inpatient care reviews: Respite Care, Hospice provided in the Community Living Center, Geriatric Evaluation Management (GEM), Rehabilitation Medicine, Blind Rehabilitation, Spinal Cord Injury (SCI), Community Living Center (CLC), and Domiciliary.

(2) NUMI requires that each facility configure treating specialties to define those that are reviewable. Facilities may elect to review additional bed services or treating specialties and may configure NUMI for these reviews, but must review at least the bed/services/treating specialties described above. NUMI can be configured only for those treating specialties for which evidenced based criteria are imbedded in NUMI.

(3) Admissions lasting less than 12 hours do not require reviews unless the patient is in observation status.

b. **Admission Review.** The UM admission review is a screening to determine the appropriateness of admission to a specific level of care. This review is typically performed within 24 hours following the admission, or no later than the first business day following the admission. Nationally-approved, standardized, objective, evidence-based criteria must be used to determine the appropriateness of admission to specific levels of care.

c. **Concurrent Review.** A concurrent review is performed during a patient's hospital stay, or course of treatment, to screen for the appropriateness of the medical services. Concurrent review commences within 24 hours of admission, or no later than the first business day following the admission, and continues daily during normal duty hours. Concurrent review allows the proactive facilitation of quality care and patient flow.

d. **Continued-stay Review.** The continued-stay review is a screening performed during a patient's hospitalization to determine the appropriateness of continuation of the patient's stay at a specified level-of-care. Continued-stay reviews are concurrent reviews performed daily, or no later than the first business day following other than normal duty hours, throughout the patient's hospitalization.

e. **Inter-rater Reliability.** Inter-rater reliability assessments are conducted in the VHA UM Program to measure consistency in the application and interpretation of standardized criteria among health care professionals.

f. **Licensed Health Care Professionals.** For purposes of this directive, a licensed health care professional is an individual who:

(1) Has undergone formal training in a health care field, and

(2) Holds an active and unrestricted license which permits:

(a) Practice independently as a Social Worker, or

(b) Practice as an Advanced Practice Registered Nurse or a Registered Nurse to the full extent of the individual's State Board of Nursing regulations.

(3) Other licensed health care professionals may perform and document UM reviews after approval by NUMAC.

g. **National Utilization Management Integration.** NUMI is a web-based application that:

(1) Automates utilization management assessment and outcomes,

(2) Standardizes UM review methodology and documentation, and

(3) Provides critical functionality to assist UM reviewers to:

(a) Organize workload,

(b) Document UM review outcomes, and

(c) Generate reports to identify opportunities for improving efficiency in relation to system constraints and barriers.

h. **Observation status.** Observation status is appropriate for a patient with a medical, surgical, or psychiatric condition showing a degree of instability or disability that needs to be monitored, evaluated, and assessed for either admission to inpatient status or assignment to care in another setting. Observation is an appropriate level of care when the physician is unsure about the patient's need for inpatient admission and requires additional time to evaluate the patient or anticipates that the patient's condition can be evaluated and/or treated within 24–48 hours and/or rapid improvement of the patient's condition can be anticipated within that time.

i. **Observation Reviews.** Observation reviews are a type of admission review despite the fact that observation is an outpatient status. Observation reviews are to be entered into NUMI using the evidence-based criteria for this level of care. Only one observation review is required regardless of the length of time that the patient is in observation status. Observation reviews are conducted on all observations regardless of the length of time in observation and reviews for observation treating specialties will also be performed on stays with duration of less than 12 hours.

j. **Physician Utilization Management Advisor.** The PUMA is the physician advisor at the facility level designated to provide recommendations for patients not meeting the standardized criteria for a specific level of care. The cases requiring review by the PUMA are referred by the UM reviewers. **NOTE:** *It is recommended that the PUMA have expertise in the service being reviewed, such as a psychiatrist designated as the PUMA for inpatient mental health reviews and a surgeon designated as the PUMA for surgical reviews not meeting criteria.* If the PUMA does not have expertise in the service being reviewed, a process must be in place for the PUMA to consult with an expert as needed.

k. **Prospective Review.** A prospective review is conducted prior to a patient's admission, stay, or other service or course of treatment. A prospective review may be enacted as a preadmission screening, or as a screening prior to a diagnostic study or planned ambulatory procedure.

l. **Retrospective Review.** A retrospective review is conducted after services have been provided, or the patient has been discharged, to screen for appropriateness of services rendered and to collect data necessary to evaluate and improve efficiency.

m. **Revenue Utilization Review.** R-UR, under the auspices of the CBO, is the systematic evaluation and analytical review of clinical information in order to maximize reimbursement from third-party payers. In 2003, guidance was established standardizing the clinical review functions with third-party reimbursement responsibilities at VA medical facilities. R-UR in this context operates to promote improvements in patient care and to maximize the potential for the recovery of funds due VA for the provision of health care services to Veterans, dependents, and others using the VA health care system.

n. **Systems Redesign.** SR utilizes "science of (quality) improvement" principles from disparate SR methodologies to continuously deliver better health care value across the health care system. An overarching concept within SR is patient flow matching supply and demand. SR uses sets of scientifically-based, patient-centered principles to enable staff to examine health care delivery processes, redesign them to eliminate delay and waste, and provide Veterans with the care that is clinically indicated and delivered in a timely manner. UM data are an integral component in this continuous improvement cycle.

o. **UM Reviewer.** The UM reviewer is the trained, licensed health care professional who performs UM reviews utilizing the NUMAC-approved, standardized, evidence-based criteria. The role of the UM reviewer includes:

- (1) Performing and documenting utilization reviews consistent with national guidance,
- (2) Communicating with the health care team, including the attending physician,
- (3) Collaborating across services and departments to impact patient flow,

(4) Participating in daily rounds, bed huddles, or Interdisciplinary Team (IDT) meetings as appropriate, and

(5) Referring to the PUMA, those reviews that do not meet criteria but require medical leadership to facilitate resolution and referring to the PUMA any case that has quality of care issues or serious system issues needing immediate attention.

p. **Value.** Value is the generation of both population health and increasing levels of patient satisfaction, health literacy, and engagement in seamless, efficient systems throughout a patient-centered experience of coordinated care at the lowest per capita cost.

4. POLICY

It is VHA policy to establish an integrated UM Program at every VHA facility that supports quality, safety, value, and efficiency; striving to ensure that Veterans receive health care services in the appropriate level of care, when that care is needed, and also receive only needed health care services at the lowest possible cost. Although daily, concurrent review of all days of care is desired, each VHA facility that provides acute inpatient care will ensure that a minimum of 75 percent of admissions, observation stays, and subsequent days of care are reviewed and entered into the NUMI application unless a waiver from acute care reviews has been granted (see Appendices A and B). For Veterans with prolonged acute care stays in the same level of care/treating specialty, such as patients on mechanical ventilation or a patient waiting for an alternative level of care that is not available, reviews past 30 days are not required to be entered into NUMI.

5. RESPONSIBILITIES

a. **National Utilization Management Advisory Committee.** The National Utilization Management Advisory Committee (NUMAC) is responsible for oversight and monitoring of VHA's UM Program. The primary goals are to:

(1) Develop and implement a tactical and strategic plan for the implementation and ongoing refinement of a national UM Program,

(2) Support an organized and standardized approach to UM processes,

(3) Foster communication and coordination of effort among programs with similar goals, such as: Systems Redesign (SR), Care Coordination, Patient Care Services, and Chief Business Office (CBO),

(4) Validate and analyze UM data generated through NUMI, and

(5) Foster communication between VHA leadership and the field in sharing priorities and goals to promote effective use of resources while improving quality of care.

b. **Assistant Deputy Under Secretary for Health for Quality, Safety, and Value.**

The Assistant Deputy Under Secretary for Health for Quality, Safety, and Value is responsible for:

- (1) Providing oversight of resources to operationally implement the UM Program.
- (2) Ensuring full implementation of the UM Program; one that yields valid insights leading to actions that improve quality of care and outcomes of importance to VHA stakeholders.
- (3) Issuing annual guidance for expanding the program across the continuum of care based on agency priorities.
- (4) Determining information technology resources needed to sustain and develop NUMI application to meet agency needs and secures funding for application as necessary.

c. **Veterans Integrated Service Network Director.** The VISN Director is responsible for ensuring that all the following key UM components are implemented in all facilities within the VISN, to include:

- (1) Establishing and meeting the annual VISN UM Program goals.
- (2) Communicating UM priorities to the facilities.
- (3) Promoting a culture conducive to integrating UM into daily patient care management activities, such as: patient flow, care coordination, and discharge planning processes.
- (4) Ensuring UM data are leveraged to drive improvement projects.
- (5) Ensuring adequate resources for planning and implementing the VISN UM Program.
- (6) Ensuring that the written VISN UM Plan includes:
 - (a) Program structure, scope, goals, and measureable objectives,
 - (b) Definition of the role of the Physician Utilization Management Advisor (PUMA) and medical leadership in UM program implementation and ongoing UM activities,
 - (c) Interface between UM, Quality Improvement, CBO, Nursing, Social Work, Care Coordination, and SR programs,
 - (d) Processes and information sources used to complete UM reviews,
 - (e) Utilization of NUMI, the automated review and reporting tool for all inpatient admission and continued stay reviews, and

(f) Goals related to improved efficiency and progress toward goal attainment.

(7) Ensuring a process for communicating UM data analyses to the VISN.

(8) Conducting annual summary reviews of all VISN facilities to validate that the UM Program is fully implemented. This review includes a process for assessing the implementation effectiveness of the UM program at each facility.

(9) Ensuring that VISN facilities are conducting a minimum of 75 percent of acute inpatient stay reviews unless a waiver to perform a sample has been granted by the NUMAC.

d. **Medical Facility Director.** The medical facility Director is responsible for ensuring the following key UM components are implemented, to include:

(1) Meeting the annual VISN UM program goals.

(2) Ensuring that the written Facility UM Plan includes all required components of this VHA directive and the VISN UM Plan.

(3) Ensuring adequate resources for planning and implementing the Facility UM Plan.

(4) Ensuring that facility UM reviewers are conducting a minimum of 75 percent of acute inpatient stay reviews unless a waiver to perform a sample of reviews, endorsed by the VISN Director, has been granted by the NUMAC. Please see Appendix A for the requirements for a review waiver.

(5) Ensuring that NUMAC approved standardized evidence-based UM review criteria are used without local modification.

(6) Ensuring review processes are consistent with national guidance. **NOTE:** *These processes are available in detail on the Office of Quality, Safety and Value UM Web site at: <http://vaww.oqsv.med.va.gov/functions/integrity/um/utilization.aspx>. This is an internal VA Web site that is not available to the public.*

(7) Ensuring utilization of NUMI, the automated reporting tool for all acute inpatient admission and continued stay reviews, observation reviews, and for other episode of care reviews when NUMI enhancements are added.

(8) Ensuring that the VHA-licensed appropriateness criteria are utilized when other types of UM reviews are performed by the facility, and that reviewers have been trained in the use of that criteria by a certified instructor. If another type of criteria is desired, approval must be obtained from the NUMAC.

(9) Ensuring those who conduct UM reviews are licensed health care professionals whose roles includes:

(a) Performing and documenting utilization management reviews consistent with national guidance,

(b) Referring to the PUMA cases not meeting criteria, if resolution is not achieved by discussion with the attending physician and when quality of care or system issues are raised,

(c) Participating in a care/case manager and UM reviewer combined role and/or collaborating across services and departments, such as with care coordinators, case managers, discharge planners, nursing staff, patient flow coordinators, social workers, transfer coordinators, and Revenue Utilization Review (R-UR) nurses, and

(d) Participating in daily rounds, bed huddles, or Interdisciplinary Team meetings as appropriate.

(10) Ensuring UM reviewer participation in annual criteria training for applying and interpreting the NUMAC approved standardized UM criteria.

(11) Ensuring the implementation of an approved process for establishing inter-rater reliability for staff who conducts reviews.

(12) Ensuring completion of an on-line inter-rater reliability competency test by each UM reviewer relative to the application and interpretation of standardized criteria as defined in the UM Program Standard Operating Procedure.

(13) Ensuring designation of at least one physician trained as a PUMA.

(14) Ensuring direction and adequate training of the physicians assigned to carry out the PUMA role.

(15) Ensuring the PUMA collaborates with facility UM and medical staff on referred cases not meeting criteria-and documents their secondary review outcomes exclusively in the NUMI application within 15 days from the expected review date, completing at least 75 percent of the PUMA referrals. Local policy may specify cases not meeting criteria that do not require referral to the PUMA and must be approved by the Medical Executive Committee.

(16) Ensuring ongoing communication of UM review findings to attending physicians and collaboration in resolving level of care discrepancies, quality of care issues or delays in care according to approved local policy.

(17) Ensuring a process for communicating all UM data, including NUMI and any facility generated UM data, within the facility and to the VISN, as a component of the Quality Management System.

(18) Ensuring UM data are used to assist with identifying initiatives to improve efficiency.

(19) Ensuring UM data are reviewed on an ongoing basis by an interdisciplinary group, including but not limited to representatives from UM, Medicine, Nursing, Social Work, Case Management, Mental Health, and CBO R-UR.

(20) Ensuring the UM data analyses are reported systematically to identify appropriate benchmarks, trends, actions, outcomes, and opportunities for improving efficiency.

(21) Ensuring the development and completion of relevant improvement initiatives are tracked.

6. REFERENCES

a. Office of Inspector General (OIG) Report: Summary Review: Evaluation of Quality Management in VHA Facilities FY 2012, published April 25, 2013.

b. The Joint Commission Comprehensive Accreditation Manual for Hospitals, Current Edition.

c. VHA Directive 1026, Enterprise Framework for Quality, Safety, and Value, dated August 2, 2013, or subsequent policy.

d. VHA Handbook 1601C.02, Revenue Utilization Review (RUR), dated May 10, 2012, or subsequent policy.

e. For detailed information about UM Program procedures, training, and NUMI visit the QSV UM Web site:
<http://vaww.oqsv.med.va.gov/functions/integrity/um/utilization.aspx>. *This is an internal VA Web site and is not available to the public.*

f. For more information about CBO programs and Revenue UR, visit the CBO Web site <http://vaww1.va.gov/cbo>. *This is an internal VA Web site and is not available to the public.*

**REQUEST FOR FACILITY WAIVER FROM ACUTE CARE UTILIZATION
MANAGEMENT (UM) REVIEW REQUIREMENTS**

1. PURPOSE

To define the process and the requirement to request a waiver from UM/National Utilization Management Integration (NUMI) reviews of all acute bed days of care.

2. BACKGROUND

Since 2010, Veterans Health Administration (VHA) has required that all days of acute inpatient care are reviewed for appropriateness using the NUMI application which incorporates evidence-based criteria into the review process and captures review results in the database. Across the country there has been significant improvement in the review outcomes of percent of admissions and percent of continued stay days meeting the evidence based criteria at multiple individual facilities, some of which have been able to sustain the improvement over several years. Yet other facilities and VHA as a whole have shown little improvement in these outcomes since NUMI's inception. Although measuring and improving inpatient appropriateness of care is important, some facilities have attained and sustained such a high level of performance (percent of admissions and continued stay days meeting criteria) that it is more efficient to decrease the percent of reviews performed so that other UM activities can be initiated by the trained UM reviewers.

3. POLICY

Individual VHA facilities may request a waiver from the requirement for review of all acute inpatient days of care. This waiver is open to facilities that have demonstrated a sustained high level of performance in UM outcomes. The waiver is requested by the medical facility Director but must have the approval of the Veterans Integrated Service Network (VISN) Director.

4. ACTION

a. Individual VHA facilities wishing to decrease the daily UM reviews for acute admission and continued stay days in order to use UM resources to review other types of care, may apply to the National Utilization Management Advisory Committee (NUMAC) for a waiver using the form in Appendix B of this directive.

b. In order to qualify for a waiver from admission reviews, the individual facility must demonstrate the following:

(1) The facility has performed a minimum of 80 percent of admission reviews for each of the most current rolling 4 quarters; and

(2) VHA Support Service Center (VSSC) reports demonstrate a sustained rate of a minimum of 90 percent admission reviews meeting criteria for that same time period.

(3) The facility must maintain the rate of 90 percent or greater or have no consecutive quarters falling below this threshold to continue with the waiver on admission stay reviews.

c. In order to qualify for a waiver from continued stay reviews, the individual facility must demonstrate the following:

(1) The facility has performed a minimum of 80 percent of continued stay reviews for the most current rolling 4 quarters; and,

(2) VSSC reports demonstrate a sustained rate of at least 80 percent continued stay reviews meeting criteria.

(3) The facility must maintain the rate of 80 percent or greater or have no consecutive quarters falling below this threshold to continue with the waiver on continued stay reviews.

(4) The facility must continue to perform a minimum of 30 percent of continued stay reviews using an acceptable method of sampling.

d. The facility must provide a summary of the efficiency reviews that will replace the daily continued stay reviews as part of the waiver request and consideration by NUMAC. Suggestions for these reviews include:

(1) Review of high-cost imaging tests such as MRI, CT scan, or PET scan using the VHA-licensed evidence-based criteria,

(2) Performance of pre-admission stay screening (prospective admission review),

(3) Pre-procedure screening or retrospective review of non-imaging procedures such as sleep studies, physical therapy, chiropractic care or endoscopy,

(4) Prospective or retrospective durable medical equipment, and or

(5) Prospective or retrospective study of post acute levels of care such as acute rehabilitation, skilled nursing or acute long term care.

SAMPLE MEMO REQUESTING WAIVER

To: Chairperson, National Utilization Management Advisory Committee (NUMAC)

From: Director, Facility Name/Station Number

Thru: VISN Director

Subject: Request for waiver from required National Utilization Management Integration (NUMI) reviews.

Date:

1. Facility name is requesting a waiver from the NUMAC for admission/continued stay review volume requirement so that other UM activities can be pursued. The most current rolling 4 quarter UM outcomes demonstrate sustained high level of performance on both the percent of reviews completed in NUMI and the percent of days of care that meet the evidence-based appropriateness criteria as defined in VHA Directive 1117, Appendix A.
2. In lieu of performing at least 75 percent of admission and/or continued stay reviews, Facility name will perform reviews of enter alternate reviews and describe methodology for conducting reviews and documentation of review outcomes.
3. During the time of this waiver, Facility name UM Program will continue to perform a representative sample of reviews. Please describe the sampling method to be used.
4. I understand, should performance decline for 2 consecutive quarters, this waiver will be cancelled and the facility will return to the review requirements described in VHA Directive 1117.