

## UTILIZATION MANAGEMENT PROGRAM

**1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) directive maintains 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:** Major changes to this directive include:

a. Additional definitions (see paragraph 3).

b. Revised responsibilities for: National Utilization Management Advisory Committee Co-chairs, Veterans Integrated Service Network (VISN) Director, Department of Veterans Affairs (VA) medical facility Director, Provider Utilization Management Advisor (PUMA), InterQual® Certified Instructors (IQCIs) and the Utilization Management Reviewer (see paragraph 5).

c. Removed the requirement for a VISN and a local UM policy. Added inter rater reliability requirement to evaluate accuracy of UM review. Standardized PUMA exclusion list.

**3. RELATED ISSUES:** VHA Directive 1036, Standards for Observation in VA Medical Facilities, dated January 13, 2020; VHA Directive 1601C.02, Revenue Utilization Review (RUR), dated February 1, 2019; and VHA Directive 1002, Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities, dated November 28, 2017.

**4. RESPONSIBLE OFFICE:** The Office of Quality and Patient Safety, Utilization Management (17PS2) is responsible for the content of this directive. Questions may be addressed to [VHACOUMProgramOffice@va.gov](mailto:VHACOUMProgramOffice@va.gov) or 202-632-8302.

**5. RESCISSIONS:** Operational Memorandum, OIG Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018, dated October 25, 2019 and VHA Directive 1117(2), Utilization Management Program, dated July 9, 2014, are rescinded.

**6. RECERTIFICATION:** This VHA directive is scheduled for recertification on or before the last working day of October 2025. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

October 8, 2020

VHA DIRECTIVE 1117

**BY DIRECTION OF THE OFFICE OF THE  
UNDER SECRETARY FOR HEALTH:**

/s/ Gerard R. Cox MD, MHA  
Assistant Under Secretary for Health  
for Quality and Patient Safety

***NOTE:*** All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.

**DISTRIBUTION:** Emailed to the VHA Publications Distribution List on October 15, 2020.

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## UTILIZATION MANAGEMENT PROGRAM

### 1. PURPOSE

This Veterans Health Administration (VHA) directive maintains 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:** Title 38 United State Code (U.S.C.) § 7301(b).

### 2. BACKGROUND

a. 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 reasons, utilizing evidence-based practices along with continuous measurement and improvement.

b. UM strategies provide guidance, but do not supersede decisions made by Department of Veterans Affairs (VA) providers. They also evaluate appropriateness, medical necessity and the efficiency of health care services, according to evidence-based criteria. UM strategies are applied to patients regardless of 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 management, nursing, social work services, mental health and discharge planning.

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

(1) Identifies the recommended level of care and services;

(2) Provides information that assists with decision-making related to patient care management, avoidable bed days of care and discharge coordination processes; and

(3) Identifies delays in treatment and services.

d. The substantive data generated through UM reviews are integrated into quality improvement initiatives and support continuous improvement, system redesign 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.

e. The UM program addresses patient admission and continued-stay review of all acute inpatient care as well as any Veterans Integrated Service Network (VISN) or VA medical facility specific priorities.

### 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 and behavioral health. **NOTE:** *Additionally, observation status in a dedicated unit, the emergency department or in beds in existing units are also reviewed and documented. Admissions lasting less than 12 hours do not require reviews unless the patient is in observation status.*

b. **Admission Review.** Using the provider order and level of care provided, UM admission review is a screening to determine the appropriateness of admission to a specific level of care. Ideally, this review is performed at the time the decision to admit is made and 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. For information on the Change Healthcare InterQual® Book Review, where evidence-based criteria is stored, see: <http://vaww.oqsv.med.va.gov/functions/integrity/um/InterQualBookView2010-2020.0.1/umInterQualBookView.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

c. **Avoidable Bed Day of Care.** Avoidable bed day of care occurs when patients are admitted to the inpatient setting for care or services that could be safely provided in the outpatient setting or patients stable for discharge but remain in the inpatient setting awaiting services appropriate for the outpatient setting.

d. **Bed Management Solution.** The Bed Management Solution (BMS) is a near real-time, web-based tool for tracking bed availability, patient movement, flow management and augmentation of emergency management response. BMS displays utilization management review information including if admission or continued stay criteria is met or not met and if it has not been evaluated. The time since the last review and the number of bed days at the current status for each inpatient Veteran is displayed. The amount of time in observation status is also tracked.

e. **Community Care Clinical Review.** Clinical review to determine appropriateness for requested services to be authorized for delivery in the community or if any service can be delivered at the local VA medical facility. These admission, observation and continued stay reviews occur outside of the UM program.

f. **Concurrent Review.** Using the provider order and level of care provided, a concurrent review is performed during a patient's hospital stay or course of treatment, to assess the appropriate level of care and the quality of care provided. Concurrent reviews are entered into NUMI. **NOTE:** *Concurrent review commences within 24 hours of admission and no later than the first business day following the admission, continuing daily during hospital stay. Concurrent review allows for the proactive facilitation of quality care and patient flow.*

g. **Continued-Stay Review.** Using the provider order and level of care provided, the continued-stay review is a screening performed during a patient's hospitalization to determine the appropriateness of continuing the patient's stay at a specified level of care. After 30 consecutive days in the same treating specialty, continued-stay reviews are not required and are not counted for the remainder of the patient's stay.

h. **Electronic Health Record.** EHR is the digital collection of patient health information resulting from clinical patient care, medical testing and other care-related activities. Authorized VA health care providers may access EHR to facilitate and document medical care. EHR comprises existing and forthcoming VA software including Computerized Patient Record System (CPRS), Veterans Health Information Systems and Technology Architecture (VistA) and Cerner platforms. **NOTE:** *The purpose of this definition is to adopt a short, general term (EHR) to use in VHA national policy in place of software-specific terms while VA transitions platforms.*

i. **Inter-rater Reliability.** IRR assessment is a performance tool that measures consistency in the application and interpretation of standardized criteria among UM reviewers. **NOTE:** *IRR allows a comparison of responses among UM reviewers with the InterQual® Certified Instructor (IQCI) gold standard. The main target of the IRR is to have a 90% or greater level of agreement in the primary outcome measure of either meeting or not meeting the InterQual® criteria for observation, admission or continued stay reviews. UM data has become a measure of VA medical facility and VISN efficiency and are increasingly used to support decision-making. The UM IRR Standard Operating Procedure can be located at <http://vaww.oqsv.med.va.gov/functions/integrity/um/umPolicy.aspx>. NOTE: This is an internal VA website that is not available to the public.*

j. **National Utilization Management Integration.** National Utilization Management Integration (NUMI) is a web-based application, used in conjunction with EHR that:

- (1) Requires each VA medical facility to configure treating specialties as reviewable or non-reviewable;
- (2) Automates utilization management assessments and outcomes;
- (3) Standardizes UM review methodology and documentation; and
- (4) Provides critical functionality to assist UM reviewers in organizing workload, documenting UM review outcomes and generating reports to identify opportunities for improving efficiency in relation to system constraints and barriers.

k. **Observation Reviews.** Observation reviews are a type of review even though observation is an outpatient status. Observation reviews are entered into EHR using the evidence-based criteria for this level of care, conducted on all observations and required daily, up to, but not including, the day of discharge.

l. **Prospective Review.** A prospective review is conducted prior to a patient's admission, observation 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.

m. **Reason Code.** For UM reviews that are “not met”, a reason code is selected by the UM Reviewer that best captures the reason why the patient does not meet criteria.

n. **Revenue Utilization Review.** Revenue Utilization Review (RUR) is a process of systematic evaluation and analytical review of clinical information to optimize recovery of funds for the provision of health care services. Third Party Payers (TPP) have clinical medical necessity criteria (most often evidenced-based), treatment protocols or clinical guidelines. The RUR nurse provides clinical information (prospective, concurrent or retrospective) as documented by the provider in the Veteran's Electronic Health Record (EHR) to the TPP to support medical necessity. These reviews occur outside of UM services.

#### 4. POLICY

It is VHA policy that every VA medical facility with acute inpatient beds is required to establish and maintain an integrated UM Program that supports quality, safety, value and efficiency to ensure Veterans receive quality care. All UM activities are considered Quality Management activities that can generate confidential records and documents and are protected as provided in 38 U.S.C. § 5705. **NOTE:** *The core requirements are the responsibility of the VA medical facility Director (see paragraph 5.h.).*

#### 5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Assistant Under Secretary for Health for Quality and Patient Safety.** The Assistant Under Secretary for Health for Quality and Patient Safety is responsible for supporting the implementation and oversight of this directive across VHA.

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

- (1) Communicating the contents of this directive to each of the VISNs;
- (2) Providing assistance to VISN Directors to resolve implementation and compliance challenges at all VA medical facilities within that VISN; and
- (3) Providing oversight of VISNs to assure compliance with this directive, relevant standards and applicable regulations.

d. **Executive Director, Office of Patient Safety.** The Executive Director, Office of Patient Safety is responsible for appointing National Utilization Management Advisory Committee (NUMAC) co-chairs (a VISN Director and UM program manager) and providing oversight of resources to operationally implement the UM Program.

e. **National Utilization Management Advisory Committee Co-Chairs.** NUMAC co-chairs ensure oversight and monitoring of VHA's UM Program. The NUMAC and co-chairs are responsible for:

(1) Providing national guidance to ensure a standardized approach for the ongoing refinement and improvement of the national UM Program. An example of this is releasing an official UM Bulletin;

(2) Supporting a licensed, organized and standardized approach to UM processes using InterQual®. **NOTE:** *How the review in InterQual® is documented is dependent on EHR. For more information please see <http://vaww.oqsv.med.va.gov/functions/integrity/um/umPolicy.aspx>. **NOTE:** This is an internal VA website that is not available to the public;*

(3) Communicating and coordinating among programs with similar priorities such as Systems Redesign and Improvement, Office of Specialty Care Services, Clinical Services, Care Management, Social Work Services, National Surgery Office, Patient Care Services and the Office of Community Care;

(4) Maintaining, validating and analyzing UM data generated through NUMI, VHA Support Service Center (VSSC) and EHR, at each NUMAC meeting;

(5) Communicating between VHA leadership and the field to share priorities during calls and promote effective use of resources while improving quality of care. NUMAC reports to the VHA Quality, Safety and Value Council quarterly; and

(6) Developing VHA-wide Provider Utilization Management Advisor (PUMA) exclusion list; see Appendix A.

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

(1) Establishing and meeting the annual UM Program priorities. **NOTE:** *These priorities are established by each VISN and are specific to each VISN;*

(2) Communicating UM priorities to the VA medical facilities within that VISN;

(3) Ensuring UM data is leveraged to drive improvement projects at each VA medical facility within the VISN. See <https://vaww.rtp.portal.va.gov/OQSV/10A4B/NUMI/enhanced/SitePages/Home.aspx> for information on UM data. **NOTE:** *This is an internal VA website that is not available to the public;*

(4) Ensuring designation, training, support of and dedicated administrative time of at least two InterQual® Certified Instructors (IQCIs) to eliminate gaps in VISN IQCI responsibilities;

(5) Complying with education, training, teaching and testing of VISN IQCIs and UM reviewers;

(6) Conducting annual UM summary reviews of all VA medical facilities within the VISN. This review includes a process for assessing the effectiveness and improvements made in the UM program at each VA medical facility and is submitted to the UM Program Office for review, consultation or action regarding the UM program; and

(7) Overseeing the implementation of the IRR Program. Sustaining rater-to-rater Level of Agreement required threshold of greater than or equal to 90% for reportable measure (Met/Not Met) Level of agreement. **NOTE:** *The UM Program Office may modify the expected implementation of the IRR program by releasing an official UM Bulletin as external demands affect the ability of the IQCIs to implement the IRR program.*

**g. Veteran Integrated Service Network Director InterQual® Certified Instructor.**

The VISN IQCI is a licensed professional trained by Change Healthcare in the interpretation and application of clinical criteria used to determine the appropriateness of health care delivery and services to patients across the care continuum and is responsible for:

(1) Completing recertification annually to maintain IQCI certification. (See paragraph 6.);

(2) Establishing a VISN training schedule and instructing UM reviewers annually in the VHA UM review process, including updated criteria revisions. (See paragraph 6.);

(3) Serving as the first line clinical criteria resource for UM staff;

(4) Conducting at least two InterQual® training classes per year, attended by UM reviewers within their VISN; and

(5) As the gold standard, implementing and completing for their VISN, the UM Program Office developed IRR program.

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

(1) Reporting UM summary review data annually to the VISN to ensure the VA medical facility's compliance with the VISN UM Program priorities;

(2) Allocating full time equivalent employees (FTEEs) for the VA medical facility's UM Program. Each VA medical facility must establish UM FTEEs to ensure a minimum of 80% of UM reviews are completed, as well as all responsibilities as noted in 5.k. below;

(3) Ensuring that NUMAC approved standardized evidence-based UM review criteria (InterQual®) are used without modification and that UM reviewers have been trained in the use of that criteria by an IQCI within 60 days of annual criteria release. For detailed information about UM Program criteria, training and NUMI visit the Office of Quality, Safety and Value (QSV) UM website:

<http://vaww.oqsv.med.va.gov/functions/integrity/um/utilization.aspx>. **NOTE:** This is an internal VA website that is not available to the public.

(4) Ensuring review processes are consistent with national standard operating procedures (SOPs). These processes are available in detail on the QSV UM website at: <http://vaww.qps.med.va.gov/divisions/ncps/um/umPolicy.aspx>. **NOTE:** This is an internal VA website that is not available to the public;

(5) Ensuring that, at a minimum, 80% of acute inpatient admissions, observation stays and subsequent days of care as defined in paragraph 3.a. are reviewed. Concurrent review of all days of care is recommended. For patients with prolonged acute care stays in the same level of care/treating specialty (e.g., 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 and are automatically removed if completed. **NOTE:** The UM Program Office may modify the 80% review expectation by releasing an official UM Bulletin as external demands affect the ability of UM reviewers to meet the 80% minimum;

(6) Ensuring VA medical facility UM reviewer participation in annual criteria training and testing for applying and interpreting InterQual® criteria. The VA medical facility UM reviewer must complete the online competency tests each year, relative to the application and interpretation of standardized criteria. (See paragraph 6.);

(7) Ensuring compliance with the UM Program Office developed VISN IQCI IRR process for their VA medical facility;

(8) Supporting VISN IQCIs who are employed at their VA medical facility with dedicated administrative time to complete all VISN IQCI responsibilities;

(9) Designating VA medical facility PUMAs. **NOTE:** It is recommended that the PUMA have expertise in the service being reviewed, such as a psychiatrist designated as the PUMA for inpatient behavioral 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 PUMA to consult with an expert as needed. If approved by the VA medical facility medical staff governing committee, the role of the PUMA may be conducted by a licensed independent practitioner;

(10) Ensuring training, direction and dedicated administrative time of at least one PUMA per each service that conducts reviews, with backup coverage, to eliminate gaps in PUMA responsibilities;

(11) Ensuring the PUMA collaborates with VA medical facility UM clinical staff and other interdisciplinary staff as appropriate on care that is not clinically indicated for the acute setting, documents 75% of their secondary review outcomes within 7 business days in NUMI or EHR and that the PUMA exclusion list is adopted (see Appendix A). **NOTE:** The UM Program Office may modify the 75% review expectation by releasing an official UM Bulletin as external demands affect the ability of the PUMA to meet the 75% minimum;

(12) Ensuring UM data at their VA medical facility is reviewed by a multidisciplinary committee, which may include representatives from UM, Pharmacy, Emergency Department, Nursing, Social Work, Care Coordination/Management, Behavioral Health, PUMA, RUR and Surgery, at least quarterly and is used to identify initiatives to improve efficiency;

(13) Ensuring the initiatives identified for improvement are tracked and reported to the VISN annually; and

(14) Ensuring the integration of UM into daily patient care management activities, such as: patient flow, interdisciplinary meetings, care coordination and discharge planning processes.

i. **Chair, VA Medical Facility Multidisciplinary Committee.** The chair of the VA medical facility multidisciplinary committee ensures the committee reviews UM data at least quarterly and uses the data to identify initiatives to improve efficiency.

j. **VA Medical Facility Provider Utilization Management Advisor.** The PUMA is responsible for:

(1) Serving as the UM advisor at the VA medical facility level;

(2) Providing recommendations for patients not clinically indicated for acute care per InterQual® as well as any case that has quality of care issues or serious systematic issues needing immediate attention;

(3) Ensuring ongoing communication of UM review findings to attending providers and collaborating to resolve level of care discrepancies, quality of care issues or delays in care; and

(4) Completing within 7 business days, at least 75% of the PUMA referrals received in NUMI or EHR. PUMA reviews completed in real time are preferable and may result in actionable items that impact patient care. **NOTE:** *The UM Program Office may modify the 75% review expectation by releasing an official UM Bulletin as external demands affect the ability of the PUMA to meet the 75% minimum.*

k. **VA Medical Facility Utilization Management Reviewer.** The VA Medical Facility Utilization Management Reviewer (UM reviewer) is trained to perform UM reviews utilizing InterQual®. The role of the UM reviewer includes:

(1) Assessing, planning, coordinating, guiding and collaborating with acute care hospital services in order to achieve high-quality patient care with cost-effective use of resources;

(2) Possessing knowledge of the evidenced-based clinical criteria, conducting reviews and inputting data into NUMI or EHR to determine the appropriate level of care for each patient;

(3) Conducting acute inpatient care reviews (admission, observation and continued stay) and selecting a reason code for UM reviews that are “not met”. The reason code should best capture the reason why the patient did not meet criteria;

(4) Functioning as an inpatient care coordinator, working across care settings, contacting health care providers and other services pertaining to patient flow;

(5) Performing and documenting in NUMI or EHR, at a minimum, 80% of acute inpatient admissions, observation stays and subsequent days of care. **NOTE:** *The UM Program Office may modify the 80% review expectation by releasing an official UM Bulletin as external demands affect the ability of UM reviewers to meet the 80% minimum;*

(6) Participating in daily rounds, bed huddles or Inter-disciplinary Team meetings;

(7) Referring to the PUMA reviews that are not clinically indicated, are avoidable and remain unresolved after communication with the health care team as well as any case that has quality of care issues or serious systematic issues needing immediate attention. **NOTE:** *Reviews that are excluded per the PUMA exclusion list (see Appendix A) are not sent to the PUMA;*

(8) Reviewing observation stays daily up to, but not including, the day of discharge and discussing the rationale for stays longer than 48 hours in interdisciplinary rounds. **NOTE:** *The Bed Management Solution (BMS) displays for each patient in observation, the amount of time in hours in observation status; and.*

(9) Performing daily continued-stay reviews, no later than the first business day following weekends or holidays.

## 6. TRAINING

The following training is required for UM reviewers: participation in annual criteria training; annual testing for applying and interpreting InterQual® criteria within 60 days of annual criteria release; and one-time completion of the VHA Talent Management System (TMS) NUMI courses, 23800 and 22647. PUMA required training is also in TMS entitled “The Provider Utilization Management –PUMA”, 14115. IQCIs must complete Change Healthcare developed and hosted InterQual® training annually. Link to Education, training and competence requirements can be found at: <http://vaww.oqsv.med.va.gov/functions/integrity/um/umPolicy.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

## 7. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive shall be managed per the National Archives and Records Administration (NARA) approved records schedules found in VA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Manager or Records Liaison.

**8. REFERENCES**

- a. 38 U.S.C. § 5705 (2.b.(1)).
- b. 38 U.S.C. § 7301(b).
- c. VHA Directive 1002, Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities, dated November 28, 2017.
- d. VHA Directive 1036, Standards for Observation in VA Medical Facilities, dated January 13, 2020.
- e. VHA Directive 1601C.02, Revenue Utilization Review, dated February 1, 2019.
- f. Office of Inspector General (OIG) Draft Report: Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018 (Project No. 2019-07040-HI-0938), dated July 11, 2019.

### VA PUMA EXCLUSION LIST

1. The Department of Veterans Affairs (VA) Medical Facility Provider Utilization Management Advisor (PUMA) Exclusion List identifies unavoidable cases that do not require referral to the PUMA even though the InterQual© criteria is not met. Although these reasons may capture important system issues requiring system improvement and possibly elevation to senior leadership, individual case review by the PUMA is unlikely to resolve the issue for that patient. These cases are:

a. Retrospective reviews when the patient has already been discharged from the VA medical facility;

b. Multiple duplicate reviews for the same patient with the same findings (same reasons not met and same recommended level of care). An example of this would be a patient who does not meet criteria for several days awaiting nursing home placement;

c. Patients admitted or continued in the hospital related to regulatory issues (i.e. Court ordered, Adult Protective Services directed inpatient admission pending investigation, awaiting Guardianship);

d. Environmental or Adverse conditions where the patient was admitted to ensure safe environment and access to medical care during times of inclement weather, natural disasters, contagious illness outbreak or power outage;

e. Level of care unavailability at VA medical facility;

f. Planned respite that requires acute care setting;

g. Some social situations such as lack of transportation;

h. Lack of caregiver;

i. Clinically indicated (unavoidable) reason code selected by Utilization Management Reviewer; clinical presentation or provider judgement are the basis for continuing care in the current level when criteria are not met;

j. Admitted or remaining in the hospital to facilitate placement; or

k. Geographically specific situations or conditions that are unavoidable.

2. Certain types of cases related to quality of care should always be referred to the PUMA irrespective of the case meeting or not meeting criteria. These include:

a. Quality of care issues or deviation from standard of care; or

b. Major delay in service delivery.