

May 23, 2001

VHA CLINICAL APPEALS

1. PURPOSE: This Veterans Health Administration (VHA) Directive creates a mechanism for both Internal and External Appeals. It is designed to establish policies, responsibilities, and procedures for handling of patient issues and/or concerns when an impasse occurs between a patient (or the patient's representative) and a health care facility pertaining to the following:

- a. Provision of clinical care that potentially could result in a different and/or improved clinical outcome for the veteran.
- b. Denial of clinical care that potentially could result in a different and/or improved clinical outcome for the veteran.

2. BACKGROUND

In 1991, VHA first issued a Directive mandating all medical centers to operate a Patient Advocate Program for handling patient inquiries and complaints. In Fiscal Year (FY) 1999, in response to Eligibility Reform and the implementation of an enrollment system with the provision of a fixed benefits package, VHA initiated a review of how clinical disputes were being handled throughout the system. As an outgrowth of that review, in FY 2000, VHA instituted an External Appeal system, which allows Networks to request prompt, impartial reviews of clinical determination decisions by a professional board external to the Agency. As an additional development, this FY 2001 Directive addresses the handling of Clinical Appeals internal to the Agency, with the goal of creating a more efficient and consistent system that incorporates Veterans Integrated Service Network (VISN)-based management into review and associated veteran customer service improvement activities.

3. POLICY: It is the policy of VHA that patients or their representatives have access to a fair and impartial review of disputes regarding clinical determinations or services that are not resolved at the facility level. ***NOTE:** This supports the vital concept that patients will be actively involved in all aspects of care that influence clinical outcomes, including decisions regarding referrals, transfers, discharge planning, and other factors which influence the clinical outcomes of care.*

4. ACTION

a. Facility Responsibilities

(1) VHA health care facilities are the first point of contact for attempting to resolve clinical disputes. Every effort is to be made to resolve disputes as close to the point of care as possible.

(2) Facilities must provide written notification of the facility's final determination to the patient, or their representatives. In addition, this notification must describe the Network Clinical Appeals process.

THIS VHA DIRECTIVE EXPIRES MAY 31, 2006

VHA DIRECTIVE 2001-033

May 23, 2001

b. **Network Responsibilities.** VHA Networks administer an Internal Clinical Appeals process regarding clinical determinations or services that are not resolved at the facility level. They ensure that the process at each level provides for a fair and impartial review. Networks must review Clinical Appeals and provide a decision to the patient within 30 days after receipt of the appeal request. That time frame may be extended to 45 days, should the Network request an External Clinical Review (see subpar. 4b(2)(c)). VHA facilities and Networks render decisions that are founded on national evidence based standards. Where there is an absence of a national evidence base standard for treatment, the local community standard prevails. **NOTE:** *VHA operates an External Clinical Review program that allows for independent review and recommendation regarding Clinical Appeals by a professional board external to the Agency. Networks have the authority to request an External Review at any time during the Clinical Appeals process, prior to rendering a final decision.*

(1) By September 1, 2001, Networks must have a written policy and procedure in place for how Internal Clinical Appeals are handled, including identification of roles and responsibilities, time frames, and requirements for data entry into the national computerized Patient Complaint database.

(2) Upon receipt of a Clinical Appeal from the patient, or their representative, the Network must conduct a preliminary review in order to determine whether the:

(a) Patient can be maintained safely in the current environment of care. If it is determined that the patient cannot be safely maintained in the current environment of care, the Network must arrange for immediate transfer of the patient to an appropriate setting.

(b) Medical facility had an opportunity to formally address the issue. If the facility has not attempted resolution, the request for review is forwarded to the facility Director.

(c) Dispute is an appropriate case for the Network Clinical Appeals process. **NOTE:** *Issues that fall outside the scope of that process (i.e., administrative disputes, other complaints) will be referred to the appropriate office or location. This directive does not impact other appeals processes available to veterans, specifically the reconsideration process and appeals to the Veterans Benefits Administration.*

(3) Once a clinical dispute is accepted as an Internal Clinical Appeal, the Network requests documentation and supporting arguments from both the facility and the patient, or as appropriate, the patient's representative. The Network will either independently review the documentation or convene an impartial Network Clinical Panel to review the documentation and make a recommendation. **NOTE:** *The Network can request an independent External Review at any time during the process.*

(4) When an independent External Review is requested, the Network Director forwards the clinical record, the statement of appeal, and other relevant documentation and/or information produced by any Internal Review, to the Office of Quality and Performance (OQP). Upon receipt, OQP arranges for the External Review through its Contractor for the External Peer Review Program. The Contractor reviews the clinical record and all accompanying documentation, as well as any evidence regarding the relevant practice described in the literature, to determine whether appropriate and/or reasonable and necessary clinical service was provided and/or denied. A final written report, fully documenting the findings and recommendations of

the reviewer(s), is provided to the Network Director within 10 days of the receipt of the full documentation request.

(5) The Network Director renders a written final decision to the patient or the patient's representative and the medical facility Director within 30 days after initial receipt of the Clinical Appeal. **NOTE:** *The time frame for final decision may be extended to 45 days for those Clinical Appeals undergoing External Review.*

(6) Networks must ensure that the Patient Advocate at the facility enters the Clinical Appeals into the national computerized Patient Complaint database where the appeal was originated. All details and decisions must be included in the final documentation before the case is closed.

(7) Attachment A provides a sample cascade for the process management of Clinical Appeals by a Network.

(8) Attachment B provides a sample memo for written documentation to support a final appeal recommendation.

(9) Attachment C provides sample considerations for decision-making.

c. **QQP.** OQP administers VHA's External Clinical Appeals program using an outside vendor. OQP must ensure that all requests for External Review are conducted in a timely and efficient manner.

d. **National Patient Advocate Program of the VISN Support Service Center Responsibility.** The National Patient Advocate Program of the VISN Support Service Center provides support for the national computerized Patient Complaint database. **NOTE:** *The national computerized Patient Complaint database is to be used for documenting Clinical Appeals and producing reports for the tracking and trending of issues.*

5. REFERENCES: None.

6. FOLLOW-UP RESPONSIBILITY: The Office of the Assistant Deputy Under Secretary for Health (10N) is responsible for the contents of this directive. Questions may be referred to (202) 273-5852.

7. RECISSIONS: None. This VHA Directive expires May 31, 2006.

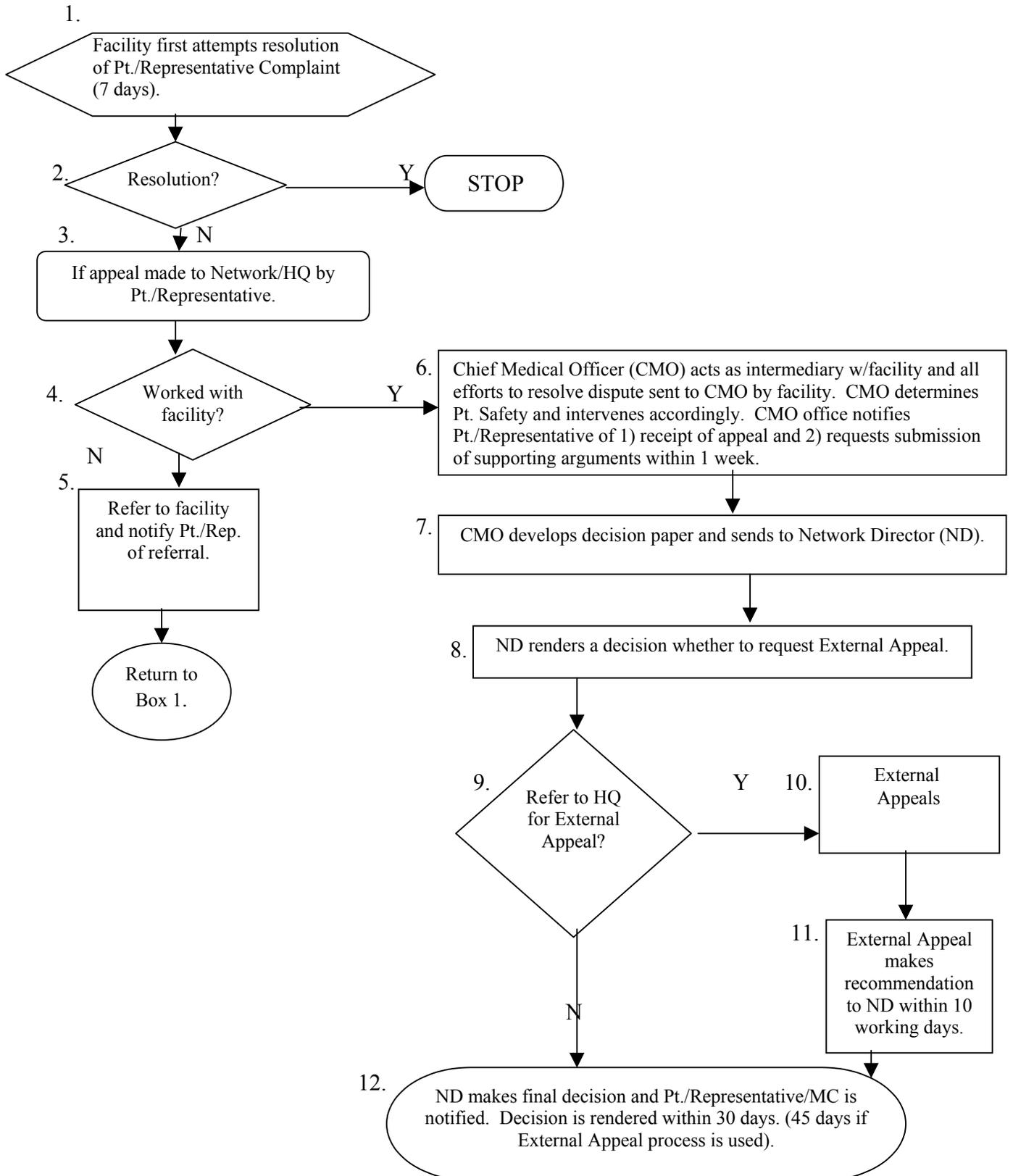
S/ by Frances Murphy, M.D. for
Thomas L. Garthwaite, M.D.
Under Secretary for Health

Attachments

DISTRIBUTION: CO: E-mailed 5/24/2001
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ATTACHMENT A

SAMPLE CLINICAL APPEALS PROCESS



ATTACHMENT B

SAMPLE EXECUTIVE DECISION MEMO

FACILITY:

TO: Network Director (10N___)

THROUGH:

FROM: Chief Medical Officer ()

SUBJECT:

PREPARED BY:

1. For Further Information Contact:

2. Action Requested: _____ Request for approval
_____ Request for discussion or further review
_____ For your Information
_____ Other (specify)

3. Statement Of Issue: A concise statement of the issue, circumstance, or situation that needs to be addressed or resolved.

4. RECOMMENDATION: A succinct statement of what action is being recommended to address or resolve the issue.

APPROVED/DISAPPROVED

Name of VISN Director

(Date)

Network Director, VISN _____

ATTACHMENT C

SAMPLE CONSIDERATIONS FOR DECISION-MAKING

1. **STATEMENT OF ISSUE:** A concise statement of the issue, circumstance, or situation that needs to be addressed or resolved.
2. **SUMMARY OF FACTS AND/OR BACKGROUND:** A succinct discussion, or review, of the relevant facts or circumstances bearing on the issue (one to three paragraphs).
3. **SYNOPSIS OF SIGNIFICANT RELATED ISSUES:** A statement of any related or peripheral issues not covered in Consideration Item #2 that also should be considered (one to three paragraphs).
4. **CRITERIA FOR DECISION-MAKING:** A listing of all significant criteria upon which the options for addressing the issue will be judged, pro or con. *NOTE: This section is to specify precisely the basis for making the decision.*
5. **STAKEHOLDER INVOLVEMENT:** A brief description of who was worked with (i.e., internal and external stakeholders) and what process was used to develop the decision criteria and options.
6. **OPTIONS AND ARGUMENTS:** A listing of the various options for actions that could be taken to address or resolve the issue or situation, and the arguments for and against each.

Option 1:

Arguments Pro:

Arguments Con:

Option 2:

Arguments Pro:

Arguments Con:

7. **RECOMMENDED OPTION:** A succinct statement of what action is being recommended to address or resolve the issue.
8. **DISSENTING OPINIONS REGARDING RECOMMENDED OPTION:** When the recommended option is the result of a committee or group process, then major dissenting views or minority opinion need to be noted as well.

VHA DIRECTIVE 2001-033

May 23, 2001

9. EFFECT OF RECOMMENDED OPTION ON EXISTING PROGRAMS AND/OR

FACILITIES: An assessment of the effect of the recommended action on existing programs or facilities.

10. LEGAL OR LEGISLATIVE CONSIDERATIONS OF THE RECOMMENDED OPTION:

A brief discussion of any legal or legislative issues, concerns, or consideration stemming from the recommended action.

11. BUDGET OR FINANCIAL CONSIDERATIONS OF THE RECOMMENDED OPTION:

A discussion of any costs and/or financial or budgetary effects of the recommended action including the present availability of any needed resources. ***NOTE:** No decision will be based solely on budgetary effects.*

12. PUBLIC RELATIONS OR MEDIA CONSIDERATIONS OF THE RECOMMENDED

OPTION: A discussion of any potential public relations or media problems, opportunities, etc., raised by the recommended action.

13. CONGRESSIONAL OR OTHER PUBLIC OFFICIAL OR AGENCY CONSIDERATIONS

OF THE RECOMMENDED OPTION: A discussion of any congressional and/or other public official/agency notification or involvement considerations raised by the recommended action.

14. IMPLEMENTATION: A brief discussion of the timing, sequence, and implementation of the recommended action, including major implementation milestones. The proposed lead office or lead person and support office need to be clearly identified. Likewise, any anticipated obstacles must be noted.

15. LESSONS LEARNED: A brief discussion of any lessons learned stemming from either the issue, or the way the issue was handled at any point along the continuum.