

### UTILIZATION REVIEW (UR)

1. **REASON FOR ISSUE.** This Veterans Health Administration (VHA) Handbook updates Department of Veterans Affairs (VA) procedures for providing information regarding Utilization Review (UR) in VHA health care facilities.
2. **SUMMARY OF CHANGES.** This VHA Handbook updates current procedures.
3. **RELATED ISSUES.** VHA Handbooks 1601A.01 through 1601E.01.
4. **RESPONSIBLE OFFICE.** The Chief Business Office (16) is the responsible for the contents of this VHA Handbook. Questions may be addressed to 202-254-0406.
5. **RESCISSIONS.** VHA Directive 2003-041 is rescinded.
6. **RECERTIFICATION.** This VHA Handbook is scheduled for recertification on or before the last working day of September 2011.

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DISTRIBUTION: CO: E-mailed 9/27/06  
FLD: VISN, MA, DO, OC, OCRO and 200 – E-mailed 9/27/06

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## UTILIZATION REVIEW (UR)

### 1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides the procedures required for utilization review (UR) functions within each Department of Veterans Affairs (VA) medical center's revenue program.

### 2. AUTHORITY

[Title 38 United States Code \(U.S.C.\), Sections 1729, 1729A, and 1729B](#) requires VHA to seek reimbursement from third-party health insurers for medical care provided by VA to insured veterans for non-service connected (NSC) treatment, or to service connected (SC) veterans for their NSC conditions (and appropriateness of care). VHA must perform UR activities under certain circumstances. *NOTE: For more information on UR, see VHA.PG.1601C.02 (To be published) (for internal VHA use only).*

### 3. BACKGROUND

a. In 2003, guidance was established standardizing the UR functions with third-party reimbursement responsibilities at VA health care facilities. 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. VHA received authority through Public Law 99-272, to seek reimbursement from third-party health insurers for medical care provided by VA to insured veterans for non-service connected treatment.

b. UR review, from a payer's perspective, is a regulatory approach designed to control health care costs and meet the payer's objectives, which includes maximizing revenue and minimizing expenditures. Many payers (i.e., insurance companies) have become fiscal intermediaries for the Federal government, providing quality assurance, administrative services, and handling claims and payments for Medicare beneficiaries; as a result, they have adopted Medicare regulatory guidelines within their private insurance subsidiaries.

c. An UR program is an effective tool for containing cost and servicing government programs. Insurance companies, health maintenance organizations, hospitals, and other providers of health care services continue to implement UR strategies. Insurance companies employ registered nurses (RNs), physicians, and other clinicians to:

- (1) Conduct UR clinical activities,
- (2) Question appropriateness and medical necessity, and
- (3) Monitor medical decisions for conformance with known standards of practice and quality care.

d. Within the health care industry, the physician or provider of medical services is recognized as the key figure in determining utilization of health care services. The provider is responsible for justifying and documenting medical need for services and for obtaining medical necessity certification for the service(s) in order to receive adequate reimbursement. In the private sector, adequate reimbursement is one impetus that ensures adherence to medical review guidelines.

e. With the broad array of health plans constantly changing, staff performing UR functions must serve as the critical link among clinicians, staff, patients, administration, and insurance companies. Staff performing UR functions for third-party reimbursement provides the clinical expertise and leadership for the implementation of a medical center's reimbursement program. This may entail working with all staff involved in the business cycle, and with other administrative and clinical staff of the medical center, to adopt new strategies on maximizing collections from third-party insurers. It is in this context that UR has become an essential core component within the VA-business cycle.

f. UR positions require advanced clinical knowledge, communication skills and management abilities. Therefore, RNs appointed under 38 U.S.C. are responsible for performing the clinical UR activities for third-party reimbursement. *NOTE: Present employees who are not RNs in these positions are to be grandfathered in until their position becomes vacant.*

#### 4. DEFINITIONS

a. **Acute Admissions.** An Acute Admission is a level of health care intervention, based on a patient's severity and intensity of illness, which is clinically appropriate for those services only performed in an inpatient setting.

b. **Admission Review.** An Admission Review is an assessment of medical necessity and appropriateness of a hospital admission after the hospitalization has occurred. This review is typically performed on admission, within 24 hours following the admission, or no later than the first business day following the admission. Standardized review criteria must be used to determine the appropriateness of care.

c. **Alternate Level of Care.** An Alternate Level of Care is alternative care that would have been more appropriate for a patient who did not meet the criteria for acuity or the admitted proposed level of care, had it been available. Possible alternatives include residential, outpatient services, home care, hospice, rehabilitation, observation, and others as defined by the facility.

d. **Concurrent Review (Continued Stay Review).** A Concurrent Review is an assessment that determines medical necessity or appropriateness of services during a patient's hospital stay or course of treatment, such as an assessment of the need for continued inpatient care for hospitalized patients. Concurrent reviews include continued-stay authorization and discharge review.

e. **Data Analysis.** Data Analysis is the study or assessment of trends in health and health care issues. It is based on the collection of information designed to facilitate performance improvement.

f. **Denial Management.** Denial Management is a process whereby all denied claims are appropriately appealed or declared uncollectible and reported in a manner that provides optimal information flow. The process also includes a consistent approach to track and appeal denials and a reporting system that measures outcome and appeal status. Non-authorizing decisions may be based on medical appropriateness or benefit coverage.

g. **Diagnosis Related Group (DRG).** DRG is a case-mix classification system that groups patients who are similar clinically in terms of diagnosis and treatment, and in their consumption of hospital resources, thus allowing comparisons of resource use across hospitals with varying mixes of patients.

h. **Diversion.** A Diversion is a status in which patients are diverted to other medical facilities due to unplanned reasons such as unavailability of beds, needed services that could not be provided, or shortage of staff.

(1) **Full Acute Medical and /or Surgical Care Diversion.** A Full Acute Medical and/or Surgical Care Diversion is a status in which all medical and surgical patient admissions are restricted. This status includes ambulance diversion and restricting transfers from other VA health care facilities.

(2) **Limited-Acute Medical and/or Surgical Care Diversion.** A Limited-Acute Medical and/or Surgical Care Diversion is a status in which medical and surgical patient admissions are restricted, but selective medical and surgical admissions are allowed (for example, elective admissions, scheduled transfers from other VA health care facilities, etc.). This status may include ambulance diversion, the Intensive Care Unit (ICU) diversion, Cardiac Care Unit (CCU) diversion, and restricting transfers from other VA health care facilities.

i. **High Cost.** High Cost is when an individual or group of patients consumes a significant amount of resources. Resources could be related to cost, time, or personnel.

j. **Level of Care.** Level of Care is the continuum of care which includes various intensities of service levels such as acute, rehabilitation, sub-acute, Skilled Nursing Facility (SNF), home care, Outpatient Rehabilitation, etc. The selection of the appropriate care setting is based on the review of an individual patient's severity of illness, co-morbidities, and complications.

k. **Medical Care Group (MCG).** MCG is a group of VA hospitals that is similar in size and complexity.

l. **Observation Beds.** An Observation Bed is an alternate level of health care comprising short stay encounters for patients who require close nursing observation or medical management. It is an area where the patients are observed and assessed following surgery or during treatment in order to determine if they need to be admitted to the hospital. This may take up to 24 hours, at which time a decision is required whether to send the patient home or to admit the patient to the hospital.

m. **Over-Utilization.** Over-Utilization is when services were provided and the provision of services was indicated in either excessive amounts or in a higher-level setting than required.

n. **Pre-Admission Review.** A Pre-Admission Review is a review performed prior to a scheduled (elective) admission. Pre-admission cases need to be reviewed for level of care and medical necessity.

o. **Prospective Review.** A Prospective Review is the assessment of the appropriateness of an admission prior to a patient's admission, service, or course of treatment. Established review criteria must be used to determine the appropriateness of care. Prospective reviews include preauthorization for inpatient and/or outpatient services.

p. **Re-admission Rate.** Re-admission Rate is the ratio of patients re-admitted to the same or different hospital within 30 days following hospital discharge compared to the total number of patients discharged. The percentage needs to be based on a standardized denominator of per 100 bed days of care.

q. **Retrospective Review.** A Retrospective Review is a review conducted after services have been provided and the patient has been discharged. Retrospective reviews include retroactive-reimbursement reviews, denial management, appeals, and UR data analysis.

r. **Utilization Management (UM).** UM is the process of evaluating and determining the appropriateness of medical care services across the patient health care continuum to ensure the proper use of resources.

s. **Utilization Review (UR).** UR is a formal evaluation (prospective, concurrent, or retrospective) of medical necessity, efficiency, or appropriateness of VA health care services and treatment plans for an individual patient.

t. **Utilization Review Criteria.** UR criteria are a set of measurable clinical indicators, as well as diagnostic and therapeutic services, reflecting the need for hospitalization or treatment. Appropriateness is based on a patient's severity of illness and the intensity of the service being provided.

## 5. SCOPE

VHA has recognized the need to employ cost containment measures that include mandated UR programs to ensure appropriateness of care, and procedures for obtaining adequate reimbursement for services. However, it has taken longer for these measures to be effective in VHA due to VHA's mission, which is to function primarily as a health care benefit program rather than as a for-profit organization. Today, VHA is recognized as a leader in implementing the technology necessary to support efficient and quality health care and to ensure an integrated health care delivery system for the veteran population. This Handbook provides details on the authority for standard UR procedures and mandates sufficient UR staff.

## **6. RESPONSIBILITIES OF VETERANS INTEGRATED SERVICE NETWORK (VISN) DIRECTOR**

The VISN Director is responsible for ensuring that:

- a. Each VA medical center has a UR program for third-party reimbursement, optimally aligned within the Business Office (or equivalent), and
- b. UR reviewers support the standardization of UR activities associated with core business cycle functions.

## **7. RESPONSIBILITIES OF MEDICAL CENTER DIRECTOR**

The Medical Center Director is responsible for ensuring that:

- a. The supervision and performance ratings for the UR nurse are conducted utilizing the VA Nurse Qualification Standard, VA Directive 5102.1, which:
  - (1) Includes nine dimensions of performance requirements for the appropriate Nurse II or Nurse III level of practice, and
  - (2) Affords staff the educational and informational opportunities required to perform their assigned duties.
- b. The administrative support necessary is assigned for acquisition of tools and resources required for UR nurses to perform their assigned duties.
- c. Qualified clinical back up is available to cover vital daily UR activities during periods of time for scheduled or unscheduled leave,
- d. There is no adverse impact on the business cycle process.

## **8. RESPONSIBILITIES OF UTILIZATION REVIEWERS**

UR staff within revenue collection programs are responsible for:

- a. Performing clinical review activities together with associated planning, developing, coordinating, implementing, and monitoring which include, but are not limited to:
  - (1) **Prospective Reviews.** Prospective reviews include: pre-admission and pre-certification for inpatient and/or outpatient services.
  - (2) **Concurrent Reviews.** Concurrent reviews include: admission, continued-stay certification, and discharge review.

(3) **Retrospective Reviews.** Retrospective reviews include: retroactive-reimbursement reviews, denial management, appeals, and UR data analysis.

b. Utilizing claims tracking to document all review results for: communication to billing, accounts receivable, coding, and other appropriate staff; data collection; and reporting. Selected Claims Tracking UR report data with analysis must be provided, at least quarterly, or as often as UR staff considers necessary for focused improvement, to the Revenue Coordinator and as needed, to medical center management and appropriate committees.

c. Serving as a patient advocate, as well as program mediator, providing accurate and timely clinical information to the insurance company. UR staff must acquire knowledge of insurance review criteria and must consult with physicians and providers, as necessary, for clinical assistance to ensure supporting documentation, and to establish collaboration for the exchange of complete and credible information between the insurance companies and the medical center.

d. Conducting focused reviews for clinical input on a consultative basis. These review requests may include: sensitive diagnosis and/or special consent issues, SC issues, tortfeasor, workers compensation and Fee Service cases, requests for information, and other issues for the interpretation of clinical information. It is recognized that the volume of VA patients with reimbursable insurance may dictate the Full-time Equivalent (FTE) staff dedicated to third-party reimbursement; therefore, the UR staff needs to be flexible to assist in other business-related clinical reviews.

e. Establishing effective collaboration with the Business Officer or Revenue Coordinator and medical center staff to: identify problem areas, initiate corrective action, facilitate educational opportunities for multidisciplinary staff, and ensure an effective UR program for third-party reimbursement. **NOTE:** *UR staff must attend Chief Business Office conference calls and other educational opportunities applicable to UR and related activities.*

f. Ensuring program compliance with established review criteria for reimbursement and appeal of denials, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, VHA requirements, and confidentiality of medical record information. UR staff must provide feedback, as appropriate, for patient case management, performance improvement, risk management, and compliance programs.