Memorandum

Date: 07/08/2022

From: [redacted] MSN MBA RN LNC

Subject: VA Proficiency 2022 for consideration for Promotion to Nurse III with Proficiency for 2021 attached

To: NPSB -Chair

[redacted] **MSN MBA RN LNC**

[redacted] MSN MBA RN LNC is an Assistant Nurse Manager (ANM) in the Mid-Atlantic Consolidated Patient Account Center (MACPAC) for Veterans Integrated Services Network (VISN) 7 for four years. ANM[redacted] has 32 years of experience as a nurse, with experience in revenue utilization review (RUR), case management, nurse consultant, telemetry, progressive care, medical-surgical, utilization management, prison health care, pediatrics, infectious disease, home health care, and public health care. During the past 12 months ANM [redacted] has continuously demonstrates knowledge of Revenue Operations and the patient satisfaction process. This knowledge bases are extracted from her expanded body of information relating to the multiple years of experience within various areas. ANM[redacted] experience and contributions have clearly impacted all aspects of the revenue cycle in positive outcomes. She has been a resource of reference regarding best evidence-based practices for the patient's seeking care within all MACPAC facilities and for RUR nurses, account managers, coder, billers, and patient support assistants (PSA). AMN[redacted] has contributed to the educational process through practicing, instructing co-workers and facility health providers in the standards of nursing practice within the primary care and revenue setting (Gonzales & Stoltman, 2020). ANM[redacted] utilizes the nursing process and critical thinking skills to guide RUR decision making on service connection determination of the visits of the veterans in their VA health care experiences including usage of the Community Care Network (CCN). ANM[redacted] is a leader in changing practice and improving veteran outcomes using ongoing assessment of system processes and improving health outcomes amongst the veterans throughout VISNs 5, 6, and 7.

A. Practice

Practice: ANM[redacted] provides leadership in the application of the nursing process to patient care, organizational processes, and/or system, improving outcomes at the program or service level. ANM[redacted] is confident in her ability to review patients/veterans billing information and makes appropriate recommendations to the accounts managers and billers regarding the expectation of patient's authorization for services from the Primary Care Clinics, Community Based Outpatient Clinics (CBOC), and the Community Care Network. Processing authorization may require submission of a Letter of Extenuating Circumstances to the insurance providers as proof of medical necessity.

Example: Authorization for some treatment prior to service delivery is optimal to mitigate patient financial risk and decrease denial for lack of timely notification. This notification may include unforeseen events or a set of circumstance which adversely affect the ability of a participating provider or facility to request prior authorization prior to service delivery. This situation can also occur when seeking approval of medications. ANM[redacted] discussed her assessment and hypothesis with the Nurse Manager, other ANM's, RUR nurses at multiple locations at MACPAC, and the MACPAC non-Medical Care Collections Fund (MCCF) nursing staff via email and Microsoft Teams discussions. The RUR nursing staff are responsible writing Letters of Medical Necessity (LMN) and Letters of Extenuating Circumstances to obtaining authorization and to dispute denial of services. ANM[redacted] asked the same question to the Nurse Manager, ANM's, MACPAC non-MCCF nursing staff, and RUR nursing staff. She spoke with 15 RUR nurse located with the eight VISN 7 facilities, three non-MCCF nursing staff, the MACPAC Nurse Manager, both MACPAC ANM's, and two private sector insurance providers.

Problem: It was determined that the most common reason for denial of authorizations and retroactive authorizations for treatment is the lack of understanding of Extenuating Circumstances. This may possibly be related to the lack of understanding of what information needs to be submitted with LMN and Letters of Extenuating Circumstances. During the collection of evidence and wording of the evidence collected during the determination process, it was discovered that greater than 80 % of the nurses used similar terminology and did not submit

sufficient information. When reasons for treatment are provided in a patient chart, understanding the diagnosis given by providers can be challenging, medications prescribed may or may not have been effective, and the clinical progression used by providers seldom follows predictable or direct linear paths (Feldman, DeBofsky, Plakun, & Potts, 2021).

Action: ANM[redacted] developed a power point presentation to discuss the verbiage required for the medical necessity and extenuating circumstances letter writing process. The presentation also included what information to look for in patient record and how to notify the insurance provider of extenuating circumstances. ANM[redacted] educated all MACPAC nurses who provided service to 21 VA facilities and their CBOC's, on utilizing the same terminology and information when submitting LMN's and Letters of Extenuating Circumstances.

Outcome: One of the MACPAC non-MCCF staff nurses had been constantly denied approval for a medication per the insurance provider policy. The nurse implemented all terminology and information from the presentation on the last allowed attempt. The nurse performed the article research as instructed and included the information with the LMN/Letter of Extenuating Circumstances. A list of references was also included. Per the email from the non-MCCF nurse "This will now bring a significant amount of revenue back into the VA as this patient has been on this high dollar medication since 2017". The practice of using similar comprehensible terminology, submission of supporting documentation, and submission of research material has improved the LMN/Extenuating Circumstances writing process. There has been a 98% improvement in understanding of what is required during this step of revenue collection process at MACPAC.

Ethics: ANM[redacted] provided leadership in identifying and addressing ethical issues that impact patients and staff, including initiating, participating, and advocating. She treats every patient account with dignity and respect while incorporating the patient's knowledge, values, beliefs and cultural background into the delivery of care for our veterans. As an RUR ANM, she consistently demonstrates leadership, in protecting the rights of patients. She is recognized as a resource for veterans and staff. She develops educational presentations to assist staff in addressing ethical issues.

Example: ANM[redacted] identified ethical concerns for the following initiative: Facility Prime Care leadership (MD's) mandated post discharge patients to speak with the RN for all post discharge follow-ups and not be required to be assessed by the PCP. The rationale given by facility leadership was that this would provide patient access for follow-up post hospital discharge. ANM[redacted] referenced ANA Code of Ethics Provisions 3 through 9 and addressed the situation professionally and systematically. She first discussed with the Prime Care Director to gain more insight on the roles and responsibilities of the RN during the proposed post discharge call.

Outcome: For access purposes, the post discharged patients continue to receive a call from the RN but will be given the option of speaking with the provider. However, there were significant changes to the original plan of the post discharge visit that benefited both the patients as well as the staff. Regardless of the type of visit (routine, urgent, emergent, post d/c, etc.), RN's must practice within the scope of their licensure. RN's complete patient intake while also, using the nursing process as the essential core of practice to deliver holistic, patient-focused care. Following the patients call with the RN, the PCP assesses and documents their assessment on each post discharged patient. ANM[redacted] continues to serve as a resource and advocate to patients, families, and other staff when ethical issues arise, and, as described above, she seeks support for resolving ethical issues.

Resource Utilization: ANM[redacted] manages and analyzes resources, evaluate options, and take action that impact not only VISN 7 staff but other MACPAC VISN's and other CPAC's. ANM [redacted] supervision of the RX specialty have given them a better understanding of the prescription approval methodology and its improvements.

Problem: An increased number of cases on the RX Reason not Billed for RXVAL and RXRNB Huron worklist were becoming delinquent and past timely filing,

Action: ANM[redacted] provided assistance with observing the RX Reason Not Billed for RXVAL, RXNB, Robotic Process Automation (RPA) project at three sites within VISN 7. The pilot was initiated to automate RUR comments from the RX Workflow Tool (WFT) bucket into VistA.

Outcome: The test pilot confirmed that the Bot is able to accurately log into the sites, accurately process each transaction at that site, and then move on to the next site and process the remaining transactions. If the account is SC/SA the nurse will only have to select the appropriate option from a "Minor 1 Deficiency" drop-down menu. No comment will be required in the comment/note field. No action will need to be taken in claims tracking to remove the RNB or to reset the prescription copayment status. If cases are Non-SC/SA the regular process will be followed but the nurse will have to reset each prescription refill number and all the alpha characters that follow that number so the Non-SC/SA refills with that same number will route off the RUR worklists.

B. Professional Development

Performance: ANM[redacted] utilize professional standards of care and practice to meet all goals during this rating period. She completed a through literature search to review standards established by American Nurses Association (ANA) and obtained VA Lean Green Belt Training.

Example: ANM[redacted] implements educational plans to meet changing program and service needs for self and others. She maintains knowledge of current performances, procedures, trends, and professional issues based on current peer-reviewed published or communicated information through reading and webinars, which she willingly shares with the staff. She uses her knowledge of professional standards of care and practice to evaluate programs and/or service activities regarding patient care and satisfaction. Her nursing practice is evidence based and grounded in the practice self and others with the American Nurses Association and Joint Commission guidelines.

Problem: Education and activation of Web VistA Remote Access Management (WebVRAM) for all RUR staff without cause a disruption in access and delay in workflow.

Action: ANM[redacted] coordinated and managed the onboarding of WebVRAM in coordination with the CPAC VRAM VistA support group and all nurses by providing email requesting information needed to initiate the process. After researching and obtaining additional information ANM[redacted] developed a WebVRAM RUR user guide available in word and PDF. The initial documentation from VistA support consisted of 54-pages but the guide developed by

ANM[redacted] consisted of 14-pages with detailed step-by-step instruction and images. Upon receiving the information needed via email and phone conversation to activate WebVRAM, ANM[redacted] initiated a Service Request Forms (SRF) for each nurse. During this process ANM [redacted] individually walked each nurse through the process to prevent disruption in access and to assist with completing urgent cases that needed to be completed is access was disrupted. She leads by example to ensure nursing excellence by encouraging staff to assist other team members during this process.

Outcome: Providing instructions and information in advance resulted in less than a 2% loss in access or downtime. ANM[redacted] continues to review the documentation available for the WebVRAM process to ensure staff remain up-to date on any additional evidence-based practices available for continued use.

Education/Career Development: ANM[redacted] graduated with a Master of Science in Nursing (MSN)with a specialization in Nurse Executive in May 2021, a Master of Business Administration (MBA) in June 2019, and a certification as a Legal Nurse Consultant in November 2021. She is VA Lean Green Belt trained and maintains current understanding of techniques, trends, and professional issues.

Example: ANM[redacted] applied for and was appointed as Chair of the MACPAC Diversity and Inclusion committee. As the D & I Chair she is responsible for supervising the presentation of EEO Special Emphasis Program and the Diversity and Inclusion Program which help to foster a model EEO environment in the workplace of approximately 7,500 employees. Prior to each monthly presentation to the staff, a presentation must be provided to the Executive Team by the Chair and Co-Chair. This date was always requested monthly and entered on the Executive team calendar for a preview to select the best date and time for the presentation. This would lead to scheduling conflicts and sometimes cancellation of the programs until the following month. After discussion with the MACPAC Director, it was determined that a standing day and time would simplify the process by adding the date in time to the Teams and Outlook calendar of those that needed to be present at the meeting.

Outcome: Monthly calendar reminders for the meeting were scheduled the first Wednesday of

each Month. The recruitment of three addition Special Emphasis Program Managers (SEPM) to assist with the staff training on diversity and inclusivity to align with the VA's strategic objective of maintaining a diverse workplace. Power-point-presentations, lectures, and visual aids were used for training. These are all effective learning tools which must be utilized to maintain a committed and diverse workforce.

C. Collaboration:

Collaboration:

Example: ANM[redacted]r model's partnerships with others that enhance patient care through interdisciplinary activities such as education, consultation, and management. She initiates and facilitates interdisciplinary work groups to identify, analyze and resolve care problems affecting patient care at the program/service/organizational level. Her collaborative efforts allowed her to identify a trend in patient complaints and a negative perception from veterans regarding access to billing services on facility campus. ANM[redacted] collegial philosophy and approach to problem solving improved the work environment not only within the RUR staff but with other MACPAC and CPAC staff.

Problem: While acting as the on-site manager for CAVHCS Facility Revenue (FRT) staff, ANM Parker investigated several complaints that were received from veterans, stating they were being sent all over CAVHCS- West Campus to either pay or inquire about bills they had received. She discovered that there were individuals on the east campus that were responsible for the bill payment process and individuals that were occasionally on west campus for bill payments.

Action: ANM[redacted] conducted an analysis of data from facility revenue and financial management services to identify delivery of service problems. ANM[redacted] initiated and facilitated interdisciplinary meetings in collaboration with Facility Revenue and Financial Management Services to identify areas for improvement and discuss patient's difficulties. Initiation of a RPIW, led to the development and implementation of a delivery of service improvement action plan to organize aggressive outreach missions to assist veterans and prevent decrease in customer service. This process possessed favorable organizational outcomes to VA customers needing to make payment or discuss items on bills.

Outcome: The payment and discussing of bills have been streamlined and stakeholders now have a clear understanding of their roles. A handout for the veterans provides them with valuable information and an overview of the billing program and process. The guide includes contact information, therefore, making it easier for veterans to make payments or inquire about inconsistencies on their bills. The processes put in place have continued to show sustained improvements for more than 2 consecutive quarters and are continuously monitored to ensure continued sustainability.

Collegiality: ANM[redacted] train and led a team of RUR nurses. Through her work with developing increased team effort, she realized that differing levels of experience can hinder unity. ANM[redacted] researched team building techniques and utilized an evidence-based teamwork system that optimized patient satisfaction by improving communication.

Outcome: ANM[redacted] led by example by sending daily messages of encouragement and giving herself an assignment during the absence of staff or during staffing shortages. ANM [redacted] reinforced that each nurse if placed in the same situation should and hopefully would perform similarly. ANM[redacted] extensive background in Nursing Management/Leadership and her nursing practice using evidence-based standards of care acts as a teaching tool by example for other RUR nurses and CPAC staff. This strategy can be taught and learned by motivated nurse in the best interest of patient care and service. This team concept has demonstrated greater cohesiveness as evidenced by lower levels staff complaints, fewer call outs, and increased customer satisfaction.

D. Scientific Inquiry:

Quality of Care: ANM[redacted] provides leadership and guidance in performance improvement by identifying and making correction action for the Legal Automated Work System (LAWS) deficiencies. LAWS is an official legal SharePoint based communication tool utilized by CPAC and Office of General Counsel (OGC) staff to communicate tortfeasor, no fault, and workers compensation case information to the respective functional areas.

Problem: Cases on the LAWS SharePoint were past processing timeframe. These cases were also being processed by assigned staff members numerous times leading to a delay in processing

for collection. ANM Parker discovered the delay was occurring because areas that needed to work by the RUR staff during the LAWS process was not being worked simultaneous by all nurses. This was leaving cases in various phases of the workflow without being completed. When a case has been settled by the veteran's attorney without the information needed from the LAWS SharePoint there is a loss of revenue to the facility and MACPAC. The large volume of incomplete cases also led to increased concerns from the MACPAC Director, OGC, attorney offices, and other staff involved in processing the cases. The following concerns and suggestions were also stated:

• Cases were backlogged and output called "unsatisfactory and is placing the veteran's legal case at great risk" by VA Office of General Counsel Revenue Law Group. External law offices were sending inquiries through numerous channels without results

• High volume of emails requesting cases to be expedited due to loss of revenue.

• Unable to negotiate veteran settlements since cases are not being processed by RUR. Calls are also being unanswered. Per another law office "I am following up on Ms. H's billing. It has been almost 7 months since your office received our request for Ms. H's billing records. I just tried calling your number and it rings with no voicemail. We cannot complete Ms. H's settlement negotiations without this billing.

• Instructions being given to work cases were unclear

• Received email from attorney on behalf of his 98-year-old WWII veteran that was attacked by a dog that became infected stating "lawsuit and my client's claim are frankly being prejudiced at this point, and we have been more than patient and are under serious time constraints with a trial court judge. We have no way to resolve this case with a reimbursement request of an unknown amount looming in the background". Per lawyer "lawsuit was filed to attempt to preserve the statute before the original statute ran, but we have now discovered that the defendant passed away so we will have some complications and trial court and probate issues to address very soon" Since the client passed the lawyer representing the veteran "a lawsuit of one person's estate vs another person's estate over a years old dog bite incident. That would dramatically lower the possible value of the

case which would bring down the likelihood of being able to reimburse the VA to a very low likelihood. A normal dog bite case is very difficult to win and prove damages with an insurance adjuster, defense attorney and/or jury, but when you add in the possibility of one estate vs another estate on a years old dog bite their little chance of any recovery of any significance.

• Per another law firm "we previously filled out this same form and faxed it in July and I forwarded it again and faxed it yesterday. We got a response saying more information was needed so we have completed the same form and sent it back. We have a hearing approaching on 10/12 and need to obtain the VA billing related to this incident."

• Cases were ready for litigations but RUR review were not complete after receiving numerous email request to expedite.

• Cases not able to be added to calendar by attorney due to backlog of cases

• Per the Chief counsel at OGC "It's clear that our current processes just don't seem to be working, and it's easy to see everyone's frustration. I look forward to working with you and our MACPAC colleagues on short- and long-term solutions. In the short-run, I would truly appreciate getting this case wrapped up as multiple RLG attorneys and paralegals are spending a lot of time on the phone with angry callers"

• Per OGC staff attorney "I know that you are aware of the issues with Atlanta, but I wanted to be sure that you were aware of how extensive the RUR issue is. This is one of a myriad of cases that is now over the -100 day mark, that I have repeatedly followed up on with the facility since July, without any response or movement in the case. The pervasive issues in Atlanta will create issues with the VA's relationship with veteran attorneys and veterans themselves if we are continuously unable to issue billing in a timely manner.

Action: Utilize innovations and a creative approach to change the RUR, FRM, FRT, and OGC practices based on performance findings. ANM[redacted] made recommendations for changes that would be needed to sustained improvements after evaluating the clinical guidelines for the LAWS. Those changes included increased communication with the LAWS specialty team,

FRT'S, FRM; ANM[redacted] provided weekly assignment specific spreadsheet to RUR nurses on LAWS specialty team; work urgent cases first to clear from worklist and as needed to keep clear; and work cases according to the number of medications, prosthetics, and non-VA count.

Outcome: ANM[redacted] tracked outcomes and reported results to the MAPCPAC Director, OGC, RRM, FRM, and RUR nurses to sustain performance improvement. Equally dividing the workload of the specialty team resulted in a over 90% decrease in the number of urgent cases leading to increase payment of revenue. Her encouragement of increased communication developed a greater understanding of workplace teamwork leaving little room for mistakes, misunderstandings, and conflicts. The monitoring of the workload of the LAWS SharePoint will continue with frequent discussions and reviews until all cases have been completed for all sites. ANM[redacted] will continued ensure all staff remains proficient in this area.

Research: ANM[redacted] demonstrate a leadership role by maintaining the MACPAC Reason for Change (RFC) provider education program within the CPAC utilizing current literature from the Department of Veterans Affairs Public Health page, TMS, and evidence-based reliable peer reviewed articles.

Problem: A number of providers had a high rate of SC/SA error on encounters when providing care to veterans. Visits incorrectly not being service connected or NSC/NSA was leading to veterans being charged co-payments based on their disability rating, income level, or special eligibility factors. Visits being incorrectly marked as service connect can lead to a lost in revenue for the VAMC facility since the veteran is not charged for service-connected visits. But when a veteran with other health insurance is seen for a non-service-connected condition the RUR nurse contacts the third-party payer to obtain authorizations for care to receive payment for services provided.

Action: ANM[redacted] track and monitor incorrect medical provider service connection determinations using the Reason Not Billable RFC report and provide training to providers quarterly reviews for four MACPAC facilities. The RNB RFC reports, proof of provider education forms, type of education, and provider education log are then annotated on the CPAC provider education SharePoint log by ANM[redacted]. She is a champion leader who works

diligently using pamphlets and PowerPoint presentations to educate providers and staff within the twenty-one MACPAC facilities on the importance of proper service connection determination.

Outcome: The quarterly reports resulted in a direct positive outcome through the reduction of the service connection determination error rate. ANM[redacted]was instrumental in obtaining the desired outcome of passing the annual review on the RUR Internal Control Audit retest after the previous audit received a significant deficiency, repeat recommendation, and was an OIG External Audit area of review. The revenue these encounters bring back to the VAMCs allow each VAMC to continue operation and provide improved care programs to veteran at a reduced cost. Researching and continuous one on one provider teaching has given care providers a better understanding of the service connection determination process.

References

Feldman, J., DeBofsky, M., Plakun, E. M., & Potts, C. (2021). Providing a Routine Medical Necessity Letter to Improve Access to Care for Our Patients. *Journal of psychiatric practice*, *27*(4), 288–295. https://doi.org/10.1097/PRA.0000000000000563

Gonzales, K., & Stoltman, A. (2020). Optimization of faculty practice. *Journal of professional nursing: official journal of the American Association of Colleges of Nursing*, *36*(1), 56–61. https://doi.org/10.1016/j.profnurs.2019.06.013

I acknowledge and concur with this memorandum.

[redacted]

RECONSIDERATION REQUEST:
MACPAC Assistant Nurse Manager (ANM)[redacted] MSN MBA RN LNC

Practice

1. **Practice: Provides leadership in the application of the nursing process to client care, organizational processes and/or systems, improving outcomes at the program or service level.**

→ met with initial submission

2. **Ethics: Provides leadership in identifying and addressing ethical issues that impact clients and staff, including initiating and participating in ethics consultations.**

ANM[redacted] leadership includes initiating, participating, and advocating for all patients. She identified and addressed ethical issues that impacted patients, family members, and health care providers that need help in making ethically significant decisions. She is aware that nurses must act to promote inclusion of appropriate individuals in all ethical deliberation. ANM[redacted] is cognizant of the general goal of health care ethics consultations She understands that the purpose and importance of ethics consultations are to improve the quality of health care through the identification, analysis, and resolution of ethical questions or concerns (Hoskins, Grady, and Ulrich, 2018). ANM[redacted] understands that effective ethics consultations promote practices consistent with ethical norms and standards; helps to foster consensus and resolve conflict in an atmosphere of respect; honors participants' authority and values in the decision-making process; and assists individuals and the institution in handling current and future ethical concerns by providing education in health care ethics, informing policy development, quality improvement, and the appropriate utilization of resources. In accordance with ANA Code of Ethics Provision 4.3 (Olson and Stokes, 2016), ANM[redacted] understands that nurses must bring forward difficult issues related to patient care and/or institutional constraints upon ethical practice for discussion and review.

Problem: The insurance peer-to-peer review (P2P) is one important strategy used to avoid or reduce claim denials and therefore prevent revenue loss. The insurance peer-to-peer review is a scheduled phone conversation during which an ordering physician discusses the need for a procedure or drug with the insurance company's medical director to obtain a prior authorization approval or appeal a previously denied prior authorization. This phone conversation typically lasts just five to ten minutes and is usually required within 24-72 hours from when the request for authorization of care was made by the RUR nurse. If no contact is made by the provider, the case can be closed and denied.

MACPAC had a high volume of delays in timely follow up by providers to requested insurance peer to peer (P2P) reviews to prove medical necessity of services being requested. These delays were leading to increased denial of patient test and procedures. According to the Agency for Healthcare Research and Quality (2021), delays in care can have several unintended consequences including poorer outcomes for patients subject to the delay and adverse impact on acute care inpatient discharge/flow resulting in unnecessary prolonged acute-care length of stay.

Action: After researching and analyzing collected information, ANM[redacted] recognized the need to create a systematic way on how to approach this ethical issue. In accordance with American Medical Association (AMA) Code of Medical Ethics Opinion 1.1.6, physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable. The National Academy of Medicine included timely access as 1 of the 6 fundamental attributes of high-quality primary care, recognizing that without it, even care that is compassionate and technically sound may not matter (Kaboli & Fihn, 2019).

ANM[redacted] reached out to the MACPAC nurses that she supervises and found across the VISN's all facilities were having the same issues and concerns. After several meeting to discuss this issue with the VISN 7 Transfer-Utilization Management Coordinator, ANM [redacted] initiated contact with the Utilization Management (UM)Nurse and Chief of Staff (COS) at each VISN 7 facility to determine a point of contact to carbon copy (cc) on each provider P2P email. During the conversation with each UM nurse and COS, ANM[redacted] was able to provide an evidence-based knowledge of the Revenue Utilization Review (RUR) system and Department of Veterans Affairs regulatory requirements. ANM[redacted] then created a excel spreadsheet for the MACPAC nursing staff and added it to the main page of the RUR SharePoint to enhance the professional interaction between the providers, UM nurses, and MACPAC nursing staff. She also created a follow up letter to send to providers via email that do not respond to the P2P request within 24-48 hours. This information was disseminated to staff via email and during the monthly MACPAC RUR staff meeting.

Outcome: The outcome has been that of increased uniformity of practice within the MACPAC RUR Department, as well as ensuring timely reviews, reduction in denials of patient test and procedures, and improved communication between the MACPAC RUR staff and the facility staff. There is a 100% compliance from the providers when completing request received via email from the MACPAC RUR staff. The providers are responding with person they spoke with on call, authorization number, and dates of authorization. ANM [redacted] continues to reevaluate this process improvement initiative by collecting and analyzing data in weekly increments.

Example of Peer-to-Peer Email to Providers

I am in the process of doing a follow up on a Peer to Peer (P2P) request from the Revenue Utilization Review (RUR) nursing staff that has not received a response from the VA physician or caregiver that ordered the services. These requests are made by the insurance company or payer to ensure appropriate care is being delivered or has been delivered to the veteran. The insurance company/payer uses the report to make an informed and appropriate decision regarding the next steps to take. Possible steps include request for modification of the treatment plan, continuation of the treatment plan without any change or denial of payment for an ordered treatment.

By law, VA can bill an eligible Veteran's private health insurance company for care furnished or paid for by VA for a nonservice-connected condition. For the purposes of billing, a Veteran's

health insurance company is known as a Third-Party Payer (TPP). The reimbursements received from TPPs supplement appropriations by Congress to pay for VA health care. TPPs must pay VA billed charges or the amount TPPs pay commercial providers for the same services in the same geographic area, which is subject to verification by VA. TPPs aren't subject to a rate verification so long as they pay billed charges. (Code of Federal Regulations Title 38 §17.101, *Collection or Recovery by VA for Medical Care or Services Provided or Furnished to a Veteran for a Nonservice-Connected Disability*.)

Peer to peer reviews can reduces medical costs by identifying and avoiding costly and ineffective medical treatment. When the insurance provider speaks with the ordering provider, they are able to gain an expert medical opinion from the treating provider or team member that provided care to that patient. They also provide the payer with an objective and credible medical opinion they can use when making payment decisions.

Any assistance given to complete this P2P process by calling the insurance provider is appreciated. I am also adding the information that was sent by the RUR nurse on (*date nurse sent email to provider).*

*Attach email from RUR nurse at bottom of email being sent with date and time highlighted.

3. **Resource Utilization: Manages program resources (financial, human, material, or informational) to facilitate safe, effective, and efficient care.**

→ **met with initial submission**

Professional Development

1. **Education/Career Development: Implements an educational plan to meet changing program or service needs for self and others. Maintains knowledge of current techniques, trends, and professional issues.**

→ **met with initial submission**

2. **Performance: Uses professional standards of care and practice to evaluate programs and/or service activities.**

→ **met with initial submission**

Collaboration

1. **Collaboration: Uses the group process to identify, analyze, and resolve care problems.**

→ **met with initial submission**

2. **Collegiality: Coaches colleagues in team building. Makes sustained contributions to health care by sharing expertise within and/or outside the medical facility**

→ **met with initial submission**

Scientific Inquiry

1. **Quality of Care: Initiates interdisciplinary projects to improve organizational performance.**

→ **met with initial submission**

2. **Research: Collaborates with others in research activities to improve care.**

ANM[redacted] provided leadership in developing and evaluating a program of research/research utilization activities in nursing and worked with other staff, disciplines, academia, and/or peers to adhere to protocols of evidenced based practices. She used scientific methodology to analyze and evaluate the effectiveness of current standards of care and practice. ANM[redacted] utilized her findings to identify alternatives to existing clinical practice to develop and implement a plan for changing care and/or practice. She provides leadership in utilizing the best available evidence, including research studies to validate or change work group practice decisions. In accordance with ANA Code of Ethics Provision 7.1, she continually reads, evaluates, and incorporates current research relevant to nursing practice.

Problem: The Revenue Utilization Review (RUR) Internal Controls/Process is tested annually during selected quarter of the fiscal year for operating effectiveness by the Internal Audit Program Analyst. The objectives of testing are to evaluate the operating effectiveness of the Internal Control (IC) detailed in the RUR Guidebook. These IC audits provide Reasonable Assurance for effectiveness and efficiency of operations; reliability of reporting for internal and external use; and compliance with applicable laws, regulations, and policies in education. The RFC Control Language and SOP were approved on 12/3/18. ANM[redacted] was assigned to maintain the MACPAC Reason for Change (RFC) provider education report on 09/17/2021 by the NM because previous IC audits were receiving Significant Deficiency (SD) ratings. A Significant Deficiency is an Internal Control Deficiency, or combination of Internal Control Deficiencies, important enough to merit attention by those charged with governance.

Numerous providers at the 21 facilities within MACPAC had a high volume of SC/SA error on encounters when providing care to veterans. Visits incorrectly marked as non-service connected was leading to veterans being charged co-payments based on their disability rating, income level, or special eligibility factors. When a veteran with other health insurance is seen for a non-service-connected condition the RUR nurse contacts the third-party payer to obtain authorizations for care to receive payment for services provided. Visits being incorrectly marked as service connect can lead to loss revenue for the MACPAC VAMC facilities since the veteran is not charged for service-connected visits.

Action: ANM[redacted] collaborated with MACPAC nursing staff and researched peer reviewed articles with known positive outcomes regarding provider education and documentation. She created an informative letter, that is sent as an email to all providers with a high number of errors. This letter utilizes current literature from the Department of Veterans Affairs Public Health page, TMS, and evidence-based reliable peer reviewed articles. She also researched InterQual criteria and how to utilize International Classification of Diseases (ICD) codes to maximize the opportunities for revenue reimbursement. According to Lorenzetti, et al. (2018), positive documentation outcome can also be achieved through audits, feedback, and reminders. The letter created by ANM[redacted] utilized the following clinical documentation improvement (CDI) guidelines (Towers, 2013):

- **Know the audience-** include Interns, residents, fellows, and mid-level providers with upper-level providers in the process. Everyone needs to be educated on the process and outcome.

- **Explain Why If questioned-** provide explanation by phone, email, or teleconference to give a better understanding and to fully embrace the concept. Explanations should be short and cogent explanation available either verbally or written.
- **Incorporate CDI in the provider workflow –** suggest using templates and reminders provided by electronic health record being utilized by the facility. Discuss the importance of including correct ICD codes to facilitate billing.
- **Provide meaningful data and feedback –** Provide queries and data related to correct and incorrect documentation.

Outcome: There has been a significant decrease in RFC errors and all Reason for Change UR-4-B audits have passed compliance with no significant deficiencies since ANM [redacted] was assigned to maintain the report. Previous audits received a significant deficiency result requiring retest, and recommendation. ANM[redacted] realized after being assigned the RFC audits that utilized the Random (RAND) function in excel to perform a random selection of the sites provided a better opportunity to review and reevaluate previous sites and providers. Previous audit received a significant deficiency result requiring retest, and recommendation. A provider in Asheville (ASH) had 38 errors on 11/29/2021. Through random selection on 06/30/2022, ASH was selected and that same provider only had 20 errors. The average number of provider errors for all data collected and enter to the provider education/RFC SharePoint for MACPAC is 25 or less, showing this provider was below the average number of errors. Tracking the provider error for reevaluation is not included in the RFC Control Language and SOP but ANM[redacted] realize this data is needed to monitor the providers understand of the service connection determination process. Collecting, analyzing, and providing feedback to those providers allow ANM[redacted] to have more one-on-one time with providers that may be having difficulties. This feedback also helps promote initiative and assist in increasing revenue.

Provider RFC Data

The attached spreadsheet (Table 1) includes the facilities reviewed, the provider, the provider department, number of errors, and the date of review. The provider mention in the outcome has been highlighted on the attached spreadsheet.

RUR Internal Controls/Process Results and Recommendations (2019-2022)

CONTROLS EVALUATION TABLE	
Code to Colors – Control Operating Effectively	
Code to Colors – Control Not Operating Effectively	
Code to Colors – Not Tested	

OIG – Office of Inspector General
SD – Significant Deficiency

FY-20, Q4 testing (01/01/2019-09/30/2020)

Education Function		
UR-4-A	Provide Education/Training to Clinical Providers and other Applicable Stakeholders. (OIG)	SD
UR-4-B	Reason Not Billable (RNB), Reason for Change (RFC) report review. (OIG)	SD

6. **Review the RNB RFC report quarterly to track and monitor incorrect medical provider SC determinations.**

   Criteria: UR 4-B – Managerial Control
   Who: RUR Nurse Manager
   What: Performs Quarterly review of the RNB RFC report.
   How: Track and monitor incorrect medical provider Service connection determinations using the RNB RFC report and coordinate training.
   When: Quarterly on 4 VAMCs.
   Where is the Evidence: RNB RFC reports, Provider Education Form: Annotate Type of Education as (RFC), and CPAC Provider Education Log.

   Control Language and SOP were approved by the SAT on 12/3/18, but the information has not yet been updated in the RUR GB.

Condition: This is an OIG External Audit area of review. Evidence was requested from the RUR Nurse Manager for the RNB RFC report review conducted during FY-20, Q3. The Manager stated that the review had not been performed.

Cause: The RUR Manager advised:
The RNB RFC report was not run due to oversight.

Effect: If incorrect medical provider SC determinations are not tracked and monitored then accurate training cannot be provided to address identified issues.

Recommendation: Review the RNB RFC report quarterly to track and monitor incorrect medical provider SC determinations.

FY-21, Q4 testing (10/1/2020-09/30/2021)

Education Function		
UR-4-A	Provide Education/Training to Clinical Providers and other Applicable Stakeholders. (OIG)	SD Repeat
UR-4-B	Reason Not Billable (RNB), Reason for Change (RFC) report review. (OIG)	SD Repeat

4. **Monitor incorrect medical provider SC determinations using the RNB RFC report and annotate RFC training on the CPAC Provider Education Log.**

Criteria: UR 4-B – Managerial Control
Who: RUR Nurse Manager.
What: Performs Quarterly review of the RNB RFC report.
How: Track and monitor incorrect medical provider Service connection determinations using the RNB RFC report and coordinate training.
When: Quarterly on 4 VAMCs.
Where is the Evidence: RNB RFC reports, Provider Education Form: Annotate Type of Education as (RFC), and CPAC Provider Education Log.

Control Language and SOP were approved by the SAT on 12/3/18, but the information has not yet been updated in the RUR GB.

Condition: This is Repeat Recommendation and an OIG External Audit area of review. Evidence was requested from the RUR Nurse Manager for the RNB RFC report review performed during FY21, Q3. The RNB RFC review had been performed during Q3; however, "RFC" had not been annotated as the type of education on the Provider Education Log.

Cause: The RUR Manager advised:
The quarterly report had been completed as referenced by the RNB RFC reports submitted and this is the same way RUR completed this last year. RUR provided monthly education through New Provider Orientation in most if not all facilities as well as direct conversations with Facility COS's. RUR does this regularly but does not have a share point for this type of documentation. However, monthly Provider Education is documented in our RUR SharePoint. The required SharePoint to be used by MACPAC RUR was something RUR was unaware of, but adjustments have been made to get this completed correctly going forward.

Effect: If incorrect medical provider SC determinations are not tracked and monitored then accurate training cannot be provided to address identified issues.

Recommendation: Monitor incorrect medical provider SC determinations using the RNB RFC report and annotate RFC training on the CPAC Provider Education Log.

FY 22, Q4 (10/01/2021-09/30/2022)

Education Function		
UR-4-A	Provide Education/Training to Clinical Providers and other Applicable Stakeholders. (OIG)	
UR-4-B	Reason Not Billable (RNB), Reason for Change (RFC) report review. (OIG)	

No recommendations needed. Evaluation of the operating effectiveness of the IC system detailed in RUR Guidebook (Version 3.3) for Education Function UR-4-B was met.

Table 1

Provider RFC Data

Facility	Provider	Department	Errors	Date of Review
MRT	[redacted]	Allopathic & Osteopathic Physicians	20	4/6/2023
ASH	[redacted]	Allopathic & Osteopathic Physicians	14	6/30/2022
MRY	[redacted]	Podiatric Medicine & Surgery	20	6/30/2022
CLA	[redacted]	Allopathic & Osteopathic Physicians	8	4/5/2022
DUR	[redacted]	Nursing Service Providers	16	4/6/2023
MRT	[redacted]	Allopathic & Osteopathic Physicians	20	4/6/2023
SBY	[redacted]	Allopathic & Osteopathic Physicians	43	12/13/2022
TUS	[redacted]	Physician Assistants & Advanced Prac	22	12/6/2022
CAV	[redacted]	Allopathic & Osteopathic Physicians	26	4/7/2023
CAV	[redacted]	Behavioral Health & Social Service	22	4/7/2023
CLA	[redacted]	Allopathic & Osteopathic Physicians	12	6/30/2022
HUN	[redacted]	Nursing Service Providers	20	10/29/2021
BHM	[redacted]	Allopathic & Osteopathic Physicians	35	2/25/2022
CAV	[redacted]	Allopathic & Osteopathic Physicians	24	4/7/2023
MRY	[redacted]	Allopathic & Osteopathic Physicians	19	6/30/2022
MRY	[redacted]	Physician Assistants & Advanced Prac	33	4/4/2022
CAV	[redacted]	Physician Assistants & Advanced Prac	29	4/7/2023
CLA	[redacted]	Physician Assistants & Advanced Prac	15	6/30/2022

MRY	[redacted]	Respiratory, Developmental, Rehabil	20	6/30/2022
SBY	[redacted]	Allopathic & Osteopathic Physicians	26	12/13/2022
DUB	[redacted]	Allopathic & Osteopathic Physicians	25	4/4/2023
ASH	[redacted]	Allopathic & Osteopathic Physicians	74	6/30/2022
CAV	[redacted]	Allopathic & Osteopathic Physicians	45	4/7/2023
DUR	[redacted]	Allopathic & Osteopathic Physicians	15	4/6/2023
AUG	[redacted]	Allopathic & Osteopathic Physicians	5	6/30/2022
ATL	[redacted]	Allopathic & Osteopathic Physicians	7	12/30/2021
HAM	[redacted]	Allopathic & Osteopathic Physicians	29	2/25/2022
DUR	[redacted]	Allopathic & Osteopathic Physicians	21	4/6/2023
CAV	[redacted]	Allopathic & Osteopathic Physicians	20	4/4/2023
DUB	[redacted]	Behavioral Health & Social Service	33	4/4/2023
AUG	[redacted]	Physician Assistants & Advanced Prac	5	6/30/2022
DUB	[redacted]	Allopathic & Osteopathic Physicians	26	4/4/2023
DUR	[redacted]	Physician Assistants & Advanced Prac	19	4/6/2023
ASH	[redacted]	Allopathic & Osteopathic Physicians	38	11/29/2021
ASH	[redacted]	Allopathic & Osteopathic Physicians	20	6/30/2022
WAS	[redacted]	Allopathic & Osteopathic Physicians	35	4/4/2022
BHM	[redacted]	Allopathic & Osteopathic Physicians	34	2/25/2022
CAV	[redacted]	Allopathic & Osteopathic Physicians	39	4/4/2023
BHM	[redacted]	Allopathic & Osteopathic Physicians	45	2/25/2022

DUB	[redacted]	Physician Assistants & Advanced Prac	27	4/4/2023
DUR	[redacted]	Allopathic & Osteopathic Physicians	17	4/6/2023
CAV	[redacted]	Physician Assistants & Advanced Prac	30	4/4/2023
CAV	[redacted]	Allopathic & Osteopathic Physicians	27	4/4/2023
TUS	[redacted]	Behavioral Health & Social Service	20	12/6/2022
TUS	[redacted]	Physician Assistants & Advanced Prac	22	12/6/2022
Average number of errors per provider			24.9	

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