Department of Veterans Affairs

Office of Inspector General

REVIEW OF ALLEGATIONS INVOLVING OPERATIONS OF THE VA COMMUNITY-BASED OUTPATIENT CLINIC SOUTH BEND, INDIANA

Report No. 00-01199-135
Date: September 4, 2001

Office of Inspector General
Washington DC 20420

Executive Summary

Review of Allegations Involving Operations of the VA Community-Based Outpatient Clinic South Bend, Indiana

The Office of Inspector General (OIG) reviewed hotline allegations related to the operations of the Department of Veterans Affairs (VA) community-based outpatient clinic (CBOC) at South Bend, Indiana. The clinic is under the supervision of the Northern Indiana Health Care System (NIHCS), Fort Wayne and Marion, Indiana. OIG staff visited the CBOC from August 7 to August 9, 2000.

We reviewed four hotline allegations regarding South Bend CBOC activities. These allegations were made during and after our March 2000 Combined Assessment Program (CAP) review of the facility. Only one of the allegations, involving the credentialing and privileging of CBOC staff, was substantiated, although two other issues arose during the hotline review.

Two recommendations resulted from this hotline review. They involved: (a) improving progress notes for CBOC patients' care in the Computerized Patient Record System and having the CBOC clinical case manager visit the CBOC regularly; and (b) developing a performance improvement program at the CBOC.

The Director concurred with both recommendations and provided acceptable implementation plans. Therefore, there are no unresolved issues in this report, although the OIG may follow up on implementation.

For the Assistant Inspector General for Auditing

(Original signed by Edward H. Kostro for:)

WILLIAM V. DEPROSPERO
Director, Chicago Audit Operations Division

Table of Contents

Introduction

The Northern Indiana Health Care System (NIHCS), Fort Wayne and Marion, IN, operated a community-based outpatient clinic (CBOC) in South Bend, IN. In April 1998, NIHCS management entered into a 1-year contract (with 2 option years) with a private health maintenance organization (HMO) to provide primary care to South Bend-area veterans.[1] Healthcare beyond the scope of primary care was referred to the NIHCS facility in Fort. Wayne. The estimated value of the contract was $1.5 million annually, or $36 per anticipated enrolled veteran per month. The HMO had several sites in the South Bend area, but 90 percent of the patients were seen at the Mishawaka facility. That site was an established family practice site that served non-VA patients at the same facility used to serve VA patients. The purpose of using an existing family practice clinic, rather than establishing a dedicated clinic for veterans was to enable both veterans and their families to obtain healthcare at one location.

Objectives and Scope

We conducted a Combined Assessment Program (CAP) review of the NIHCS in March 2000. That review identified administrative and quality of care concerns that were discussed in our May 25, 2000 report (Report No. 00-01199-72). However, during and after our CAP review, we received allegations that amplified and expanded on issues related to those reviewed in March. Consequently, in August 2000, we performed another review to determine whether those particular allegations were substantiated.

The allegations were:

1. That HMO staff billed Medicare for services that were provided to veterans under the auspices of the VA contract.[2]
2. That two particular HMO clinicians were not credentialed and privileged by the NIHCS.
3. That one HMO physician signed progress notes that a nurse practitioner (NP) had written so that the HMO could bill at a higher rate.
4. That one HMO physician was providing substandard health care to veterans.

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[1] *The CBOC contractor was located in South Bend, but the clinic consisted of several separate sites. For all administrative purposes, NIHCS staff regarded the CBOC as a single clinic. The particular site under review was actually located in Mishawaka, IN, a suburb of South Bend.*

[2] *With regard to this allegation, it is important to understand that the HMO did not "bill" VA for individual episodes of care provided to veterans. Rather, veterans were "enrolled" in the CBOC just as any veteran might be enrolled as a patient at a VA facility. VA paid a monthly "premium" to the HMO for each enrolled veteran, regardless of whether that veteran sought care at the CBOC or of the extent of any care actually provided.*

The scope of our review was limited to reviewing these four allegations to determine their validity and affect on patient care. We interviewed NIHCS and HMO employees and managers and reviewed documentation from both entities.

Results and Recommendations

Review of Allegations Involving Operations of the VA Community-Based Outpatient Clinic South Bend, Indiana

Allegation No. 1: That HMO staff billed Medicare for services that were provided to veterans under the auspices of the VA contract.

The allegation was **not substantiated.** Reviews of HMO medical and billing records of 50 veterans revealed that, in four instances HMO staff did bill Medicare for services provided to veterans. However, in three of the four cases the services that the HMO provided were not covered under its contract with the NIHCS.

In one case the services that the HMO provided and billed Medicare for went beyond primary care. The contract with the NIHCS covered only primary care services, and because neither the HMO nor the NIHCS could compel patients to seek non-primary care at VA's Fort Wayne facility, the HMO felt entitled to seek reimbursement from Medicare. In a second case, a patient received care from his personal private physician whose office happened to share the HMO's billing system. This gave a false indication to reviewers that the HMO had treated the veteran. In a third case, the patient was treated at an affiliate of the HMO, and the affiliate was not included in the contract with the NIHCS. Billing Medicare in these three cases did not constitute double billing as alleged.

In the fourth instance, the HMO did bill Medicare inappropriately for primary care provided to a veteran, in addition to being paid $36 per month by VA for the veteran's care. HMO business staff agreed that this billing was in error and agreed to make the necessary adjustment with Medicare. The error may have occurred because both the veteran and his non-veteran spouse, who was also an HMO patient, were listed in HMO records under the same account. HMO staff agreed to establish separate accounts for them.

Allegation No. 2: That two particular HMO clinicians were not credentialed and privileged by the NIHCS.

The allegation was **substantiated.** We reviewed CBOC documentation for patient encounters for a physician and a nurse practitioner (NP) for the period from January 1999 to June 2000. We also reviewed credentialing and privileging information for both individuals. Neither practitioner had been granted privileges to treat VA patients, even though they had been treating veterans during the 18-month period.

When asked why the physician had been allowed to treat veterans even though the NIHCS had not granted privileges to do so, HMO employees stated that the physician had been granted a waiver. They presented an undated, unsigned document as evidence of a meeting that had occurred at the HMO at which this issue was discussed. The document was entitled "VA Project Update" and stated that the physician "had been granted a waiver by VA and will be allowed to treat veterans; credentialing should be done by the end of next week." Content suggested that the document was generated prior to the point that the physician began treating VA patients.

No one from the NIHCS or the HMO could recall who might have awarded this waiver. The NIHCS Chief of Staff and the Chief of Patient Care Support Services stated that they were unaware that uncredentialed providers were seeing patients until approximately 6 weeks prior to this review in August 2000. However, we had discussed this issue with top managers during the March 2000 CAP review and in the May 2000 report of that review. NIHCS staff finally completed the physician's credentialing and privileging processing on August 3, 2000. Thus, we are not making a recommendation, although we note that it took approximately five months to correct a relatively simple problem.

Allegation No. 3: That one HMO physician signed progress notes that a nurse practitioner (NP) had written so that the HMO could bill at a higher rate.

The allegation was **not substantiated.** However, the procedures for entering electronic progress notes into the NIHCS' Computerized Patient Record System (CPRS) created errors that gave the impression of impropriety.

This allegation stemmed primarily from inaccurate progress note entries made into NIHCS' CPRS by an HMO physician. Even though NIHCS management was aware of electronic documentation problems, they did not attempt to confirm their suspicions about the physician's actions by conducting an on-site review of paper medical records maintained by HMO staff.

The process for electronically entering progress notes into the CPRS was complicated. The electronic entry process into the CPRS was as follows:

- HMO clinicians dictated their progress notes.
- A transcription company picked up the tapes, completed the transcription, and returned the notes to the HMO.
- A copy of the notes was electronically sent to a designated individual at the HMO.
- The responsible clinicians signed the paper progress notes, which were then placed into the HMO's medical records.

- The HMO employee who received the electronic progress notes entered them into the CPRS by downloading them into a word processing document and then cutting and pasting them into the CPRS.

As a result of this complicated process, frequent errors occurred. For example, progress notes were sometimes not entered under the correct providers' names. In addition, several other problems and legal concerns stemmed from this process:

- It gave the appearance that a physician was signing for care provided by an NP.
- Providers were not reviewing and electronically signing their own progress notes. Instead, an uninvolved HMO employee was entering the progress notes under the providers' names and then electronically signing the notes.
- Inaccurate progress notes were being entered into the CPRS, creating inconsistencies between the electronic medical records and the paper medical records.
- The providers' professional designation, such as "MD" (medical doctor) or "NP," did not appear after the providers' names in the progress notes.

Our review of paper medical records maintained by HMO clinicians showed that the appropriate provider had, indeed, signed the progress notes for each specific episode of care.

NIHCS and HMO employees told us that neither NIHCS management nor the CBOC clinical case manager conducted regular visits to the CBOC. This resulted in limited communication between the organizations and a decreased ability for NIHCS management to promptly or effectively address issues. Employees from both facilities stated that regular visits by the clinical case manager would be beneficial. Employees recalled that during the first year of the contract, both facilities' managers met regularly, but that such meetings no longer occurred, even though HMO employees had requested them. It appears that many of the issues discussed above could have been resolved if the two organizations had maintained open communications. One possible solution may be to give the transcriptionist the ability to send progress notes directly to the CPRS. HMO providers who treat VA patients would then be required to review and electronically sign their notes. Paper copies of the notes could also be placed in HMO medical records.

Allegation No. 4: That one HMO physician was providing substandard health care to veterans.

The allegation was **not substantiated**, although we did identify an issue that required corrective action.

NIHCS and HMO employees had implemented a quality management (QM) program that included procedures to report, review, and follow up on quality of care issues. However, due to the HMO's flawed process of electronically entering progress notes into the CPRS, progress notes were sometimes entered into the wrong patients' records, or the same progress notes were entered for two different patients, and peer reviews were erroneously attributed to the wrong provider. These problems led to the appearance of substandard patient care. A review of medical records, patient representative data, and peer review results did not reveal any problems with the quality of care provided to veterans by the provider.

However, there were problems with the way in which the HMO monitored quality of care, particularly for chronic diseases. The contract outlined 11 specific performance improvement (PI) measures to track and trend the quality of patient care at the CBOC, including Chronic Disease and Preventative Health Indices. At the time of our review, minimal QM data was being sent to NIHCS staff, and only one chronic disease indicator was being tracked and reported despite the fact that External Peer Review Program data showed the HMO to be a frequent outlier. While HMO management had begun providing QM data at the time of this review, it was not complete and was not in compliance with the contract.

Recommendation No. 1:

The NIHCS Director should ensure that:

a. Managers from the NIHCS and the HMO develop a process that will allow accurate entry of progress notes into the CPRS.

b. The CBOC clinical case manager visits the CBOC on a regular basis.

VA Northern Indiana Health Care System Director Comment

a. Concur. It should be noted that the HMO referred to was the previous CBOC contractor. A new contract for South Bend CBOC services was awarded in April 2001. NIHCS managers expanded the Medical Records Requirement portion of the Statement of Work to ensure timely, accurate entry of progress notes.

b. Concur. NIHCS expects to have various disciplines visiting the South Bend CBOC at various times, such as the case manager, CBOC coordinator, PI staff, and administrative staff to ensure compliance with the contract. We expect an NIHCS representative to visit at least quarterly, and more frequently as necessary.

Office of Inspector General Comment

The Director's comments and implementation plans are acceptable. We consider this issue resolved, although we may follow up on implementation actions.

Recommendation No. 2:

The NIHCS Director should ensure that NIHCS and HMO managers develop a comprehensive PI program that will provide aggregate data on the 11 PI measures that are specified in the contract, including all applicable Chronic Disease and Preventative Health Indices.

VA Northern Indiana Heath Care System Director Comment

Concur. It should be noted that the HMO and contract referred to by the OIG are the previous CBOC contractor and contract. A comprehensive PI program was included in the new South Bend CBOC contract awarded April 2001. This PI plan is similar to the plan already in effect at the Muncie CBOC and includes Clinical Practice Guidelines and Performance Measures, Infection Control, waiting times, patient satisfaction, clinical pertinence reviews, occurrence screens, medication errors, and risk management indicators. PI staff have provided education at the CBOC sites for staff and are monitoring compliance with indicators.

Office of Inspector General Comment

The Director's comments and implementation plans are acceptable. We consider this issue resolved, although we may follow up on implementation actions.

Other Issues

During the review, we identified issues that concerned the quality of patient care but that were not within the scope of the original allegations. These issues did not require formal recommendations, but were brought to management's attention to allow improvements in internal controls.

- NIHCS and HMO managers should develop a process to provide notification to NIHCS employees when a veteran chooses to use Medicare or private insurance for care that could be provided by the NIHCS. Such care may include mammography, dermatology services, or other care that is beyond the scope of the CBOC primary care contract. This would help avoid misunderstandings about appropriate delivery of services and billing issues.

- NIHCS and HMO managers should develop a process that will ensure that HMO clinicians schedule appointments for VA patients through the CPRS. The capability existed to do this, but was not being used, partly because the VA computer was not accessible at the HMO's front desk where employees make appointments. The VA computer should be located so that it is accessible to HMO scheduling clerks. Scheduling CBOC appointments in the CPRS will allow NIHCS staff to accurately monitor the number of visits that VA patients make to the CBOC.

VA Northern Indiana Health Care System Director Comments

Department of Veterans Affairs

Memorandum

Date: June 13, 2001

From: Director, VA Northern Indiana Health Care System (610)

Subj: Draft Report, VA Community Based Outpatient Clinic, South Bend, IN
Project No. 2000-01199-R4-0012

To: Assistant Inspector General for Auditing (52)

1. In accordance with your letter of May 31, 2001, our comments to the recommendations from your draft report are attached.

2. If you have any questions, please contact me at 219-460-1310.

E/S/ *Robert Beller*

For and in the Absence of
Michael W. Murphy, Ph.D.

Attachment

Automated VA FORM 2105

VA Northern Indiana Health Care System Director Comments (Continued)

VA Northern Indiana Health Care System response to Office of Inspector General Draft Report, Hotline Review – VA Community Based Outpatient Clinic, South Bend, IN – Project No. 2000-01199-R4-0012.

Recommendation No.1:

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b. The CBOC case manager visits the CBOC on a regular basis.

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b. Concur. NIHCS expects to have various disciplines visiting the South Bend CBOC at various times, such as the case manager, CBOC coordinator, performance improvement (PI) staff, and administrative staff to ensure compliance with the contract. We expect an NIHCS representative to visit at least quarterly, and more frequently as necessary.

Recommendation No. 2:

The NIHCS Director should ensure that NIHCS and HMO managers develop a comprehensive PI program that will provide aggregate data on the 11 PI measures that are specified in the contract, including all applicable Chronic Disease and Preventive Health indicators.

VA Northern Indiana health Care System Director Comments:

Concur. It should be noted that the HMO and contract referred to by the OIG are the previous CBOC contractor and contract. A comprehensive Performance Improvement Program was included, in the new South Bend CBOC contract awarded April 2001. This performance improvement plan is similar to the plan all ready in effect at the Muncie CBOC and includes Clinical Practice Guidelines and Performance Measures, Infection Control, waiting times, patient satisfaction, clinical pertinence reviews, occurrence screens, medication errors, and risk management indicators. Performance Improvement staff have provided education at the CBOC sites for staff and are monitoring compliance with indicators.

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