Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Salem, Virginia

Report No. 03-03210-109

March 18, 2004

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General
Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities and regional offices on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Conduct fraud and integrity awareness training for facility staff.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244

Contents

Executive Summary

Introduction

During the week of November 3-7, 2003, the OIG conducted a CAP review of VA Medical Center Salem, Virginia (the medical center) which is part of Veterans Integrated Service Network (VISN) 6. The purpose of the review was to evaluate selected operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 182 employees.

Results of Review

Facility Management Service (FMS) staff effectively developed and used an on-line tracking system for environment of care deficiencies. Information technology (IT) security controls were adequate and contingency and security plans were current and complete. Unliquidated obligations were reviewed monthly and cancelled when not needed. To improve operations, the VISN and Medical Center Directors needed to:

- Approve draft QM policies to ensure that annual performance improvement plans are implemented.
- Enhance billing procedures and improve physician documentation of resident supervision.
- Reduce excess supply inventories and strengthen inventory management controls.
- Strengthen accountability controls over controlled substances.
- Implement internal controls for patient transportation services.
- Develop procedures for requesting employee background investigations.
- Obtain and maintain current signed means test forms in veterans' administrative records.
- Fully document contract award decisions and price reasonableness determinations and establish better methods for validating services received prior to making payments.

VISN 6 and Medical Center Directors' Comments

The VISN 6 and Medical Center Directors agreed with the findings and recommendations and provided acceptable implementation plans (See pages 13-19 for the full text of the Directors' comments). We will follow up on the planned actions until they are completed. This report was prepared under the direction of William H. Withrow, Director, and Joseph T. Janasz, Jr., CAP Review Coordinator, Kansas City Audit Operations Division.

(original signed by:)
RICHARD J. GRIFFIN
Inspector General

Introduction

Medical Center Profile

Organization. Located in Salem, Virginia, the medical center provides tertiary care and a range of inpatient and outpatient health care services. Outpatient care is also provided at two community-based outpatient clinics located in Danville and Tazewell, Virginia. The medical center is part of VISN 6 and serves a veteran population of about 123,000 in a primary service area that includes 25 counties in Southwestern Virginia.

Programs. The medical center provides medical, surgical, and mental health services and maintains 110 acute care; 67 subacute care; 5 intermediate care; and 90 nursing home beds. The medical center also has 25 sharing agreements with 16 provider organizations for radiation therapy, teleradiology, dialysis, and specialty clinical staff services.

Affiliations and Research. The medical center is affiliated with the University of Virginia School of Medicine and the Edward Via Virginia College of Osteopathic Medicine and supports 45.7 medical resident positions in 9 training programs. For Fiscal Year (FY) 2003, the research program had 47 active projects and a budget of $489,000.

Resources. The medical center's FY 2003 medical care budget was $133.1 million, a 6.7 percent increase over the FY 2002 budget of $124.8 million. FY 2003 staffing was 1,260.3 full-time equivalent employees (FTEE), including 66.8 physician and 400.6 nursing FTEE. FY 2002 staffing was 1,276.8 FTEE, including 65.3 physician and 397.6 nursing FTEE.

Workload. In FY 2003, the medical center treated 28,693 unique patients, a 3.7 percent increase over FY 2002. The patient care workload for FY 2003 totaled 4,649 inpatients treated and 266,632 outpatient visits, which represented a decrease of 2.5 percent and a 2.3 percent increase, respectively, from FY 2002 workload (4,769 inpatients treated and 260,515 outpatient visits).

Objectives and Scope of the CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high-quality VA health care services. The objectives of the CAP review program are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care, QM, and financial and administrative controls.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and general management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered medical center operations for FYs 2002 and 2003 and was conducted in accordance with OIG standard operating procedures for CAP reviews.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered the following activities:

Accounts Receivable	Means Tests
Contract Award and Administration	Medical Care Collections Fund
Controlled Substances Accountability	Patient Transportation Services
Employee Background Investigations	Pharmacy Security
Environment of Care	Quality Management
Information Technology Security	Supply Inventory Management
Laboratory Security	Undelivered Orders

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of service and the quality of care. Questionnaires were sent to all medical center employees, 125 of whom responded. We also interviewed 38 inpatients and 22 outpatients during the review. The full survey results were provided to medical center management.

During the review, we presented three fraud and integrity awareness briefings for medical center employees. These briefings, attended by 182 employees, covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflict of interest, and bribery.

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of the report (page 3). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4-12). For these activities, we make recommendations or suggestions. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by VISN and medical center management until corrective actions are completed. For the activities not discussed in the Organizational Strengths or Opportunities for Improvement sections, there were no reportable deficiencies.

Results of Review

Organizational Strengths

Annual Program Review Provides a Tracking System For Environment of Care Deficiencies and Other Projects. The medical center developed an on-line tracking system for environment of care deficiencies that includes the description of the deficiency/project, necessary action, scheduled completion date, responsible party, and supporting documentation. All employees can access and report deficiencies using this program. FMS monitors this program in order to follow through on their respective areas of responsibility and ensure compliance with VA directives and Government regulations. This data is presented in meetings and shared with other service managers. FMS managers conduct periodic analysis of the deficiencies and the outcomes and, where applicable, develop cooperative efforts to improve the medical center environment of care.

IT Security Was Effective. The medical center had adequate IT controls to protect automated information system resources from unauthorized access, disclosure, modification, destruction, or misuse. Physical security for computer rooms and equipment was adequate and critical data was regularly backed up and properly stored off-site. Contingency plans, security plans, and risk assessments were current and complete, and annual computer awareness training was provided to employees as required.

Unliquidated Obligations Were Properly Monitored. Fiscal Service staff reviewed unliquidated obligations monthly, contacted the appropriate services to determine the continued validity of obligations, and promptly cancelled obligations that were no longer needed.

Opportunities for Improvement

Quality Management – Annual Performance Improvement Plans Needed To Be Developed

Condition Needing Improvement. The medical center generally had an effective QM program to monitor and improve the quality of care. However, annual performance improvement plans had not been developed for FYs 2002 and 2003. The medical center utilized various methods to analyze QM data, detect trends, and take actions to address identified issues. Administrative investigations, peer reviews, and root-cause analyses were appropriately conducted and corrective actions were implemented. Medical center managers demonstrated support for the QM program through participation in QM committees and root-cause analysis teams and by providing necessary resources to accomplish performance improvement initiatives. Employees were knowledgeable about quality improvement initiatives and participated on task forces to improve patient care activities and health care operations.

The existing structure of the medical center QM program did not provide for a centralized process that would ensure that all QM performance measures were prioritized into goals and objectives as part of an annual performance improvement plan. The QM Director drafted a new policy that would create a central quality council with responsibility for developing annual performance improvement plans that encompasses performance plans from all medical center services/service lines, as well as Veterans Health Administration (VHA) and VISN performance measures. We reviewed the draft policy and recommended its implementation to ensure that all medical center QM needs are fully considered and incorporated into annual performance improvement plans.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director implements the draft QM policy to ensure that annual performance plans are developed that encompass performance improvement plans from all services/service lines, as well as VHA and VISN performance measures.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that the services/service lines have developed an organizational performance improvement plan and implemented it through an approved Medical Center Memorandum. The plan establishes a quality council to monitor and improve performance initiatives. The improvement plan is acceptable and we consider the issue resolved.

Medical Care Collections Fund – Third Party Billing Procedures and Documentation of Resident Supervision Needed Improvement

Condition Needing Improvement. The medical center increased Medical Care Collections Fund (MCCF) collections from $5.6 million in FY 2001 to $7.3 million in FY 2002 and $9.1 million in FY 2003. However, medical center management could further improve MCCF program results by strengthening billing procedures for fee-basis care[1] and ensuring physicians adequately document the attending physicians'[2] supervision of residents[3] in the medical records. We found additional billing opportunities totaling $125,680.

Fee-Basis Care. From October 1, 2002 through August 31, 2003, the medical center paid 6,708 fee-basis claims totaling $375,783 to non-VA providers who provided medical care to veterans with health insurance. Payments included claims for both outpatient and inpatient care, and ancillary services related to the inpatient care. To determine whether the fee-basis medical care was billed to the patients' insurance carriers, we reviewed a judgment sample of 1,088 claims totaling $122,615. Of these 1,088 claims, 263 were not billable to the insurance carriers either because the fee-basis care was for service-connected conditions or the care was not billable under the terms of the insurance plans. The remaining 825 fee-basis payments were billable to the insurance carriers, but no bills had been issued. The bills were not issued because a reliable process was not in place to identify and bill for fee-basis care. At our request, MCCF staff reviewed these claims to determine what should have been billed. For nine cases, which involved high cost inpatient institutional charges, they determined that $89,320 should have been billed. For the other 816 cases, which involved less costly outpatient or ancillary services, MCCF staff told us that additional information was needed from the fee-basis providers to prepare bills for the insurance carriers. Using the fee costs as a basis, we estimated that additional billings totaling $32,384 could have been issued for these 816 cases.

VA Care. We reviewed 25 outpatient visits and found that MCCF staff appropriately billed for outpatient care provided at the medical center. However, we found missed billing opportunities related to inpatient care. In June 2003, 40 inpatient discharges were for veterans who had health insurance. To determine whether all appropriate care was billed, we reviewed 15 of these discharges. MCCF staff appropriately issued 59 bills totaling $209,950 for these discharges. However, we found that in four discharges, additional professional service fees totaling $1,104 were not billed because the medical record documentation was not adequate. In these cases, residents provided the care. VA guidelines state that care provided by residents can be billed only if the attending physicians' supervision of the residents is documented in the patients' medical records. MCCF staff determined that the medical records in the four cases did not contain adequate documentation of the attending physicians' supervision of the residents.

[1] Fee-basis care is medical care provided to veterans by non-VA providers. VA reimburses the non-VA providers for the care.

[2] An attending physician is a staff physician responsible for the patient care provided by resident physicians in training.

[3] A resident is an individual who is engaged in a graduate training program in medicine, dentistry, podiatry, or optometry, and who participates in patient care under the direction of attending physicians.

To further test the quality of documentation of resident supervision, we reviewed the medical center's *Reasons Not Billable Report*. This report identifies the reasons potential billings were cancelled. According to this report, which was compiled on October 21, 2003, during the period July 1 to September 30, 2003, 218 potential billings totaling $27,477 were cancelled with the reason code "non-billable provider (resident)". This reason code was used when a resident provided the medical care and the supervision of the resident was not adequately documented in the medical record. We reviewed nine cases and found eight totaling $2,873 that could have been billed if the medical records contained adequate documentation. The remaining case would not have been billable even if the documentation had been adequate because the medical care provided was for a service-connected condition.

Potential Collections. Improving billing procedures for fee-basis care and ensuring attending physicians adequately document supervision of residents will enhance revenue collections. We estimated that additional billings totaling $125,680 ($89,320 + $32,384 + $1,104 + $2,873) could have been issued for the cases discussed above. Based on the medical center's historical collection rate of 32.8 percent, MCCF staff could have increased collections by $41,223 ($125,680 x 32.8 percent).

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director requires that:

a) MCCF staff develop a process to identify and bill for care provided on a fee-basis.
b) The attending physicians' supervision of residents is adequately documented in the medical records.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that a process has been developed to identify potential billable fee-basis care and forward the information to MCCF staff for generation of the bill to the veteran or third party insurer. Coders have been placed in outpatient clinics and inpatient units to assist providers in improving documentation of resident supervision in the medical records. The improvement plans are acceptable and we consider the issues resolved.

Supply Inventory Management – Excess Inventory Needed To Be Reduced and Controls Strengthened

Condition Needing Improvement. The medical center needed to reduce excess inventories and make better use of automated controls to more effectively manage supply inventory. VHA established a 30-day supply goal and requires that medical centers use VA's Generic Inventory Package (GIP) to manage inventories of most types of supplies. Inventory managers can use GIP reports to establish normal stock levels, analyze usage patterns to determine optimum order quantities, and conduct periodic physical inventories. VHA also requires the use of the Prosthetics Inventory Package (PIP) to manage prosthetic inventory.

Supply Inventory. Supply Processing and Distribution (SPD) staff used GIP to manage and control supply inventory. However, they were not fully using GIP features to meet the inventory goal of 30 days. As of August 31, 2003, the 9 primary inventory control points included 2,049 items with a reported value of $844,921.

To test the accuracy of the inventory balances and reasonableness of inventory levels, we reviewed 20 items and found the following 2 deficiencies. First, the GIP value of stock was overstated. We conducted a physical inventory of the 20 items and found that for 12 items the counts did not agree with the balances shown in GIP. For the 20 items reviewed, the GIP-reported value was $62,373. However, the actual value of this stock was $24,469, which was only 39 percent of the GIP-reported value. Applying the 39 percent figure to the $844,921 value for the entire supply stock shown in GIP would yield an estimated value of $329,519.

Second, for 14 of 20 items reviewed, stock on hand exceeded a 30-day supply or was no longer needed. Only 7 of the 20 items had usage data recorded in GIP. For five of the seven items, the stock on hand exceeded a 30-day supply, with inventory levels ranging from 40 days to over 4 years of supply. The estimated value of stock exceeding 30 days for the five items was $7,149. For the remaining 13 items, GIP showed there was no usage for these items during the 12-month period ending August 2003. This occurred because staff removed items from inventory but did not record this action in GIP, or the items were not used. At our request, the Chief, SPD, reviewed these 13 items and determined that 8 items had stock on hand totaling $4,724 that exceeded a 30-day supply and 1 item totaling $345 that was no longer needed. The estimated value of stock exceeding 30 days or not needed was $12,218 ($7,149 + $4,724 + $345), or 50 percent of the total value of the 20 items ($24,469).

The inaccuracies in GIP and excess stock on hand occurred because for three of the nine primary inventory control points, medical center staff did not record usage. Also, staff was not properly recording transactions, monitoring usage rates, or adjusting GIP stock levels in the other six control points to meet the 30-day standard. In addition, there was no documentation that the required annual wall-to-wall inventories were conducted for seven of the nine primary inventory control points. Because GIP data was inaccurate, we could not determine the value of stock on hand or the value of excess stock for the entire inventory. However, by applying the 50 percent of excess stock for the sampled items to the entire stock, we estimate that the value of excess stock was about $164,760 (50 percent x $329,519 estimated value of stock).

Prosthetic Inventory. Prosthetics Service staff used PIP to control inventory. To determine the accuracy of the inventory balances shown in PIP, we inventoried five items and found that counts for two items did not agree with the inventory balances shown in PIP. In both cases the amount actually on hand was greater than the balance shown in PIP. As a result, prosthetics inventory was understated by $1,380. According to the Assistant Chief, Prosthetics Service, staff had not updated PIP to reflect the return of one item. He was unable to explain why the other item was understated.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director requires:

a) SPD to reduce supply inventory to the 30-day supply goal and improve the accuracy of GIP.
b) SPD to conduct and document annual wall-to-wall inventories.
c) Prosthetics Service to improve the accuracy of PIP.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that SPD inventory would be reduced to a 30-day supply by February 27, 2004. In addition, SPD staff will conduct and document annual wall-to-wall inventories by March 31, 2004, and Prosthetics Service staff have corrected PIP. The improvement plans are acceptable and we will follow up on the planned actions until they are completed.

Controlled Substances Accountability – Selected Controls Needed Improvement

Condition Needing Improvement. The Pharmacy Manager needed to strengthen controls to fully comply with VHA policy and help ensure accountability of controlled substances. The following deficiencies were identified:

- Inventories of Schedule III, IV, and V controlled substances were not verified every 72 hours.

- Access to the controlled substances vault was not limited to less than 10 employees within a 24-hour period.

72-Hour Inventories of Controlled Substances. VHA policy requires a perpetual inventory of all controlled substances that is verified by Pharmacy Service staff at a minimum of every 72 hours. Our review of the inventory records found that during the 3-month period ending September 30, 2003, Pharmacy Service staff had completed the inventory for Schedule II controlled substances as required; however, for Schedule III, IV, and V controlled substances, 72 hours elapsed on 11 occasions without inventories being taken. The elapsed time between inventories for these 11 occasions averaged 95 hours and ranged from 90 to 99 hours. The 72-hour inventory for all controlled substances is an important control in identifying discrepancies at an early stage when corrective actions are more easily taken.

Access to the Controlled Substances Vault. VHA policy requires that access to controlled substances storage sites be limited to less than 10 employees within a 24-hour period. We found that 26 individuals (22 pharmacists and 4 technicians) had access to Pharmacy Service's controlled substances vault. The Pharmacy Manager stated that Pharmacy Service is in the process of installing a new electronic security system that will reduce access to the vault to less than 10 employees within a 24-hour period.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Medical Center Director requires that:

a) All controlled substances inventories are verified at a minimum of every 72 hours.
b) Access to the controlled substances vault be limited to less than 10 employees during a 24-hour period.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that 72-hour inventories are now being conducted. A new electronic security system has been installed and the Pharmacy Manager has established access limits to the vault. The improvement plans are acceptable and we consider the issues resolved.

Patient Transportation Services – Internal Controls Needed Strengthening

Condition Needing Improvement. Service line managers needed to: a) establish timelines to ensure health examinations of current employee drivers are completed every 4 years, b) perform yearly verifications of employee driving records, and c) complete driver screening and training for current volunteer drivers and establish a screening and training program for future volunteer drivers.

Employee Drivers Screening and Training. VA policy requires that supervisors responsible for Motor Vehicle Operators ensure that employee drivers receive physical examinations, possess valid state drivers' licenses, and maintain safe driving records. These components of driver screening should be accomplished at a minimum of every 4 years. We reviewed the training records, Official Personnel Folders, and health records for three of the five medical center employee drivers and found that none had a physical in the last 4 years and the files did not contain any evidence that drivers' licenses had been verified. We interviewed the Chief, Facility Management Service, the Engineering Division Manager, and the Chief, Human Resources Management (HRM) Service, and confirmed that physical examinations and re-verification of driving records were not routinely performed. During our visit, medical center staff provided verifications of drivers' licenses for the three employee drivers.

Volunteer Drivers Screening and Training. VA policy requires supervisors to ensure that volunteer drivers receive physical examinations, possess valid state drivers' licenses, maintain safe driving records, and provide proof of automobile insurance. These components of volunteer driver screening should be accomplished at a minimum of every 4 years. We reviewed the records of three of the nine volunteer drivers and interviewed the Chief, Voluntary Service. Prior to September 2003, volunteer drivers had not been appropriately screened. They were only required to provide a copy of their driver's license. There had been no verifications of driving records or automobile insurance and no health examinations were given. At the time of our CAP review, all nine volunteer drivers were in the process of being screened.

We also reviewed training records for the three volunteer drivers we sampled. Voluntary Service's records showed that safe driving training was not provided prior to October 2003. At the time of our review, there was no program in place for screening and training new volunteer drivers.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the Medical Center Director requires that:

a) Health screening of employee drivers be performed every 4 years.
b) Re-verification of driving records be completed according to VA policies.
c) Volunteers who transport patients receive initial screening and annual safe driver training.
d) A screening and training program be established for new volunteer drivers. hour period.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that medical center policies have been revised. A volunteer driver screening and training program has also been established. The improvement plans are acceptable and we consider the issues resolved.

Employee Background Investigations – Investigations Needed to Be Completed

Condition Needing Improvement. HRM Service managers could not certify that all employees who had been employed for more than 90 days had valid and up-to-date background investigation clearances in their Official Personnel Files, in accordance with Federal directives. We randomly selected and reviewed the personnel files for 12 clinicians and found that 9 did not have background investigations. The Chief, HRM Service confirmed that background investigations were not consistently ordered for all employees as required. While we were onsite, the Medical Center Director developed a plan of action to address these background investigation issues.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the Medical Center Director implements the plan of action to complete background investigations on all employees.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that a plan had been implemented and procedures were being developed to complete background investigations on all employees. The target date for full implementation of the recommendation is March 31, 2004. The improvement plan is acceptable and we will follow up on the planned actions until they are completed.

Means Tests – Signed Means Test Forms Needed To Be Retained

Condition Needing Improvement. MCCF staff needed to ensure signed means test forms were retained in the veterans' administrative records. Means tests are administered during each 12-

month period to obtain income information from certain veterans in order to establish their eligibility for medical care. Each year, veterans who may be subject to medical co-payments must complete a means test. VHA facilities are required to retain signed means test forms in the veterans' administrative records. We reviewed the administrative records for a judgment sample of 30 veterans subject to means testing and found that 4 veterans did not sign means test forms within the last 12 months.

Suggested Improvement Action. We suggested that the VISN Director ensure that the Medical Center Director requires that MCCF staff obtain signed means test forms and retain them in the veterans' administrative records.

The VISN and Medical Center Directors agreed with the suggestion and reported that means tests processing procedures have been updated which require the tests to be scanned electronically and made part of the veteran's electronic health record upon completion and signature. The original hard copy will still be filed in the veteran's administrative record as back up. The improvement plan is acceptable and corrective actions should be monitored by VISN and medical center management until they are completed.

Contracts – Contract Award and Administration Needed Improvement

Condition Needing Improvement. Medical center staff needed to improve contract file documentation and ensure services were received prior to making payments. To determine the effectiveness of contract award procedures and contract administration, we reviewed a judgment sample of 17 contracts valued at $6.3 million.

Contract File Documentation. In two contracts, contracting staff did not fully document the rationale for the award amounts. In one contract for an anesthesiologist, a price analysis was prepared concluding that the contract award amount was fair and reasonable. Three days later, this contract was cancelled and a new contract was awarded to the same vendor at a higher rate. The contracting officer informed us that serviced provided by the contractor did not meet the requesting service's minimum requirements, due to a misunderstanding between the medical center and the contractor as to what was specifically required in the contract. The contractor would not meet the minimum requirements at the original contract rate and thus a higher rate was negotiated. However, the price analysis was not updated to explain the rationale for the higher rate. In the second contract, a Price Negotiation Memorandum (PNM) was not prepared when the contract was awarded. A year later the current contracting officer prepared a PNM after the fact from information in the contract file. However, this PNM did not use Medicare or Medicaid rates as a benchmark. Instead it compared the cost of a contract physician performing certain procedures at VA (ranging from $104 to $413 per procedure) to the cost of performing the procedures at a community hospital (ranging from $3,106 to $16,832 per procedure). There was no discussion or explanation of what these price quotes included (such as physician services, administrative costs, malpractice insurance) to ensure that the PNM was comparing prices for comparable services.

Verifying Services Prior to Payment. Contracting Officer's Technical Representatives (COTRs) are required to review contractor's invoices to ensure that they accurately reflect the work completed in accordance with the requirements of the contract before certifying acceptance. In three contracts totaling $472,298, payments were made without the COTR certifying acceptance. Also, COTRs did not have an effective method to verify that services were received. In one contract for physician services totaling $81,358, the vendor was required to sign in and out when providing outpatient services, and the COTR used these sign-in sheets to verify invoices. However, there was not a similar method for verifying surgical services (for example, comparison of invoices with surgical reports). In two other contracts totaling $390,940, vendors provided adult day health care services for veterans. The COTR certified acceptance based only on patient listings generated by the vendor.

Suggested Improvement Action. We suggested that the VISN Director ensure that the Medical Center Director improves the documentation of contract awards and administration by:

a) Requiring contracting officers to fully document the rationale for awarding contracts and the basis for price reasonableness determinations.
b) Establishing a more effective process to verify that contracted services were provided prior to payment.

The VISN and Medical Center Directors agreed with the suggestions and reported that VISN 6 Central Acquisition Service (CAS) is in the process of formalizing and executing a standard operating procedure for price reasonableness determinations. In the interim, a *Training and Information Document* has been issued to all VISN 6 contracting officers outlining the requirements for price reasonableness determinations. It is standard practice of the CAS to meet at least quarterly with the COTR to review contract performance. A Training and Information Document has been issued that standardizes VISN 6 COTR duties. The improvement plans are acceptable and we consider the issues resolved.

Appendix A

VISN 6 Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 20, 2003

From: Network Director, VA Mid-Atlantic Health Care Network, VISN 6 (10N6)

Subject: **Combined Assessment Program (CAP) Review of the VA Medical Center Salem, Virginia**

To: William H. Withrow, Director, Kansas City Office of Audit (52KC), Kansas, City, MO 64105

1. As requested, the attached subject report is forwarded electronically for your review and further action. I have read the recommendations of the OIG and responses to them from the Director of VA Medical Center Salem, and concur with both.

2. If you have any questions or require a paper-copy of the report, please contact Stephen L. Lemons, Ed.D., Director, VAMC Salem, via MS Exchange or at (540) 983-1045.

/ s / Daniel F. Hoffmann, FACHE

Attachment

Appendix B

VA Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 14th, 2003

From: Director, VAMC Salem (658/00)

Subject: Combined Assessment Program (CAP) Review of the VA Medical Center Salem, Virginia

To: William H. Withrow, Director, Kansas City Office of Audit

I have reviewed the findings included in the draft report and concur with recommendations. Actions taken along with planned actions are listed on this submission.

The staff and I perceive the OIG CAP program as an opportunity to learn from our own review and those reviews conducted at other facilities.

I personally appreciate the demeanor of OIG CAP review team. The team members required us to take a critical look at our programs but did so in a manner that was assistive and not punitive.

/s/ STEPHEN L. LEMONS, Ed.D.

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations and suggestions in the Office of Inspector General Report:

OIG Recommendation(s)

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director implements the proposed QM policy to ensure that annual performance plans are developed that encompass performance plans from all services/service lines, as well as VHA and VISN performance measures.

Response: Services/service lines submitted specific performance improvement initiatives for FY 2004 that have been consolidated into an organizational performance improvement plan. Medical Center Memorandum 00-03-38 has been published and implemented to establish the Salem Quality Council. This Council is charged with the review of all performance improvement reports for the organization, as well as, the mandatory performance measures of the VHA and VISN, making recommendations for improvements in all areas. In addition, the Council has responsibility for accreditation preparation and management of continuous quality improvement teams. The new council structure will support the performance improvement functions as identified by Joint Commission.
STATUS: Complete

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director makes certain that:

a) MCCF employees develop a process to identify and bill for care provided on a fee-basis.

b) The attending physicians' supervision of the residents is adequately documented in the medical records.

Response:

2.a) During the initial authorization process, the fee basis technician will identify whether the authorization for service will be billable to a third party insurance company, co-payment requirement on the veteran's part and or under a tort claim process. The fee basis technician will indicate in the remarks section when appropriate as follows: "***MCCR BILLING CASE***".

When the bill is received with supporting documentation, the fee basis technician is required to review the electronic file and will take note of the potential billing by the authorization clerk. Upon physician review with the

claims technician, the physician will make the determination whether this case is service-connected or not. If after physician review the charges are billable, then a copy of the bill and documentation will be sent to the appropriate MCCF billing office for generation of the bill to the veteran and/or third party insurer.

Weekly, the claims assistant will compile the "Potential Cost Recovery Report" from the fee computer applications package. The listing will be reviewed for potential additional or missed billable cases. After review, the claims assistant will forward the report to the fee supervisor for audit and review of actions taken.
STATUS: Complete

2.b) Our coders are now following VISN 6 guidelines for coding and billing Physician's at Teaching Hospitals. These guidelines ensure that no improper encounters are forwarded to the Centralized Revenue Unit for billing.

To assist our providers in improving documentation and coding issues, our coders have been placed in outpatient clinics and inpatient units to better educate and provide feedback.
STATUS: Complete

Background: Billing for care rendered by residents has been in an ever-changing environment this past year. On July 11, 2003 it was announced that the documentation requirements for residents had changed in the VA. The Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) ruled that attending presence and documentation requirements did not apply to the VA since VA facilities did not receive either direct or indirect medical education funds from CMS. It was determined that the VA could submit claims for care that was provided by residents in a properly supervised environment. CMS explicitly stated that the teaching physician billing rules did not apply to physicians in the VA. On July 18, 2003, VHA Directive 2003-039, Updated Billing Guidance for Services Provided By Teaching Physicians and Residents was released. On August 11, 2003, stations were advised to hold off on billing residents until official guidelines were issued from the Director of Business Operations. On September 5, 2003 these guidelines were issued. On November 19, 2003, the Director of Business Operation submitted a memorandum that reversed the July 18th directive. A final memorandum signed by the Under Secretary for Health was issued on December 29,2003 stating that medical centers should only bill in the name of the attending physician, and that proper attending documentation by the attending physician was necessary for any bills submitted. Since the OIG visit occurred during this period of uncertainty concerning resident billing, it was felt this background information was beneficial in explaining the discrepancies that occurred during the OIG visit.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Medical Center Director requires:

a) SPD to reduce supply inventory to the 30-day supply goal and improve the accuracy of GIP.
b) SPD to conduct and document annual wall-to-wall inventories.
c) Prosthetics Service to improve the accuracy of the PIP.

Response:

3.a) SPD will implement GIP in a uniform manner so that data and inventory management operations are standard throughout the Medical Center; utilize automatic level setter; utilize delivery systems that allow the Primaries to carry the lowest possible levels on hand; utilize Secondary Inventory Points to accuracy reflect usage history.
STATUS: Target date to reduce SPD inventory to 30-day supply is February 27, 2004.

3.b) SPD will conduct and document annual wall-to-wall inventories.
STATUS: Target date for completion is March 31, 2004.

3.c) Prosthetics Service staff have reviewed requirements for full implementation and on-going operations of the Prosthetics Inventory Package (PIP). During the CAP review, one returned/replacement item had not been interred into PIP due to confusion regarding appropriate cost. The item has now been entered. The other item cited during the CAP review pertained to the soft-caps that were stocked in one location although there were 3 different sizes. This item is now correctly segregated.
STATUS: Complete

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Medical Center Director requires that:

a) All controlled substances inventories are verified at a minimum of every 72 hours.
b) Access to the controlled substance vault be limited to less than 10 employees during a 24-hour period.

Response:

4.a) Pharmacy is in full compliance of VHA Handbook 1180.2 by assigning an additional Pharmacy Technician to assist the vault pharmacist in performing 72-hr inventories of all controlled substances.
STATUS: Complete

4.b) A new electronic security system requiring a magnetic swipe card and a PIN number has been installed for the vault and all Pharmacy entry points. The Pharmacy Manager has established access limits to the vault based on workload requirements for dispensing controlled substances. A review of the Pharmacy vault record, after system installation, for a 7-day period (12/23/03 – 12/29/03) showed full compliance of VHA policy with no more than 10 employees per day entering the Pharmacy controlled substance vault.
STATUS: Complete

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Medical Center Director requires that:

a) Health screening of employee drivers be performed every four years.
b) Re-verification of driving records be completed according to VA regulations.
c) Volunteers who transport patients receive initial screening and annual safe driver training.
d) A screening and training program be established for new volunteer drivers.

Response:

5.a) Revised Medical Center policy requires medical examination at least once every four years for employee drivers.
STATUS: Complete

5.b) Revised Medical Center policy requires review of employee's authorization to operate Government-owned or leased motor vehicles in accordance with 5CF Chapter 1, 930.109
STATUS: Complete

5.c) and 5.d) Volunteer drivers will undergo an initial and annual review of their medical history and answer questions per screening criteria (OF 345). Occupational Health will review the completed OF 345 and determine the need for a physical exam. The Occupational Health Physician will perform a medical exam if appropriate and determine if the volunteer driver is approved/disapproved for the driver assignment. Initial and annual refresher training for Volunteer Drivers will be coordinated with the annual Volunteer training to avoid inconvenience to our volunteers. A checklist for specific driver training will be maintained in the volunteer driver file.
STATUS: Complete

Recommended Improvement Action 6. We recommend that the VISN Director should ensure that the Medical Center Director implements the plan of action to complete background investigations on all employees.

Response

Action item 1: A 100% audit of all current staff employees was initiated on November 19, 2003. Action plan implemented.
STATUS: Complete

Action item 2: Current procedures were reviewed for improvements. Background investigation adjudication date will be added to the current logbook for all future investigations. Action plan implemented.
STATUS: Complete

Action item 3: Procedures identified and implemented IAW VA Handbook 0710. Microsoft Excel spreadsheet developed and updated as status changes. Action plan implemented.
STATUS: Complete

Action item 4: Procedures being developed for initiating background checks for all other types of appointments. Clinical staff will be given the highest priority. Background checks to be completed. Procedures to be developed.
STATUS: March 31, 2004

OIG Suggestion(s)

Suggested Improvement Action. We suggest that the VISN Director ensure that the Medical Center Director makes certain that MCCF staff obtain signed means tests and retain them in the veterans' administrative records.

Response. Means test processing procedures have been updated which require them to be scanned electronically into the database upon completion and

signature. During the scanning process, the means test information is automatically faxed to the Health Eligibility Center and the signed document becomes a part of the patient's electronic health record, and is stored in CPRS. The original hard copy will still be filed into the patient's administrative record as back up. Once the document has been scanned successfully into the database, a signed copy will then be available at all times electronically.
STATUS: Complete

Suggested Improvement Action. We suggest that the VISN Director ensure the Medical Center Director improves the documentation of contract awards and administration by:

a) Requiring contracting officers to fully document the rational for awarding contracts and the basis for price reasonableness determinations.
b) Establishing a more effective process to verify that contracted services were provided and ensure certifying officials obtain appropriate verification that services were provided prior to approving payments.

Response:

a) Determining price reasonableness prior to awarding contracts and/or change orders to contracts, along with documenting contracting officers rationale for awarding a contract is a standard business practice for all VISN 6 contracting officers. As a result of this suggestion, the VISN 6 Central Acquisition Service (CAS) is in the process of formalizing and executing a Standard Operating Procedure for price reasonableness determinations. In the interim, a Training and Information Document has been issued to all VISN 6 Contracting Officers.
STATUS: Complete

b) It is a standard business practice of the CAS to meet as least quarterly with Contracting Officer's Technical Representatives (COTR) to review contract performance. One of the monitors the COTR must report on regards ensuring services are provided and that payment is made in accordance with the contract.
STATUS: Complete

In response to this suggestion for improvement, we have issued a Training and Information Document that standardizes VISN 6 COTR delegations. In the delegation we reiterate the role of the COTR to monitor contract performance and certify payments accordingly.
STATUS: Complete

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
2	Better use of funds by ensuring all billing opportunities are realized.	$41,223
3	Better use of funds by reducing supply inventories to 30-day supply level.	164,760
	Total	$205,983

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	William H. Withrow, Director, Kansas City Audit Operations Division (816) 426-7100
Acknowledgments	Nelson Miranda, Director, Washington Office of Healthcare Inspections Joseph T. Janasz Jr., CAP Review Coordinator Randall Snow, Healthcare Inspections Team Leader Dennis A. Capps Jim L. Garrison Sarah Lake C. Russell Lewis Rayda Nadal Michelle Porter Carla S. Reid Marion Slachta Ray Tuenge Oscar L. Williams

Appendix E

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on VA, HUD, and Independent Agencies
House Committee on Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on VA, HUD, and Independent Agencies
Senate Committee on Government Affairs
National Veterans Service Organizations
General Accounting Office
Office of Management and Budget
The Honorable John W. Warner, U. S. Senate
The Honorable George Allen, U. S. Senate
The Honorable Rick Boucher, U. S. House of Representatives
The Honorable Bob Goodlatte, U. S. House of Representatives
The Honorable Virgil H. Goode Jr., U. S. House of Representatives

This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/52/reports/mainlist.htm. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.