



Department of Veterans Affairs Office of Inspector General

Combined Assessment Program Review of the Providence VA Medical Center Providence, Rhode Island

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.
- 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.

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

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Executive Summary

Introduction

During the week of May 2–6, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Providence VA Medical Center, Providence, Rhode Island. 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 154 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 1.

Results of Review

The CAP review covered 12 operational activities. The medical center complied with selected standards in the following two activities:

- Colorectal Cancer Management
- Quality Management

The following organizational strengths were identified:

- The medical center established an additional pre-procedure clinic in the gastroenterology section to enhance patient education and stress the benefits of having colonoscopy procedures performed.
- The medical center's QM Patient Safety Program was recognized in the Rhode Island health care community for its effectiveness in reducing risk to patients.

We identified 10 activities that needed additional management attention. To improve operations, the following recommendations were made:

- Strengthen controls to improve oversight of the contracting activity and contract administration.
- Use Relative Value Units (RVUs) to measure and monitor VA staff and contract radiologists' productivity to help the medical center manage future services costs and determine needed staffing levels.
- Increase Medical Care Collections Fund (MCCF) collections by improving documentation of medical care and identifying and processing all billable patient health care services.

- Improve inventory procedures and controls over nonexpendable equipment.
- Improve compliance with VA's purchasing hierarchy.
- Strengthen controls to ensure purchase cardholders comply with the Federal Acquisition Regulation (FAR) and obtain competition for purchases exceeding \$2,500.
- Improve controls over controlled substances inspections and strengthen other controls.
- Strengthen controls for information technology (IT) security.
- Develop and implement processes, including a comprehensive policy, for pressure ulcer prevention and management and collect and analyze pressure ulcer data.
- Correct environment of care deficiencies.

The following observation was also made:

- The medical center met the Veterans Health Administration (VHA) performance measure for colorectal cancer screening.

The report was prepared under the direction of Mr. Thomas Cargill, Jr., Director, and Mr. Philip D. McDonald, Audit Manager, Bedford Audit Operations Division.

VISN 1 and Medical Center Directors Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 27–38, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)

JON A. WOODITCH
Deputy Inspector General

Introduction

Medical Center Profile

Organization. The Providence VA Medical Center is a tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community-based outpatient clinics located in Middleton, RI; and New Bedford, Hyannis, Nantucket, and Martha's Vineyard, MA. The medical center serves a veteran population of about 140,000 in a primary service area that encompasses Rhode Island and southeastern Massachusetts.

Programs. The medical center provides a broad range of medical services in primary care and 32 subspecialty clinics. Comprehensive care is provided in areas of medicine, surgery, and psychiatry. The medical center has 73 operating beds.

Affiliations and Research. The medical center is affiliated with the Brown University and Boston University Medical Schools. There are also nursing affiliations with Harvard University, the University of Rhode Island, and Rhode Island College. The medical center research program had 85 active research studies and a budget of approximately \$5 million in fiscal year (FY) 2004. Important areas of research include oncology, cardiology, mental health, neuroscience, substance abuse, and pulmonary disease.

Resources. The medical center's FY 2004 medical care budget totaled \$126.8 million, a 13.6 percent increase from the FY 2003 budget of \$111.6 million. FY 2004 staff was 782 full-time equivalent employees (FTE), including 82 physician FTE and 209 nursing FTE.

Workload. In FY 2004, the medical center treated 30,201 unique patients, a 6 percent increase from FY 2003. The FY 2004 inpatient care workload totaled 3,244 inpatients treated and 272,752 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 and benefits services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility and regional office operations focusing on patient care, QM, benefits, 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 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 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.

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 12 activities:

Colorectal Cancer Management	Medical Care Collections Fund
Controlled Substances Accountability	Pressure Ulcer Prevention and Management
Environment of Care	Procurement of Prosthetic Supplies
Equipment Accountability	Quality Management
Government Purchase Card Program	Radiology Services
Information Technology Security	Service Contracts

The review covered medical center operations for FY 2004 and FY 2005 through April 2005, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations of our prior CAP review of the medical center (*Combined Assessment Program Review of the VA Medical Center Providence, Rhode Island*, Report No. 2001-01516-29, May 28, 2002).

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 employees, and 98 employees responded. We also interviewed 30 patients during the review. The survey results were shared with medical center managers.

We also presented 2 fraud and integrity awareness briefings for 154 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Activities needing improvement are discussed in the Opportunities for Improvement section (see pages 4–24). For these activities, we make recommendations. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. For those activities not discussed in the Opportunities for Improvement section, there were no reportable deficiencies.

Results of Review

Organizational Strengths

Compliance Initiative. The medical center's gastroenterology section had high cancellation and no-show rates from patients who were scheduled for colonoscopies. In an effort to increase compliance with scheduled appointments in this high-risk patient population, clinic managers established an additional pre-procedure clinic in January 2004. Patients seen in this clinic had either cancelled or had not presented for their scheduled colonoscopies at least once, and they had not rescheduled the procedure. The purpose of the clinic was to offer enhanced patient education and stress the benefits of having the procedure performed. At the time of the CAP review, 23 of 29 patients who were seen in this clinic had colonoscopies performed.

QM Patient Safety Program. The medical center's QM Patient Safety Program was recognized in the Rhode Island health care community for its effectiveness in reducing risk to patients. Since 2003, the medical center's QM Coordinator and Patient Safety Coordinator have presented the Patient Safety Program four times to various state organizations. In November 2004, they presented the patient safety benefits of automated processes for pharmacy/physician order entry, allergy tracking, medication administration, and the Computerized Patient Record System to Quality Partners of Rhode Island (QPRI).¹

¹ QPRI is a non-profit organization sponsored by the Rhode Island Medical Society. It is the primary quality institute in Rhode Island, and its mission is to develop quality initiatives throughout the state.

Opportunities for Improvement

Service Contracts – Oversight of the Contracting Activity and Contract Administration Needed To Be Improved

Conditions Needing Improvement. Medical center management needed to improve contracting activity performance by strengthening controls to ensure that the Head of the Contracting Activity (HCA), contracting officers, and Contracting Officer's Technical Representatives (COTRs) perform their responsibilities in accordance with the FAR, the VA Acquisition Regulation (VAAR), and VA policy. To evaluate the effectiveness of the contracting activity, we reviewed 14 contracts valued at \$6.2 million from a universe of 59 service contracts valued at \$15.7 million. We identified the following issues that require management attention.

HCA Performance. The HCA is responsible for implementing and maintaining an effective and efficient contracting program and establishing controls to ensure compliance with the FAR, the VAAR, and VA policy. The HCA could improve oversight of the contracting activity by conducting reviews of contract files to ensure contracting officers and COTRs perform duties as required.

- Contract Reviews. The HCA did not conduct contract file reviews of five contracts valued at \$3.6 million. The review and evaluation, typically conducted by the HCA, helps ensure the completeness and accuracy of solicitations and contract documentation packages and ensures compliance with the FAR, the VAAR, and VA policy.

Our review of these five contracts identified deficiencies that could have been prevented had the HCA conducted required contract file reviews. The type of deficiencies included potential conflicts of interest, lack of contract price reasonableness determinations, lack of OIG preaward audits, and lack of verification of liability insurance for contract physicians.

Contracting Officers Performance. Contracting officers did not take necessary actions to avoid potential conflicts of interest, ensure negotiated contract prices were fair and reasonable, ensure that legal/technical reviews and preaward audits were conducted, and maintain files containing records of required preaward and postaward administrative actions. In addition, contracting officers need to ensure COTRs are trained before they assume responsibility for monitoring contractor performance.

- Potential Conflicts of Interest. We determined that the Chief, Medical Service, and the Chief, Pulmonary Service, had potential conflicts of interest involving five contracts valued at \$1.6 million with associated practice groups of the medical center's affiliate, Brown University. Their faculty appointments at the medical school

annually paid \$26,000 and \$96,000, respectively. Generally, if a VA physician has a faculty appointment and receives any compensation, or is under the direction of the school, the VA physician has at least an imputed financial interest in the VA contracts with the school. No VA physician who has a financial interest in the contract, including an imputed financial interest, may lawfully participate in the contract. Prohibited activities regarding these contracts include issuing decisions, approvals, recommendations, and the rendering of advice relating to contract negotiations. VHA policy requires a written opinion from the VA Regional Counsel that an affiliated physician may lawfully participate in the contract before participation occurs. In the contracts under discussion, the physicians participated in the contracts without obtaining opinions from the VA Regional Counsel.

- Contract Prices. The FAR requires contracting officers to ensure that negotiated contract prices are fair and reasonable. We identified the following two contracts where the contracting officers should have negotiated better prices for the medical center.
 - Magnetic Resonance Imaging Services. The medical center had a \$237,438 contract to have Magnetic Resonance Imaging (MRI) procedures performed at a local hospital for the period April 2003–September 2005. A review of the contract showed the medical center had a basis for negotiating a lower price for the MRI contract. During a 21-month period ending March 2005, the contractor performed 264 MRIs with contrast and 262 MRIs without contrast totaling \$481,800 (203 percent of the estimated contract value). Negotiated unit prices were \$1,170 for MRIs with contrast and \$660 for MRIs without contrast. VHA policy states that the preferred way of purchasing clinical services is through the use of procedure based contracts, with Medicare rates as the benchmark for procedure prices. Average Medicare rates for the 53 MRI procedures listed in the contract were \$838 and \$547, respectively. Had the medical center used Medicare rates, the medical center could have saved \$117,254 $[(\$332 \times 264) + (\$113 \times 262)]$. Based on historical usage, the medical center will pay \$34,032 $[(\$332 \times 78) + (\$113 \times 72)]$ over the Medicare rate for MRIs to be performed during the remaining 6 months of the contract. In summary, we estimated that the medical center could have avoided paying MRI procedural costs totaling \$151,286 $(\$117,254 + \$34,032 = \$151,286)$.
 - VA Physician Services. The medical center had a \$75,000 contract to sell the services of the Chief, Pulmonary Service, to a medical organization for the period August 2004–August 2007. A review of the contract showed the medical center undersold these services to the medical organization. The contract provided for the medical organization to reimburse VA \$25,000 annually, which should have represented 25 percent of the VA physician's time and annual VA compensation. However, 25 percent of the actual VA compensation amounted to \$48,383 (VA

compensation including benefits totaled \$193,534 x 25 percent = \$48,383). Because this contract had a base year and 2 option years, the medical center undersold the physician's services by \$70,149 [(\$48,383 – \$25,000) x 3 = \$70,149].

- Preaward Audits of Sole Source Contracts. VHA policy requires that sole-source contracts with affiliated medical schools valued at \$500,000 or more be sent to the VA OIG Contract Review and Evaluation Division for preaward audits. The primary purpose of the audits is to determine whether the prices are fair and reasonable in accordance with VA regulations and policy. Contracting officers did not request preaward audits for a radiation treatment therapy contract valued at \$2.6 million or a nephrology services contract valued at \$558,000. We estimated that preaward audits would have resulted in cost savings of \$411,919.²
- Required Preaward Administrative Actions. Contracting officers did not conduct the required preaward administrative actions including workload analysis to support the need and level of procurement for four contracts valued at \$3.8 million and did not adequately define contract requirements and/or measures to monitor contractor performance for four contracts valued at \$3 million. Contracting officers did not send two contracts valued at \$500,000 or more to the VA Office of Acquisition and Materiel Management for legal and technical review. For one contract valued at \$426,852, a contracting officer did not search the Excluded Parties Listing System (EPLS) database to determine whether the prospective contractors were excluded from Federal contracts and did not prepare a price negotiation memorandum documenting the negotiation process. In addition, documentation of medical liability insurance was not in the contract file for physicians providing services for four contracts valued at \$3.8 million.
- Required Postaward Administrative Actions. Contracting officers did not conduct required postaward administrative actions, including initiating background investigations of contract personnel with access to VA computer systems for five contracts valued at \$2.4 million, and did not prepare written justifications before exercising option years for two contracts valued at \$737,346.
- COTR Training. Contracting officers did not ensure three COTRs for five contracts valued at \$3.3 million had received training before assuming their responsibilities for monitoring contractor performance. The training identifies COTR duties, responsibilities, limited authority, and prohibited actions which include the delegation of validation and certification responsibilities. The COTR for three of the five

² The OIG has determined that pre-award audits have historically resulted in potential savings of 21 percent of the total value of the proposed contract prices. The OIG has also determined that 62 percent of the potential cost savings has been sustained during contract negotiations. Applying these percentages to the total estimated value of the contracts (\$3,163,740 x 21 percent x 62 percent) resulted in estimated cost savings of \$411,919)

contracts valued at \$3 million inappropriately delegated validation and certification responsibilities to fee basis employees.

(See Appendix C, page 39, for a table summarizing the types of contract services acquired, the estimated value of each contract, and contract administrative deficiencies noted.)

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires:

- (a) The HCA to conduct contract file reviews to ensure compliance with the FAR, the VAAR, and VA policy and to detect, correct, and prevent future contract deficiencies.
- (b) Contracting officers strengthen controls to prevent potential conflicts of interest and, if required, seek VA Regional Counsel opinions.
- (c) Contracting officers renegotiate the MRI contract at or below Medicare rates and use Medicare rates in negotiating future procedure-based contracts.
- (d) Contracting officers make sure the medical center is adequately compensated for the selling of physician services.
- (e) Contracting officers send all sole-source contracts valued at \$500,000 or more with the affiliate to the OIG for preaward audits.
- (f) Contracting officers correct the required preaward and postaward administrative deficiencies.
- (g) COTRs receive proper training.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that contract reviews will be conducted for all contracts prior to award to ensure compliance with the FAR, the VAAR, and VA policy. A sharing agreement advisory subcommittee will evaluate potential conflicts of interest as part of the pre-solicitation process, negotiation, award, and administration for each contract and will seek a VA Regional Counsel opinion when needed. The MRI contract was renegotiated using Medicare rates. Medicare rates will also be used in negotiating future procedure-based contracts. Contracting officers will ensure the medical center is adequately compensated for selling services. All sole-source contracts valued at \$500,000 or more with the affiliate will be forwarded to the OIG for preaward audits. Contracting officers have corrected the required preaward and postaward administrative deficiencies. A checklist will be used and included in each contract file. COTRs will receive refresher training annually. New COTRs will take the Federal Acquisition Institute's on-line training course. The improvement plans are acceptable, and we will follow up on implementation of the planned actions.

Radiology Services – Relative Value Units Needed To Be Applied for Measuring and Monitoring Radiologists’ Productivity and Determining Needed Staffing Levels

Conditions Needing Improvement. Productivity for VA radiologists at the medical center during FY 2004 was low and could be improved by using RVUs³ to measure and monitor productivity. Prior to our review, the medical center did not have a viable, weighted measurement tool to assess the productivity of VA and contract radiologists. Instead, they used the number of diagnostic imaging examinations generated per radiologist to quantitatively measure productivity. Due to an expected loss of staff radiologists, the medical center is expecting to obtain contract radiologists’ services until they can fill the positions with VA staff radiologists. Using RVU benchmarks to establish productivity levels for VA staff and contract radiologists will help the medical center manage future services costs, monitor staff and contractor productivity, and better enable them to determine staffing needs.

Productivity Benchmarks. During March 2004, the Director, VHA National Radiology Program, informed the OIG⁴ that there were no productivity standards for VA radiologists, and he advocated the use of RVUs to assess their productivity. He stated that 5,000 RVUs would be the norm for full-time VA radiologists who have collateral administrative, educational, or research duties.

There are various factors that can impact a VA radiologist’s productivity, such as lack of support staff, time involved with supervising or training residents, and medical equipment limitations. Based on the findings in the OIG report and discussions with the Director, VHA National Radiology Program, we determined that 5,000 to 6,000 RVUs was a reasonable benchmark to use in assessing the medical center’s radiologists productivity. We used 5,000 RVUs as a reasonable benchmark for VA staff radiologists because of their administrative, training, and teaching duties that detracted from their actual service line time. For contract radiologists we used 6,000 RVUs as a benchmark in the absence of any collateral duties.

Benchmarking Productivity. The anticipated loss of VA staff radiologists is going to require the medical center to hire additional staff or contract radiologists from an outside source. At the time of our review, management informed us that for a lack of anything else, staffing levels are determined by the number of diagnostic imaging examinations performed at the medical center. Management also said that 9,000–10,000 examinations per radiologist are generally used as the formula to determine the needed staffing level.

³ RVUs are numbers established by Medicare and are used in its fee formula, along with practice and malpractice expenses. The work RVU indicates the professional value of services provided by a physician. RVUs take into account calculations involving patients and procedures performed, along with the skill of the physician, and the risk of the procedure.

⁴ See OIG Report No. 04-01371-177, issued August 11, 2004, *Issues at VA Medical Center Bay Pines, Florida and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS)*.

In FY 2004, the medical center provided 38,517 examinations, which represented 16,623 RVUs and also equated into .43 RVUs per examination (16,623 RVUs / 38,517 examinations).

Using 9000–10,000 examinations as a benchmark for recruitment of 1 full-time radiologist is not as effective as using a weighted RVU productivity benchmark since it does not factor in many variables and the complexity of different examinations. The table below shows the difference in productivity standards by using the two methods to measure and monitor productivity. We compared the productivity of 9,500 examinations per FTE to the RVU benchmark of 5,000 to illustrate the difference in output. The table shows that 9,500 examinations at the medical center equates into 4,085 RVUs, which is 915 RVUs (or 18 percent) below the productivity benchmark of 5,000 RVUs.

TABLE 1

Examinations per FTE Benchmark	RVU Value of Examinations	RVU Benchmark	Benchmark Difference (RVU Benchmark – RVU Value of Examinations)
9,500	4,085 RVUs	5,000 RVUs	915 RVUs

Actual Productivity. During FY 2004, there were 4.43 VA staff and contract radiologists who produced 16,623 RVUs. VA’s Decision Support System (DSS)⁵ Labor Mapping tool shows that the Chief, Radiology Service, spent 40 hours per pay period (50 percent of her time) performing administrative duties—this is also supported by her FY 2004 productivity numbers. To properly account for this, we deducted .5 FTE from the 3.9 FTE and based our analysis using 3.4 FTE VA staff radiologists. Table 2 on the following page shows that the medical center also had .53 contract radiologists⁶ produced 1,982 RVUs.

Table 2 shows that the average productivity for 3.93 service line radiologists in FY 2004 was 4,306 RVUs. Applying the productivity benchmark of 5,000 RVUs per FTE, the projected output for the 3.93 radiologists could be 19,650 RVUs, which is 18 percent (3,027 RVUs) more than their actual output of 16,623 RVUs. The number of examinations read in FY 2004 by the medical center’s radiologists was 500 examinations less than what could be expected using management’s benchmark of 9,500 examinations per FTE.

⁵ DSS is a management information system that integrates cost, quality, and clinical information into a patient centered database.

⁶ A contract radiologist who provided services to the medical center from October 2004 through January 2005 became a full-time VA-staff radiologist in February 2005. We allocated .33 of his FTE and RVU totals for his 4 months as a contract radiologist and the remaining .67 for the 8 months he spent as a staff radiologist.

TABLE 2

FY 2004 Staffing Level	Total FTE	RVUs Per FTE	Total RVU Output	Applying 5,000 RVU Benchmark	Total Examination Output	Applying 9,500 Examination Benchmark
Service Line Radiologists	3.93	4,230	16,623 RVUs	19,650 RVUs	37,855	37,335

The total workload for the first 2 quarters of FY 2005 was 8,369 RVUs, which would project to 16,742 RVUs (8,369 RVUs x 2) for the entire year. In January 2005, the medical center's staffing level was at 4.7 FTE radiologists (4.5 VA staff + .2 contract) until a part-time VA staff radiologist's (.5 FTE) employment terminated in February 2005, which reduced the medical center's staffing level to 4.2 FTE. At the time of our review, the medical center was recruiting radiologists in an anticipation of the departure of additional staff radiologists. The medical center needs to ensure a weighted workload analysis is conducted to determine the amount of staff needed to efficiently fulfill its workload.

If FY 2005 staffing levels are consistent or exceed FY 2004 levels—which were 3.93 FTE service line radiologists + .5 FTE for administration—the medical center should evaluate ways to utilize available staff resources through the use of teleradiology. Through the technology of Picture Archive Communication Systems (PACS), medical service providers have the capability to capture, store, view, and share radiology images from remote facilities. PACS allows for diagnostic examinations to be remotely read and could allow radiologists to absorb workload from facilities that have excess workload or are not meeting timeliness standards.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director: (a) develops an action plan to improve the productivity of radiologists, (b) uses RVUs to identify its existing workload, and (c) monitors and measures productivity of VA and contract radiologists using RVUs.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported the Chief, Diagnostic Imaging Service (DIS), will incorporate RVU productivity monitoring into the service performance improvement (PI) plan. The plan includes the development of an indicator methodology sheet for RVUs. Provider-specific results will be tracked by the Chief, DIS. The medical center also reported that Class III RVU software is being used to monitor and measure the productivity of staff and contract radiologists. The improvement plans are acceptable, and we will follow up on implementation of the planned actions.

Medical Care Collections Fund – Improvement Is Needed To Prevent Overbilling and Underbilling Insurance Carriers

Conditions Needing Improvement. The medical center’s MCCF program exceeded its collection goal of \$7,919,283 by almost \$443,300 during FY 2004. However, our review of statistical samples of outpatient encounters found instances of both overbilling and underbilling that were the result of documentation errors, insufficient review and monitoring of MCCF reports, improper coding, and billing errors. We estimate that during the period April 1, 2004–March 31, 2005, about \$613,824 could have been overbilled with \$184,086 improperly collected. The medical center also needed to prevent underbilling by validating and reviewing the “Reasons Not Billable Report” (“RNB Report”) and identifying and billing all patient services and fee basis care provided to insured patients. We estimate that during the period April 1, 2004–March 31, 2005, an additional \$1.16 million could have been billed, and MCCF revenues could have been increased by about \$349,245, or 4.1 percent of \$8.55 million collected.

Outpatient Billing Review. As of June 15, 2005, there were 80,749 outpatient encounters valued at \$12,059,404 billed to third party payers for care provided during the period April 1, 2004–March 31, 2005. We reviewed a statistical sample of 138 outpatient encounters, billed at \$107,601 with collections of \$21,322. We identified 38 errors in the sample, which included coding, billing, and documentation of medical records errors. Twenty (14.5 percent) of the 138 encounters were overbilled by \$7,400 (5.09 percent of the total amount billed) and 18 were underbilled by \$7,479 (5.14 percent of the total amount billed).

- **Overbilled Encounters.** Twenty encounters were overbilled in the amount of \$7,400, and \$1,343 was improperly collected as a result. Fifteen errors involved coding and billing issues and five errors involved documentation of medical records. Following are examples of these errors.
 - In six cases valued at \$649, medical care provided by students had been billed. Students are not permitted to conduct examinations, and their services are not billable because they are not licensed practitioners.
 - Medical care provided to a patient involved in a research project was inappropriately billed at \$1,515.
 - There was inadequate documentation to bill five encounters valued at \$3,410. In three of the five encounters, resident supervision had not been documented. No documentation of care was provided for the remaining two encounters.

Medical center management needs to enhance the compliance program to correct, detect, and prevent overbilling. Action needs to be taken to identify improper collections resulting from overbilling and refund or credit the insurance carriers as

appropriate. Coding staff should have returned the medical progress notes written by the students to the responsible attending physicians so they could have completed separate progress notes, which would have allowed the medical center to appropriately bill for the encounters. In addition, medical center management should promptly contact providers and request that proper documentation be submitted. Projecting our sample results to the universe valued at \$12,059,404, we estimate that \$613,823 ($\$12,059,404 \times 5.09$ percent) could have been overbilled, and based on the medical center's average collection rate of 29.99 percent, \$184,086 could have been improperly collected ($\$613,823 \times 0.2999 = \$184,086$).

- Underbilled Encounters. Underbilling occurred in 18 encounters in our sample valued at \$7,479. Fifteen errors involved coding and billing, and 3 encounters were billed incorrectly as the result of medical documentation errors. Examples of coding and billing and medical documentation errors follow.
 - Seven bills for pathology examinations valued at \$871 and two bills for a colonoscopy valued at \$2,839 were not generated and submitted to the insurers. Not coding and billing these procedures resulted in missed billing opportunities of \$3,710.
 - Four bills were cancelled in error by MCCF staff. This resulted in missed billing opportunities of \$1,728.
 - Professional fees for three encounters could have been billed if resident supervision had been documented. This resulted in missed billing opportunities of \$520.

Health Information Management, MCCF staff, and the Compliance Officer should have review processes that can identify and correct for situations where charges are missed, encounters are not coded, bills are incorrectly cancelled, and medical documentation is inconsistent or incomplete. Improvement in these areas will increase both billing and collections as well as improve medical record documentation.

Projecting our sample results to the universe valued at \$12,059,404, we estimate that \$619,853 ($\$12,059,404 \times 5.14$ percent) could have been underbilled. Based on the medical center's average collection rate of 29.99 percent, we estimate that an additional \$185,894 could have been collected ($\$619,853 \times 0.2999 = \$185,894$) on unbilled healthcare services.

“RNB Report.” We reviewed three segments – Insufficient Documentation, No Documentation, and Nonbillable Provider (Resident) – of the outpatient “RNB Report” for the period April 1, 2004–March 31, 2005. These segments identify missed billing opportunities due to poor documentation by medical care providers. Coding staff review documentation such as provider progress notes, test results, and surgical reports of patient

encounters. They then assign diagnoses codes from the International Classification of Diseases (ICD-9-CM) and procedure codes from the Common Procedural Terminology and, if they determine that the encounter is billable, they forward the coded encounter to MCCF staff, who process the bill. If they consider the encounter nonbillable, it is forwarded to MCCF staff to be listed on the “RNB Report.” As of May 19, 2005, there were 1,315 encounters valued at \$294,130 listed in the 3 segments of the outpatient “RNB Report” for treatment provided during the period of our review. There were 274 encounters valued at \$51,653 in the Insufficient Documentation segment, 21 encounters valued at \$16,006 in the No Documentation segment, and 1,020 encounters valued at \$226,471 listed in the Nonbillable Provider (Resident) segment.

These three segments of the “RNB Report” can be used as a tool to monitor provider documentation. When there is no documentation or an encounter is inadequately documented, medical center management should promptly contact providers and request that proper documentation be submitted.

If providers would have appropriately documented all medical care provided, an additional \$294,130 (\$51,653 + \$16,006 + \$226,471) could have been billed for the encounters on these three segments of the “RNB Report.” Based on the medical center’s average collection rate of 29.99 percent, an additional \$88,210 could have been collected ($\$294,130 \times 0.2999 = \$88,210$).

Fee Basis. The medical center paid 1,594 fee basis claims totaling \$868,113 to non-VA providers who provided medical care to VA patients during the period April 1, 2004–March 31, 2005. Payments to fee basis providers included 179 claims for inpatient/ancillary care valued at \$727,738, and 1,415 claims for outpatient care valued at \$140,375. The medical center did not bill any of these fee basis claims for patients with health insurance. The medical center’s business office reported that Utilization Review (UR) support to MCCF was allocated 0.5 FTE and that they could not review fee basis care for billing while maintaining the UR workload in the other required areas.

To estimate the medical center’s lost revenue for fee basis care, we reviewed a statistical sample of 63 inpatient/ancillary claims paid to fee basis providers at \$255,915 and 91 outpatient claims paid at \$10,787.

- None of the 63 inpatient/ancillary claims were billable to third party payers because in 61 of the 63 cases, the care provided was for contract nursing home care or respite care not covered by the patients’ insurance. In two cases, the patients were insured by the military health system, Tricare. At the time of treatment, these patients must elect to be treated under Tricare or as veterans. If they elect to be treated as veterans, as these two patients did, Tricare cannot be billed.
- Of the 91 outpatient claims, 29 claims (31.9 percent) were billable to third party payers under Reasonable Charges for \$16,111, with an average bill amount of

\$555.55 ($\$16,111 / 29 = \555.55). Projecting our results to the universe of 1,415 outpatient fee basis encounters, we estimate that 451 claims would have been billable for \$250,553 ($1,415 \times 31.9 \text{ percent billable} \times \$555.55 = \$250,553$) to third party payers. Based on the medical center's average collection rate of 29.99 percent, we estimate that an additional \$75,141 would have been collected ($\$250,553 \times 0.2999 = \$75,141$).

Statistical Projections. The samples were drawn with a confidence level of 95 percent and a precision rate of +/- 5 percent. Following is a summary of the projected additional billable amounts and collections.

Source	Projected Additional Billable Amount	Projected Additional Collectible Amount
Outpatient Encounters	\$619,853	\$185,894
Reasons Not Billable Report		
Insufficient Documentation	51,653	15,491
No Documentation	16,006	4,800
Non-Billable Provider (Resident)	226,471	67,919
Fee Basis	250,553	75,141
Totals	\$1,164,536	\$349,245

We also estimate that about \$820,000 ($\$12,059,404 \times 6.8 \text{ percent}$) could have been overbilled in error and \$245,918 could have been improperly collected ($\$820,000 \times 0.2999 = \$245,918$).

Conclusion. Medical center management needs to enhance the compliance program to prevent overbilling, and improper collections resulting from overbilling should be refunded or credited to the appropriate insurance carriers. The medical center could increase MCCF billings and collections by improving documentation of medical care and ensuring that MCCF staff identify and process all billable patient health care services. Medical center management needs to assign responsibility for reviewing and following up on the "RNB Report" to identify and correct documentation deficiencies and take action on billable encounters. Health care providers should receive additional training on documentation requirements. Internal controls such as compliance reviews or other monitors should be expanded to include a full review of patients' medical records to ensure all billable patient care was coded and billed. Medical center management should consider increasing UR staff time to ensure that applicable fee basis claims are billed to insurers. By strengthening controls, the medical center has the opportunity to increase MCCF revenues by about \$349,245 annually.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director improves billing practices by taking action to: (a) enhance the compliance program to correct, detect, and prevent overbilling and to identify improper collections resulting from overbilling and refund or credit insurance carriers, as appropriate; (b) establish a monitoring system to review the “RNB Report,” correct documentation deficiencies, and appropriately bill insurance carriers for health care provided; (c) promptly follow up on missing or inadequate documentation by contacting providers and requesting that proper documentation be submitted; (d) provide additional training to health care providers on documentation requirements; and (e) establish internal controls and expand compliance reviews to capture all episodes of care that need to be coded and billed.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that the Compliance Officer will conduct a review to identify any claims that were overbilled resulting in improper collections and report this information to the Chief, Patient Financial Services (PFS). The Chief of PFS will ensure that all corrective actions, to include refunds to the insurance carriers are processed in a timely manner. A monitoring system has been established to review the “RNB Report,” correct documentation deficiencies, and bill insurance carriers. Coding staff and the Chief, Health Information Management, will be reviewing all encounters not billed due to missing or incomplete documentation. Letters will be forwarded to health care providers notifying them of needed documentation. Additional training on documentation requirements will be provided to health care providers. The Compliance Officer will be reviewing the “RNB Report,” and coding staff will be reviewing inpatient/ancillary services to ensure all episodes of care are coded and billed. The improvement plans are acceptable, and we will follow up on implementation of the planned actions.

Equipment Accountability – Inventory Controls Needed To Be Strengthened

Conditions Needing Improvement. Medical center management needed to improve procedures to ensure that nonexpendable equipment and sensitive equipment is properly accounted for and safeguarded. VA policy requires that periodic inventories be done to ensure that equipment is properly accounted for and recorded in accountability records called Equipment Inventory Lists (EILs). Acquisition and Materiel Management Service (A&MMS) staff are responsible for coordinating the EIL inventories, which includes notifying all services when inventories are due and following up on incomplete or delinquent inventories.

As of April 13, 2005, the medical center had 51 active EILs listing 7,878 equipment items with a total acquisition value of \$36.6 million. We identified four equipment accountability issues that required corrective action.

Accuracy of EILs. To assess equipment accountability, we reviewed a statistical sample⁷ of 98 items (combined acquisition value = \$3,501,139). These items were listed in the Automated Engineering Management System/Medical Equipment Reporting System (AEMS/MERS) on the over \$5,000 current inventory list (742 items with total acquisition value = \$21,897,878). We were able to locate 93 (95 percent) of the 98 items. We identified the following accountability discrepancies.

- A&MMS staff could not locate five items that included an uretero-roscope, a patient data management system, printer, medical bed, and desktop computer (total acquisition value = \$37,011). These items were acquired from 1988–1994. “Reports of Survey” need to be completed in order to delete the items from AEMS/MERS.
- Thirteen items did not have properly recorded serial numbers.
- Four items were missing property bar code labels. Additionally, the property bar code labels for two firearms were affixed to the wrong lock boxes. The lock boxes are used to store the weapons when they are not issued.

Projecting our sample results to the universe, we estimated that 38 items could be unaccounted for. Further, we estimated that 98 items could have discrepancies between the serial numbers recorded in AEMS/MERS and the actual serial numbers on the equipment. We also estimated that 30 items could be missing bar code labels.

Sensitive Equipment. VA policy requires that certain sensitive equipment items be accounted for regardless of cost, life expectancy, or maintenance requirements. Sensitive items are those, such as computer equipment, that are subject to theft, loss, or conversion to personal use. To evaluate the accountability controls of sensitive equipment, we selected 20 of 86 sensitive IT items, (total acquisition value = \$56,105) and assessed the accuracy of the EIL data. We were able to account for all 20 IT items. However, the following discrepancies required corrective action.

- One laptop computer, which was pending disposal (turn-in), was located in a warehouse bin (along with many other laptop computers) in an unsecured area. The warehouse garage door was open and the equipment was vulnerable to theft.
- Two laptop computers did not have serial numbers recorded in AEMS/MERS.
- Seven items had incorrect serial numbers recorded in AEMS/MERS.

Disposed Equipment. We reviewed a sample of 10 items that had been disposed of (acquisition value = \$52,392) from a list of 1,535 disposed items (total acquisition value = \$3,669,749) covering the period October 2003–April 2005. We received the appropriate paperwork showing nine of the items had been properly disposed of.

⁷ The statistical sample was selected with a 90 percent confidence level, 10 percent error rate, and a margin of error of 5 percent.

However, one item in our sample (Pentium III computer, acquired in 2002, value = \$1,918) that reportedly was pending disposal had not been disposed of. The item was still in use and improperly listed as turned in.

Access to Property Menu Options. We determined that 32 employees had the capability to add, edit, and dispose (turn in) items listed in AEMS/MERS. A&MMS staff needs to conduct a review to determine if the options for each employee were justified. The integrity of the property database was vulnerable to manipulation or misuse because so many employees had access to the system.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) responsible officials or their designees perform the physical inventories of nonexpendable property in a complete and thorough manner and ensure that all items listed on their respective EILs are recorded accurately and are accounted for and (b) employee access to the EIL database is restricted to employees who need access.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that responsible officials will perform the physical inventories of nonexpendable property and ensure appropriate procedures are followed. Also, quarterly spot checks of the EILs will be conducted. A review will be conducted every 6 months to limit the number of employees who have access to the EIL database to only employees who need access. The improvement plans are acceptable, and we will follow up on implementation of the planned actions.

Procurement of Prosthetic Supplies – Purchases Needed To Comply With VA’s Purchasing Hierarchy

Condition Needing Improvement. Management needed to ensure that prosthetic supplies are purchased in accordance with VA’s purchasing hierarchy. VA policy requires medical facilities to purchase supplies according to the hierarchy, which organizes vendors from the most to least preferred sources as follows: national contracts; national, VISN, or locally awarded Blanket Purchase Agreements; Federal Supply Schedule (FSS) purchases; VISN and local contracts; and open market purchases. We identified the following condition that required corrective action.

Prosthetic Supplies. Procurement personnel did not purchase prosthetic supplies (hip and knee components) from preferred sources, such as VA national contracts and FSS contracts. During FY 2004, the medical center purchased prosthetic supplies (hip and knees) on the open market, the least preferred source.

To determine if the medical center purchased prosthetic supplies effectively, we reviewed a sample of 29 open market purchases of hip and knee components at a total cost of \$202,362. We found that eight purchases valued at \$69,075 had proper clinical waiver

documentation. However, procurement personnel purchased 21 hip and knee components valued at \$133,287 from 2 vendors and did not comply with the purchasing hierarchy. Prior to the awarding of a national contract on June 7, 2004 (October 1, 2003–June 6, 2004), procurement personnel made a total of 17 purchases, consisting of 5 hip components purchased at a cost of \$42,080 and 12 knee components purchased at a cost of \$64,449. Data obtained from the VA National Acquisition Center showing that an FSS vendor offered comparable items at lower prices. A comparison of prices paid by the medical center to FSS prices showed that the medical center could have paid 61 percent less for hip components and 42 percent less for knee components, resulting in a savings of \$52,738 $[(\$42,080 \times 61 \text{ percent}) + (\$64,449 \times 42 \text{ percent}) = \$52,738]$. The four open market purchases valued at \$26,758 made after June 7, 2004, did not have the required clinical waiver documentation. We estimated the medical center could have saved \$52,738 by purchasing these products from an FSS vendor.

Recommendation 5. We recommended that the VISN Director ensures that the Medical Center Director requires that: (a) procurement personnel comply with the VA purchasing hierarchy and (b) clinicians request waivers from the Chief of Staff as required.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that procurement personnel will comply with the VA purchasing hierarchy. Procurement staff will attend a VISN 1 training conference that will include a review of prosthetic procurement practices. Prosthetic purchasing agents will search the VA National Acquisition Center online listing of national contracts prior to initiating obligations for open market purchases. Additionally, clinicians will comply with the Prosthetic Clinical Management Program (PCMP) and, when indicated, request waivers according to the PCMP. The improvement plans are acceptable, and we will follow up on implementation of the planned actions.

Government Purchase Card Program – Compliance with the Federal Acquisition Regulation Is Needed

Condition Needing Improvement. Medical center management needed to strengthen controls to make sure Government purchase cardholders seek competition for open market purchases exceeding \$2,500. For the period October 1, 2003–April 19, 2005, the medical center’s 42 cardholders and 18 approving officials processed 34,718 transactions valued at approximately \$11.8 million. The universe of transactions greater than \$2,500 totaled 684 transactions valued at approximately \$4.4 million. We identified the following condition that required corrective action.

Competitive Procurements. Purchase cardholders did not maintain documentation to support competition for purchases exceeding \$2,500. The FAR requires purchase cardholders to use competition to obtain supplies and services at the best prices. Cardholders must consider three sources for competition or document the justification for using a sole source.

To determine if the medical center purchased supplies in accordance with the FAR, we reviewed 26 prosthetic purchases consisting of wheelchair carriers, stair lifts, scooters, and motorized wheelchairs valued at \$97,279. We found that cardholders for 9 (35 percent) of the 26 purchases valued at \$46,482 did not comply with the FAR and made purchases on the open market without documenting bids from 3 sources or documenting justifications for using the sole sources. The Chief Prosthetics Service stated that price comparisons were sought but not documented.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires cardholders to consider three sources of competition for purchases over \$2,500 or document the justifications for using sole sources.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that cardholders will seek competition for open market purchases exceeding \$2,500. Cardholders will receive training on the requirement. Supervisory reviews will be conducted by A&MMS and Prosthetics Service staff to ensure cardholders comply with the FAR. The improvement plans are acceptable, and we will follow up on implementation of the planned actions.

Controlled Substances Accountability – Inspection Deficiencies Should be Corrected and Other Controls Strengthened

Conditions Needing Improvement. Medical center management needed to improve controls to fully comply with VHA policy and ensure accountability of controlled substances and address weaknesses in controlled substances inspections. Also, improvements were needed to ensure the Controlled Substances Coordinator trains inspectors, Pharmacy and Nursing Services use the Veterans Health Information Systems and Technology Architecture (VistA) Controlled Substances Package, and local policy complies with VHA policy. We identified five deficiencies that require corrective action.

Controlled Substances Inspections. VHA policy requires medical facilities to conduct monthly unannounced inspections of all controlled substances storage and dispensing locations. To evaluate controlled substances accountability, we reviewed 72-hour inventories and controlled substances inspection reports for the 3-month period December 2004–February 2005, interviewed inspectors and the Controlled Substances Coordinator, and observed an unannounced inspection of selected areas where controlled substances were stored and dispensed. Our review disclosed the following deficiencies:

- Inspectors did not verify that Pharmacy Service staff were conducting required 72-hour controlled substances inventories.
- Inspectors did not compare controlled substances held for destruction to VistA electronic reports to ensure that drug stock removed from inventory for destruction was properly accounted for.

Inspector Training. VHA policy requires the Controlled Substances Coordinator to conduct the training program for controlled substances inspectors. The Chief Pharmacy Service provided training to the inspectors instead of the Controlled Substances Coordinator.

Pharmacy Electronic Records. VHA policy requires that Pharmacy Service use the prime vendor inventory management software for ordering and receiving drugs. Also, Pharmacy Service is required to use the VistA Controlled Substances Package to maintain an electronic perpetual inventory of controlled substances and reports of controlled substances held for destruction. Our review disclosed the following deficiencies:

- Pharmacy Service did not use the prime vendor inventory software for ordering and receiving controlled substances. Instead, staff maintained manual records for controlled substances orders and receipts.
- Pharmacy Service did not use the VistA Controlled Substances Package to update controlled substances inventories and controlled substances held for destruction. Pharmacy Service staff maintained manual records of inventories and controlled substances held for destruction. The Pharmacy Service Supervisor updated perpetual inventory reports of controlled substances every other day rather than daily. Also, the drugs held for destruction report was updated quarterly in the VistA Controlled Substances Package rather than daily.

Pharmacy Service can improve accountability for controlled substances receipts, inventories, and controlled substances held for destruction by daily use of the prime vendor inventory software and the VistA Controlled Substances Package.

Nursing Electronic Records. VHA policy requires that Nursing Service requests and receipts for controlled substances are electronically entered into the VistA Controlled Substances Package. Nursing Service management was unaware of this requirement. Nursing Service staff did not have access to the nursing menu option on their computers or the necessary training to use the option. Nurses were completing handwritten Dispensing and Receiving Reports (VA Forms 10-2321) to request and receive controlled substances. Pharmacy Service staff updated the electronic records for nurses on a daily basis.

Pharmacy Policy. VHA policy requires that each medical facility have written procedures identifying the job titles of those employees who have the authority to order, receive, post, and verify controlled substances orders. The medical center policy did not specify which job titles had been assigned these duties. VHA also mandates that the OIG Office of Investigations be notified of any suspected theft, diversion, or suspicious loss of drugs. This requirement was not included in the medical center's local policy.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that:

- (a) Controlled substances inspectors conduct inspections in accordance with VHA policy.
- (b) The Controlled Substances Coordinator conducts inspector training.
- (c) Pharmacy Service staff use the prime vendor software for controlled substances orders and receipts.
- (d) Pharmacy Service staff use the VistA Controlled Substances Package for updating perpetual inventories and drugs held for destruction.
- (e) Nurses have access to the nurse's menu option, are trained, and use the VistA Controlled Substances Package for ordering and receiving controlled substances.
- (f) Medical center policy identifies the job titles of those employees who have the authority to order, receive, post, and verify controlled substances orders.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that controlled substances inspectors will use a newly developed template to document that inspections are conducted in accordance with VHA policy. The Controlled Substances Coordinator will conduct training for all inspectors. The prime vendor software is being used for ordering and receiving controlled substances. The VistA Controlled Substances Package is being used to update inventories and return controlled substances to stock or for destruction. Nursing Service staff have access to the nurse's menu option and have received appropriate training. Nurses are now using the VistA Controlled Substances Package for ordering and receiving controlled substances. The improvement plans are acceptable, and we will follow up on implementation of the planned actions.

Information Technology Security – Controls Needed To Be Strengthened

Conditions Needing Improvement. Medical center management needed to strengthen IT security. We evaluated IT security to determine whether controls and procedures were adequate to protect automated information systems (AIS) resources from unauthorized access, disclosure, modification, destruction, and misuse. We found that the medical center's Information Security Officer (ISO) was proactively writing and implementing security policies and ensuring employees completed initial and annual security awareness training. Security features, such as password protected screen savers, had also been activated on all medical center workstations. The following issues required management attention.

Physical Security. Proper safeguards must be in place to protect each facility's AIS resources, including physical security of the computer room and all communication closets. The door leading into the computer room area from outside the building and the interior door leading into the computer room both contained glass windows. Also, the

computer room, which is on the ground level, contained several windows which could be accessed by an intruder. The Chief Information Officer (CIO) stated that a work order to improve these physical security vulnerabilities had been initiated.

Background Investigations. All personnel who have access to sensitive data and information must have background investigations (BIs) completed. We selected 10 employees who held positions requiring background investigations (i.e., CIO, ISO, and Information Resource Management (IRM) staff). As of April 22, 2005, high-level BIs had been initiated for 6 of the 10 employees. Of these six employees, documentation revealed BIs had been completed for two and four were pending. The other four employees were identified as computer specialists with regular access to AIS resources, including programming level access. Moderate-level BIs had been requested for these four employees. Documentation revealed that moderate-level BIs had been completed for two while two were pending. Due to the high level of access these individuals have, high-level BIs need to be requested for all of them, and Human Resources personnel need to follow up with the Office of Personnel Management on the four pending high-level BIs to make sure they are completed.

Segregation of Duties. Prior to his recent appointment as ISO, the ISO worked in Bio-Med Service. As a BioMed Service employee, he had access to VistA where he could access the inventory menu for BioMed Service. This allowed him access to functions that were needed to perform his job. At the time of our review, the ISO still had access to these functions. We believe that since it is the ISO's responsibility to monitor system access, it would be a prudent business practice not to have access to any VistA functions. We also found that the alternate ISO had programming level access to VistA which was needed to perform her primary job functions within IRM. The Director stated these individuals retained access because the ISO's previous position remains vacant and because of staffing limitations within IRM. In order to strengthen internal controls, we recommend that the ISO not have access to VistA functions and that medical center management consider appointing an alternate ISO who does not have programming level access.

Recommendation 8. We recommended that the VISN Director make sure that the Medical Center Director takes action to: (a) improve physical security of the computer room to reduce the risk of unauthorized access, (b) request high-level BIs for the identified employees and follow-up on all pending BIs, and (c) remove the ISO's access to VistA functions and consider appointing an alternate ISO who does not have programming level access.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported a work order has been submitted to the Facilities Management Service (FMS) for corrective actions. The ISO has identified all IRM employees that need high-level BIs and Human Resources personnel have submitted the appropriate paper work. Also, the ISO's access to VistA functions has been removed. An alternate ISO has been

appointed who does not have programming level access. The improvement plans are acceptable, and we will follow up on implementation of the planned actions.

Pressure Ulcer Prevention and Management – Processes Needed To Be Improved

Conditions Needing Improvement. Pressure ulcers⁸ are common causes of morbidity (i.e., infections) for immobile hospitalized and long-term care patients; consequently, hospital costs and lengths of stay are significantly higher for patients who develop pressure ulcers. Medical center managers needed to establish consistent processes and a comprehensive policy to ensure that pressure ulcers are prevented or appropriately managed throughout the medical center. In addition, they needed to collect and analyze pressure ulcer data.

Prevention and Management. A review of 10 patients' medical records showed that 6 patients developed hospital acquired pressure ulcers, and 7 patients experienced a worsening of their pressure ulcers during their hospitalizations. While there was some medical record documentation to support that high risk patients were assessed and were turned and repositioned (especially in the intensive care unit), 5 of the 10 medical records had deficiencies in documentation (such as omissions in nursing notes) regarding skin assessments and turning and repositioning.

The medical center's current skin care policy was not comprehensive. For example, it did not include a skin integrity risk assessment tool that would help ensure consistent evaluation of risk for the development of pressure ulcers. The policy also did not include pressure ulcer treatment protocols, requirements to report and trend the development of pressure ulcers, or the need to evaluate the effectiveness of prevention and management interventions.

At the time of our visit, a registered nurse had just obtained certification as a wound care specialist and this will be a full-time position. Also during our visit, a draft VISN policy titled *Prevention and Management of Pressure Ulcers* was issued for review. We were told that the VISN policy will soon be approved by the VISN Executive Leadership Committee. In addition, managers showed us an early draft of a medical center skin care policy. The new medical center policy will need to address the elements mentioned in the previous paragraph, incorporate the requirements of the VISN policy, and define the functions of the wound care specialist. Also, the policy needs to provide guidance regarding wound care specialist consultations and establish response times for such consultations.

⁸ A pressure ulcer is any lesion caused by unrelieved pressure, typically on a bony prominence, that results in damage to underlying tissue.

Pressure Ulcer Team. While medical center managers told us that there is plan to establish a formal pressure ulcer team, the purpose, function, and patient referral processes had yet to be determined. Once determined, this information will need to be included in the medical center's policy. One function of the team should be the collection and analysis of pressure ulcer trends, effectiveness of interventions, and cost impact data. At the time of our visit, no pressure ulcer trending or cost impact analysis was being performed.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director: (a) develops and implements pressure ulcer prevention and management processes, including a comprehensive skin care policy and (b) establishes processes to collect and analyze pressure ulcer trends, effectiveness of interventions, and cost impact data.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that pressure ulcer prevention and management processes have been developed and implemented. The processes will be incorporated into the service PI process. The processes include the development of monitors that describe how data is collected and tracked. Also, a skin care policy has been implemented. A process has been established to analyze pressure ulcer trends. A skin integrity/wound monitor has been established and data collection begun. The improvement plans are acceptable, and we will follow up on implementation of the planned actions.

Environment of Care – Areas Needed Management Attention

Conditions Needing Improvement. VHA regulations require that the medical center's environment of care be clean and present minimal risk to patients, employees, and visitors. The medical center was generally clean and safe; however, areas needed management attention.

Curbs and Sidewalks. Sidewalk curbs were in disrepair in four locations around Building 1. Two of these areas included handicap access ramps in front of the outpatient clinic. Also, a portion of a cement sidewalk near the physician parking lot was removed and replaced with a fence. This required pedestrians going to the parking lot to walk into the street to get around the fence. In addition, a portion of another concrete sidewalk at the rear of Building 1 was replaced with cobblestone paving blocks. This area was the primary walkway for pedestrians going from a patient parking area to the outpatient clinic area. The uneven surface of paving blocks made the area difficult to traverse and created potential falling or tripping hazards for patients utilizing wheelchairs, walkers, or other assistive devices.

Unsecured Cleaning Supply Closets. Two of six housekeeping closets (one in the outpatient mental health clinic and the other on a medical unit) containing cleaning chemicals were unlocked and unattended. These closets were easily accessible to

patients. Unsecured closets that contain chemicals pose a safety risk to patients, employees, and visitors.

General Housekeeping Issues. The inpatient psychiatric unit had soiled and moldy floor tiles in the patients' shower. Also, the Formica covering around the sink in the same shower was loose and could be easily peeled off. The sharp edges from the torn covering could be used as a weapon to inflict self-harm or harm to others. Managers began taking corrective action while we were on site and told us that this unit is scheduled for renovation in 2006.

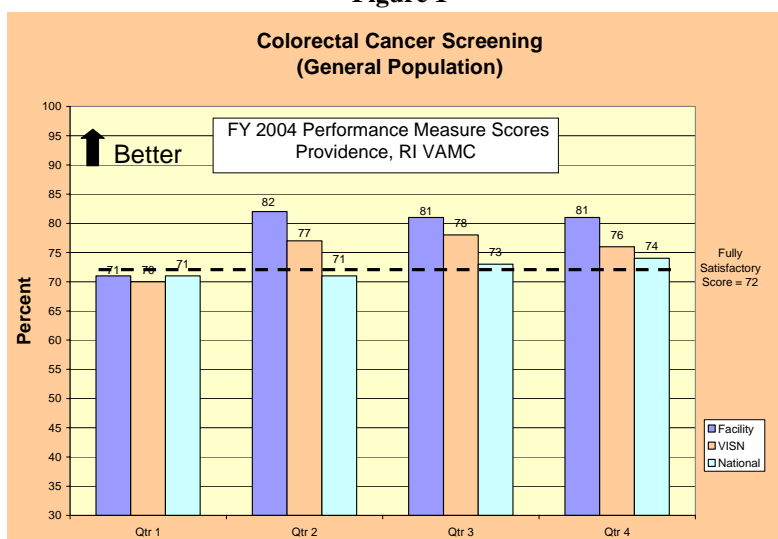
Recommendation 10. We recommended that the VISN Director ensures that the Medical Center Director take actions to: (a) repair sidewalks and curbs that pose potential safety risks, (b) secure all cleaning supply closets, and (c) improve general housekeeping on the inpatient psychiatric unit.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported a design and construction contract will be issued for corrective actions. All cleaning supply closets will be secured and defective locking mechanisms replaced. Additional staff training was conducted for all housekeeping aides in the inpatient psychiatric unit. Supervisory oversight will be enhanced until performance is acceptable and top management "environmental rounds" will target review of the area. The improvement plans are acceptable, and we will follow up on implementation of the planned actions.

Other Observation

Colorectal Cancer Review. The medical center met the VHA performance measure for colorectal cancer screening (see Figure 1 on the following page), provided timely Gastrointestinal (GI), Surgical and Hematology/Oncology consultative and treatment services, informed patients of diagnoses and treatment options, and developed coordinated interdisciplinary treatment plans.

Figure 1



Criteria. The cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We assessed these items in a sample of 10 patients who were diagnosed with colorectal cancer during FY 2004 (see Figure 2). To determine reasonableness of timeframes, we used the medical center's 30-day goal for GI evaluation (taking into consideration factors outside the medical center's control).

Figure 2

Patients Appropriately Screened	Patients Appropriately Notified Of Their Diagnoses	Patients With Interdisciplinary Treatment Plans	Patients Received Timely Initial Treatments
9/10*	9/10**	10/10	10/10

*Documentation revealed that one patient was repeatedly offered screening and refused.

** We were unable to determine when one patient was notified.

VISN 1 Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: September 23, 2005
From: VISN 1 Director
Subject: **Providence VA Medical Center Providence, Rhode Island**
To: Office of Inspector General, Bedford Audit Operations Division

Attached is the response to the Draft CAP Report for the Providence VA Medical Center review.

If you have any questions, please contact Steve Borden 401-273-7100 x 3042.

(original signed by:)

Jeannette A. Chirico-Post, MD

Network Director

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: September 20, 2005
From: Medical Center Director
Subject: **Providence VA Medical Center Providence, Rhode Island**
To: Jeannette Chirico-Post, M.D., Network Director, VISN 1

Enclosed is the VHA Office of Inspector General (OIG), Combined Assessment Program (CAP) report for the Providence VA Medical Center for the review conducted in May 2005. Included in the report after each section of recommendations are our corrective action plans, target dates and comments. We concur with the findings, recommendations, and monetary benefits as presented in the report.

I would like to express my appreciation to the OIG CAP audit team for the professional and collaborative manner in which the review was performed. The team was thorough and willing to engage in discussions in those areas requiring further explanation.

(original signed by:)

VINCENT NG

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

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

OIG Recommendations

Recommendation 1. We recommend that the VISN Director ensure that the Medical Center Director requires: (a) the HCA to conduct contract file reviews to ensure compliance with FAR, VAAR, and VA policy and to detect, correct, and prevent future contract deficiencies; (b) contracting officers strengthen controls to prevent potential conflicts of interest and, if required, seek VA Regional Counsel opinions; (c) contracting officers renegotiate the MRI contract at or below Medicare rates and use Medicare rates in negotiating future procedure-based contracts; (d) contracting officers make sure the medical center is adequately compensated for the selling of physician services; (e) contracting officers send all sole-source contracts valued at \$500,000 or more with the affiliate to the OIG for preaward audits; (f) contracting officers correct the required preaward and postaward administrative deficiencies; and (g) COTRs receive proper training.

Concur **Target Completion Date:** January 2006

- a. The Chief, A&MMS will conduct reviews on all contracts prior to award to ensure compliance with FAR, VAAR, and VA policy.
- b. The Sharing Agreement Advisory Subcommittee was recently implemented at Providence VAMC to review contract solicitations specifically to preclude conflict of

interest. The committee will evaluate potential conflict of interest as part of the pre-solicitation process, negotiation, award, and administration for each contract and will seek VA counsel opinion when needed.

c. A contract modification was executed June 20, 2005 to contract no. V650P-3693 with a re-negotiated rate that is at or below Medicare rates. Medicare rates will be used in negotiating future procedure-based contracts. **Completion Date:** June 20, 2005.

d. Contracting officers will ensure the medical center is adequately compensated for the selling of VA physician services. The contracting activity will comply with VHA Directive 1660.1 Selling Health Care Resources Under 8153 Sharing Authority. A contract renewal for pulmonary services contract no. V650P-3702 dated July 1, 2005 incorporated the directive.

e. Contracting officers will send all sole source contracts valued at \$500,000 or more with the affiliate to the OIG for preaward audits. Draft VHA Directive for Healthcare Resources – Buying, that includes the requirement for IG pre-award audit is now implemented in the contracting activity.

f. Contracting officers have corrected the required preaward and postaward administrative deficiencies. The Business Review Checklist issued by VA Office of Acquisition and Materiel Management now being utilized and included in each contract.

g. The Chief, A&MMS will ensure that all COTRs receive refresher training annually. New COTRs will take GSA's Federal Acquisition Institute's on-line course or outside training.

Recommendation 2. We recommend that the VISN Director ensure the Healthcare System Director: (a) develops an action plan to improve the productivity of radiologists, (b) uses RVUs to identify its existing workload, and (c) monitors and measures productivity of in-house and contract radiologists using RVUs.

Concur
2005

Target Completion Date: November 1,

a. The Chief, Diagnostic Imaging Service (DIS) will incorporate RVU productivity monitoring into the service PI plan with the overall goal to target improvements for RVU/radiologist levels. The DIS PI plan includes the development of an indicator methodology sheet for RVU which defines the process. Aggregate results will be reviewed monthly and included in staff minutes. Provider-specific results will be tracked by the DIS chief. Annual evaluation of PI plans are reviewed and approved by the Chief of Staff and Director.

b. During the CAP review, the OIG provided us with the FYs 2004 and 2005 RVU workloads. Until the OIG CAP review, there was no automated software approved or available to the facility for RVU tracking. We are now using the Class III RVU software that allows us to use RVUs to assess the radiologists' workload.

c. We support and will use RVUs to monitor and measure the productivity of staff and contract radiologists. We believe the process will be enhanced once VHA establishes uniform productivity standards.

Recommendation 3. We recommend that the VISN Director ensure that the Medical Center Director improves billing practices by taking action to: (a) enhance the compliance program to correct, detect, and prevent overbilling and to identify improper collections resulting from overbilling and refund or credit insurance carriers, as appropriate; (b) establish a monitoring system to review the "RNB Report," correct documentation deficiencies, and appropriately bill insurance carriers for healthcare provided; (c) promptly follow up on missing or inadequate documentation by

contacting providers and requesting that proper documentation be submitted; (d) provide additional training to healthcare providers on documentation requirements; and (e) establish internal controls and expand compliance reviews to capture all episodes of care that need to be coded and billed.

Concur **Target Completion Date:** October 15, 2005

a. The compliance officer will utilize the AR PERFORMANCE MONITOR - DETAIL REPORT to identify 15 paid claims per month. The compliance officer will then conduct a review to identify any claims that were overbilled resulting in improper collections and report this information to Chief, Patient Financial Services (PFS). The Chief, PFS will ensure that all corrective actions, to include refund to the insurance carriers are processed in a timely manner. Data will be tracked and trended for analysis by the compliance officer monthly.

b. The Chief, PFS will generate the "RNB Report" on a biweekly basis. The Chief, PFS will use the "RNB Report" to develop a detailed spreadsheet, which will give an expanded view of the documentation issue and responsible provider. The spreadsheet will then be reviewed by the Chief PFS in conjunction with the compliance officer making recommendations to the appropriate Service Chief or Care Line Manager for corrective action to be taken within 5 business days.

c. The coding staff along with the Chief, Health Information Management (HIM) is reviewing all encounters not billed due to missing or incomplete documentation through the use of a suspension list maintained within QuadraMed, the coding and billing software utilized in VISN 1. Compliance letters are sent to the providers notifying them of the documentation needed. These encounters remain on the suspension list and are followed up until the documentation is received.

The Chief, HIM reviews the lists weekly and notifies the clinical services if the documentation is not received within two weeks of the encounter. The Health Information Chief reviews the “RNB Report” monthly to monitor insufficient and missing documentation. This report will be provided to all clinical services for follow-up and reported to the Compliance Committee to analyze and make recommendations to the Clinical Executive Board.

d. The compliance auditor generates a QuadraMed report titled “E&M Reason for Change”. This report lists all the visits with PCE changes. The auditor chooses providers who have a high percentage of changes based on the number of visits. The three clinical services included in this report are: Primary Care, Medical and Surgical. Mental Health and Behavioral Science’s providers are chosen based on coder input. Once the chosen provider’s visits are reviewed for documentation appropriateness a memo is generated. This memo with the results of the review and an offer to train is sent to the provider through the Service Chief. Copies of the memo are submitted to the compliance officer.

e. As in b above, the compliance officer will be reviewing the “RNB Report” with Chief, PFS to assure that all episodes of care are coded and billed and making recommendations to the appropriate Service Chief or Care Line Manager for corrective action. Coding is reviewing ancillary services for a date of visit to ensure that all episodes of care are coded and billed. (This will ensure that pathology visits are billed appropriately.) Billing will ensure that pathology cases will be referred to coding by changing the way the Code Me report in QuadraMed is run.

Recommendation 4. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) responsible officials or their designees perform the physical inventories of nonexpendable property in a complete and thorough manner and ensure that all items listed on their respective EILs are recorded accurately and are accounted for and (b) employee access to the EIL database is restricted to employees who need access.

Concur **Target Completion Date:** January 2006

a. Responsible officials or their designees will perform the physical inventories of nonexpendable property in accordance with Medical Center Policy Memorandum 90-1, Government Property, Accountability and Responsibility, and ensure the appropriate procedures for the inventory of equipment is strictly followed. Additionally, quarterly spot checks of the EILs will be conducted.

b. We will conduct a management review every 6 months to limit the number of employees who have access to the EIL database to only employees who need access. **Completion Date:** June 2005

Recommendation 5. We recommend that the VISN Director ensures that the Medical Center Director requires that: (a) procurement personnel comply with the VA purchasing hierarchy and (b) clinicians request waivers from the Chief of Staff as required.

Concur **Target Completion Date:** Most by October 1, 2005

a. Procurement personnel will comply with the VA purchasing hierarchy. The requirement for procuring hip and knee prostheses through the national program contract was delayed because new products required that surgeons and operating room staff were technically proficient in their use. Staff will be trained in using the new products. Implementation plans follow:

- Providence procurement staff will attend a VISN 1 Prosthetics Purchasing Agent Training Conference that will include a review of prosthetic procurement practices. **Target Completion Date:** August 1, 2006.
- Prosthetic purchasing agents will search the National Acquisition Center online listing of FSS – Medical Equipment and Supplies 65-IIA and Patient Mobility Devices 65-IIF for available FSS contracts prior to initiating an obligation for an open market purchase.

- Prosthetic Manager will review all open market purchases over \$2,500 prior to forwarding purchase orders to vendors.
- The number of bids for open market purchases over \$2,500 will be documented in the prosthetic GUI purchasing package.

b. Clinicians will comply with the PCMP – Clinical Practice Recommendations and, when indicated, request “waivers” according to PCMP – National Contract Guidelines. The Prosthetics Manager will continue to provide the National Contract Guidelines to the appropriate clinicians as they are updated.

Recommendation 6. We recommend that the VISN Director ensure that the Medical Center System Director requires cardholders to consider three sources of competition for purchases over \$2,500 or document the justification for using a sole source.

Concur **Target Completion Date:** December 31, 2005

Purchase cardholders will seek competition for open market purchases exceeding \$2,500. Cardholders with authority over \$2,500 will receive in-house training on the FAR requirement. A&MMS and Prosthetics staff will conduct supervisory reviews to ensure compliance.

Recommendation 7. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) controlled substances inspectors conduct inspections in accordance with VHA policy; (b) the Controlled Substances Coordinator conducts inspector training; (c) Pharmacy Service staff use the prime vendor software for controlled substances orders and receipts; (d) Pharmacy Service staff use the VistA Controlled Substances Package for updating perpetual inventories and drugs held for destruction; (e) nurses have access to the nurse’s menu option, are trained, and use the VistA Controlled Substances Package for

ordering and receiving controlled substances; and (f) medical center policy identifies the job titles of those employees who have the authority to order, receive, post, and verify controlled substances orders.

Concur **Target Completion Date:** September 31, 2005

a. A standardized controlled substances inspector response template has been developed and implemented. The template contains all inspection areas and responsibilities. Controlled substance inspectors will use the template in documenting that inspections are conducted in accordance with VHA policy. **Completion Date:** May 2005.

b. The Providence VAMC Controlled Substance Coordinator is now responsible for conducting the training of all inspectors. The Chief of Pharmacy may be asked to assist with certain aspects of the training as a subject matter expert. **Completion Date:** May 2005.

c. Pharmacy staff are now using prime vendor software for ordering and receiving controlled substances. **Completion Date:** June 2005.

d. Pharmacists are now using the VistA Controlled Substance Package to update inventories and return controlled substances to stock or for destruction. **Completion Date:** June 2005.

e. Nursing Service has access to the nurse's menu option and have received appropriate training. Nurses are now using the VistA controlled substances package for ordering and receiving controlled substances. Implementation will include all areas within the Medical Center. **Completion Date:** September 2005.

f. Medical center policies and Pharmacy Service standard operating procedures will be updated to add the job titles of those employees who have authority to order, receive, post, and verify control substance orders.

Recommendation 8. We recommend that the VISN Director make sure that the Medical Center Director takes action to: (a) improve physical security of the computer room reduce the risk of unauthorized access, (b) request high-level BIs for the identified employees and follow-up on all pending BIs, and (c) remove the ISO's access to VistA functions and consider appointing an alternate ISO who does not have programming level access.

Concur **Target Completion Date:** March 2006

- a. A work order has been submitted to FMS for corrective actions. The Chief, FMS has created a project to fix all the discrepancies.
- b. The ISO has identified all IRM employees that need a high level background investigation and HRMS has submitted the paper work.
- c. The ISO's access to VistA functions has been removed. An alternate ISO has been appointed who does not have programming level access. **Completion Date:** September 16, 2005.

Recommendation 9. We recommend that the VISN Director ensure that the Medical Center Director: (a) develops and implements pressure ulcer prevention and management processes, including a comprehensive skin care policy; and (b) establishes processes to collect and analyze pressure ulcer trends, effectiveness of interventions, and cost impact data.

Concur **Target Completion Date:** November 2005

- a. Develop Pressure ulcer process.
 - The pressure ulcer process described below will be incorporated into the service performance improvement process. This process includes the development of monitors that describe how data is collected and tracked. The PI process requires that data is trended over time and that improvement actions are taken. The PI process includes a

written plan, minutes, and annual evaluation. The plan and the annual evaluation are approved in writing by the Chief of Staff, facility Director and the Associate Director for Patient Care. Other specific actions include:

- Skin Care Policy Implemented.
- Skin Care Protocol has been developed and has concurrences.
- Skin Integrity Committee (Interdisciplinary) was established.
- Skin protocol algorithm development in process
- Revisions of skin integrity care plan complete.
- Interdisciplinary Wound /Skin Care Education Week scheduled for October 2005

b. Analyze pressure ulcer trends

- Skin Integrity/Wound monitor established and data collection begun.
- Prevalence study completed March 4, 2005
- Next Prevalence study schedule for November 2005

Recommendation 10. We recommend that the VISN Director ensures that the Medical Center Director take actions to: (a) repair sidewalks and curbs that pose potential safety risks, (b) secure all cleaning supply closets, and (c) improve general housekeeping on the inpatient psychiatric unit.

Concur

Target Completion Date: March 2006

a. A design and construction contract will be issued for corrective actions.

b. All cleaning supply closets will be secured and defective locking mechanisms corrected. **Completion Date:** June 2005.

c. Additional staff training was conducted for all housekeeping aides in that area. Housekeeping supervisory oversight of the area will be enhanced until performance is acceptable and top management “environmental rounds” will target review of the area. **Completion Date:** June 2005.

Service Contract Administration Deficiencies

Contract Deficiencies	VA Physician Services (Sell)	VA Physician Services (Sell)	MRI Services	Radiation Treatment Services	MOH Surgery Services	Endocrinology Services	Orthopedic Services	Vascular Surgery Services	Wheelchair/Van Services	Brachytherapy Services	Nephrology Services	Urology Services	Transcription Services	Pulmonary Services
	\$290,000	\$75,000	\$237,438	\$2,605,740	\$210,000	\$198,328	\$749,608	\$400,800	\$439,000	\$499,908	\$558,036	\$486,670	\$426,852	\$54,000
HCA Responsibilities														
Contracts not reviewed	X	X		X	X			X						
Prices do not appear to be fair and reasonable		X	X											
Contracting Officer Responsibilities														
Potential conflicts of interest						X		X		X		X		X
Workload analysis not conducted				X	X						X		X	
Statement of work/monitoring measures not well defined	X	X					X	X						
Legal/technical review not conducted				X							X			
Preaward audit not conducted				X							X			
EPLS database search not conducted													X	
Price negotiation memorandum not prepared											X			
Current medical liability insurance not verified			X	X		X	X							
Background investigations not conducted						X	X				X	X	X	
Written justification to exercise option not prepared			X							X				
COTR not trained			X	X	X				X				X	
COTR Responsibilities														
COTR not monitoring contract adequately			X	X	X									
COTR delegated validation and certification responsibilities to other VA employees			X	X	X									

Monetary Benefits in Accordance with IG Act Amendments

<u>Recommendation</u>	<u>Explanation of Benefit(s)</u>	<u>Better Use of Funds</u>
1c	Better use of funds by negotiating an MRI services contract in accordance with Medicare rates.	\$151,286
1d	Better use of funds by ensuring VA is properly compensated for the selling of VA physician services.	70,149
1e	Better use of funds by requesting preaward audits that would reduce contract prices.	411,919
3b	Better use of funds by increasing MCCF collections through improved documentation of medical care and identifying and processing all billable patient health care services.	349,245
5a	Better use of funds by purchasing prosthetic supplies according to the VA purchasing hierarchy.	<u>52,738</u>
	Total	\$1,035,337

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