Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Togus VA Medical Center Togus, Maine

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VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

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

Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.

Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.

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 July 18–22, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Togus VA Medical Center, Togus, Maine. 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 56 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 four activities:

- Colorectal Cancer Management
- Environment of Care
- Government Purchase Card Program
- Quality Management

We identified eight 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.
- Monitor contract radiologist productivity.
- 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 for information technology (IT) security.

- Improve controls over pharmaceutical accountability and strengthen other controls.
- Develop processes to monitor the completion and timeliness of radiology examinations that are performed by contract radiology agencies.

We also made the following observation:

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

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 Appendix A and B, pages 25–34, 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 medical center is a primary and long-term care facility that provides inpatient and outpatient health care services. Outpatient care is provided at five community-based outpatient clinics located in Bangor, Calais, Caribou, Rumford, and Saco, ME. The medical center serves a veteran population of about 142,700 in a primary service area that includes 16 counties in Maine.

Programs. The medical center provides primary, medical, surgical, mental health, and geriatric and extended care services. It also offers dentistry, physical and rehabilitation medicine, audiology, and dialysis services. The medical center has 67 hospital beds and 100 Nursing Home Care Unit beds. The long term care facility consists of two 50-bed units, one of which provides general nursing home care in addition to rehabilitative care and offers respite and hospice programs. The second unit provides care to dementia patients.

Affiliations and Research. The medical center is affiliated with the Massachusetts Eye and Ear Infirmary in Boston, MA for residents in ophthalmology. Students in psychiatry, clinical psychology, and dentistry also complete rotations at the medical center. The medical center is affiliated with the University of New England, the University of Rhode Island, and the University of Maine in several programs. The medical center does not have a research program at this time.

Resources. The medical center's fiscal year (FY) 2005 medical care budget was $150.5 million, a 4.6 percent increase over FY 2004 funding of $143.8 million. FY 2004 staffing was 935 full-time equivalent employees (FTE), including 47 physician FTE and 263 nursing FTE.

Workload. In FY 2004, the medical center treated 35,994 unique patients, a 10.3 percent increase from FY 2003. The inpatient care workload totaled 1,997 discharges, and the average daily census, including nursing home patients, was 115. The outpatient care workload was 297,200 patient 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
Environment of Care	Pharmaceutical Accountability
Equipment Accountability	Procurement of Prosthetic Supplies
Government Purchase Card Program	Quality Management
Information Technology Security	Radiology Services
Laboratory and Radiology Timeliness	Service Contracts

The review covered medical center operations for FY 2004 and FY 2005 through July 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 Togus VA Medical Center Togus, Maine*, Report No. 03-03207-120, April 2, 2004).

As part of the review, we used interviews to survey patient satisfaction with the timeliness of service and the quality of care. We interviewed 30 patients and shared the results with medical center managers.

We also presented 2 fraud and integrity awareness briefings for 56 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 (pages 3–22). 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

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 (COs), and Contracting Officer's Technical Representatives (COTRs) perform their responsibilities in accordance with the Federal Acquisition Regulation (FAR), the Veterans Affairs Acquisition Regulation (VAAR), and VA policy. To evaluate the effectiveness of the contracting activity, we reviewed 12 contracts (4 VISN and 8 medical center) valued at $19 million from a universe of 69 contracts valued at $29 million. The VISN contracts were administered by COs and COTRs located at the medical center. We identified the following issues that require management attention.

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

- Contract Review. The HCA did not conduct contract file reviews of six contracts valued at $2.9 million. The review and evaluation, typically conducted by the HCA, helps ensure the completeness and accuracy of solicitations and contract documentation packages and to ensure compliance with the FAR, VAAR, and VA policy.

  Our review of these six contracts identified deficiencies that would have been identified had the HCA conducted required contract file reviews. The type of deficiencies identified included lack of workload analysis, lack of background investigations, and lack of COTR training.

Contracting Officer Performance. COs are responsible for completing all necessary administrative actions, ensuring compliance with the terms and conditions of the contract, and maintaining contract files containing records of preaward and postaward administrative actions. In addition, COs need to ensure COTRs are trained before they assume responsibility for monitoring contractor performance.

In our prior CAP report, we determined that COs did not conduct a number of required preaward and postaward administrative actions. These actions included workload analysis, the preparation of COTR appointment letters, and the initiation of background investigations. The medical center submitted an implementation plan to address the recommendations. However, our review of service contracts on the current CAP review found the same deficiencies. We found the following contract deficiencies related to the 12 contracts reviewed.

- Required Preaward Administrative Actions. COs did not conduct the required preaward administrative actions, including workload analysis, to support the need and level of procurement for three contracts valued at $756,000. COs did not appoint station COTRs needed to validate laboratory services for three VISN contracts valued at $13.3 million. Also, COTR appointment letters were not prepared by COs for two medical center contracts valued at $478,000. COs did not search the Excluded Parties Listing System (EPLS) database to determine whether the prospective contractor was excluded from Federal contracts before awarding one contract valued at $1.4 million. Additionally, a CO who had authority to award contracts up to $1.5 million twice exceeded her authority by executing a $6.7 million laboratory service contract and a $3 million physician services contract.

- Required Postaward Administrative Actions. COs did not conduct required postaward administrative actions including initiating background investigations for contracted personnel with access to VA computer systems and sensitive information for three contracts valued at $2.3 million. Contracted personnel included one radiologist, three oncologists, the owner of a transcription company, and four transcriptionists. COs did not prepare written justifications to exercise option years for two contracts valued at $920,000.

- Contracting Officer's Technical Representative Training. COs did not ensure four COTRs, responsible for monitoring seven contracts valued at $8 million, had received training before they assumed responsibility for monitoring contractor performance. The COTRs were responsible for monitoring services provided under the laboratory, medical officer of the day, transcription, oncology, cardiology, neurology, and radiopharmaceutical contracts.

Contracting Officer's Technical Representative. COTRs are responsible for monitoring contractor performance and ensuring that services are provided and payments are made in accordance with contract terms and conditions. Our review showed COTRs did not properly monitor the transcription, oncology, neurology, and home oxygen services contracts.

- Transcription Services. The medical center had a $1.4 million contract to provide transcription services for the period October 2004–September 2009. The contract terms indicated payments were to be made based $.135 cents per 65-character lines,

which included spaces, but excluding headers and footers. We determined the COTR (a medical center transcriptionist) did not properly verify the line counts of transcribed reports (such as radiology, operative, compensation and pension examination and consultations/progress notes) before certifying the contractor's payments. Rather, the COTR certified payments based on the gross total of lines, which was contrary to contract terms and resulted in significantly higher and inaccurate line counts. Furthermore the Chief, Health Information Management Service (HIMS) informed us the "line count process" is reportedly skewed if verification of the transcription reports does not occur within approximately 4 hours from the time period when the reports are uploaded into the Veterans Health Information Systems and Technology Architecture (VistA) system. Because the COTR did not properly verify line counts, the medical center lacked assurance that payments totaling $203,366 made from October 2004–July 2005 were appropriate.

The contractor was also required to transcribe radiology reports within 4 hours, "stat" and operative reports within 2 hours, and all other reports within 24 hours. The COTR did not monitor turnaround times to the extent needed to track compliance and to administer penalties for non-compliance, including non-payment for reports not returned within the specified turnaround times.

- Oncology Services. The medical center had a $585,000 contract to provide oncology services for the period April 2004–April 2006. The COTR, the Chief, Medical Service, did not inform the CO when the contractor worked less than the required number of hours and did not adjust payments to the number of hours worked. The contractor was required to work 4 days per week at $1,425 per 8-hour day ($178.13 per hour) for the base year ending April 2005 and $1,500 per day ($187.50 per hour) for the option year ending April 2006. The COTR validated work records showing oncologists worked less than the required 8 hours per day; however, an Administrative Officer (AO) certified invoices paying the contractor billed daily rates. The COTR and not the AO was responsible for certifying invoices and adjusting payments to actual hours worked. For the period April 2004–May 2005, the medical center paid the contractor $287,775 for 1,608 hours while oncologists worked only 1,344.5 hours. The medical center overpaid the contractor $47,164 (239.25 x $178.13 + 24.25 x $187.50).

- Neurology Services. The medical center had a $277,800 locum tenens contract[1] to provide neurology services for the period July 2004–July 2005. The neurologist was required to work 40 hours per week at $133.78 per hour, 8 a.m.–4:30 p.m. The COTR, the Chief, Medical Service, did not maintain time and attendance records. Instead, the neurologist maintained his own records. The COTR validated the neurologist's records showing the physician worked less than the required 40 hours

[1] A locum tenens contract offers temporary placement of physicians, allied health professionals, nurses, and managers. The Togus contract was for the temporary placement of a neurologist.

per week but did not inform the CO as required. On June 2, 2005, the contractor and not the COTR informed the CO that the neurologist submitted time and attendance records to the COTR for the period April 18–May 27, 2005, showing he worked 215.5 hours instead of the required 240. The contractor billed and the medical center paid only for actual hours worked but again, an AO and not the COTR certified invoices.

To determine whether workload existed to support 40 hours of contracted services, we reviewed clinic schedules and conducted an interview with the clerk that scheduled clinic hours. The clerk, acting under the direction of a staff neurologist, did not schedule a full clinic. The clinic, which was scheduled to begin at 9 a.m. and end at 4 p.m., began as late as 10:30 a.m. and ended as early as 1:30 p.m., even though a 3–4 month wait list existed. Based on a review of clinic records for the period April 18–May 27, 2005, we estimate the neurologist could have seen as many as 85 additional patients during the 6-week period. A review of June 2005 records showed that by mid June, management had taken action to ensure the neurologist was working a full clinic schedule.

- Home Oxygen Services. The VISN had a $3.5 million contract to provide home oxygen services for the period January 2001–September 2005. The contractor was required to provide therapy services including the services of a Registered Respiratory Therapist (RRT) or Certified Respiratory Therapist (CRT) credentialed by the National Board for Respiratory Care and familiar with the life sustaining nature of the equipment involved. While a medical center COTR was not officially designated, a Home Oxygen Coordinator did monitor contractor performance. The coordinator informed us that the contractor was notified numerous times dating back to December 2003 that they were not in compliance with the VISN contract. We were not provided documentation showing the medical center had contacted the CO of record, who was located at the Connecticut Healthcare System, of serious compliance issues until April 19, 2005. Compliance issues included not seeing patients within 96 hours of initial visits, not conducting 90-day follow-up visits, and not providing oximetry studies within 30 days of the order. The CO attributed these problems to low staffing levels of RRTs and CRTs at the contractor's Bangor and Portland locations.

  As of August 2005, the coordinator said that he had not received approximately 104 (74 percent) of 130 reports dating back to October 2004 indicating that patients were seen within 96 hours of the initial visits. The visits are to determine if the set-ups, made by unlicensed persons, were done correctly and to determine if the patients understood the prescriptions, safety considerations, and the patients' care plans. The coordinator also had not received approximately 1,800 90-day follow-up reports dating back to July 2004. The 90-day visit gives VA a sense of how the patient is doing. Its purpose is to determine if the patient is compliant with therapy, and to

obtain vital signs and oximetry[2] data for the patient. The coordinator also had not received approximately 40 overnight oximetry studies dating back to December 2004. The studies are needed to determine if the patient still qualifies for home oxygen services or to determine if the current level of oxygen is sufficient or if it needs to be adjusted.

The coordinator informed us that medical center and VISN management met with the contractor on August 4, 2005, and that the contractor submitted an action plan to reduce the backlog and to ensure future compliance by increasing staff at the Bangor and Portland locations.

See Appendix C, page 35, for a table summarizing the types of contract services acquired, the estimated value of each contract, and contract administrative deficiencies identified.

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, VAAR, and VA policy and to detect, correct, and prevent future contract deficiencies.
b. COs correct the required preaward and postaward administrative deficiencies.
c. COTRs receive proper training.
d. COTRs properly monitor contracts to include validation of services and ensure payments are made in accordance with contract terms.
e. COs seek reimbursement of the overpayment for oncology services.
f. Contracting officials collaborate with HIMS management to establish a process to verify billed line counts.
g. The HCA collaborate with the CO of record to ensure the action plan for the home oxygen services contract is implemented.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that a contract review check list has been developed and implemented to ensure the HCA has completed a contract file review and COs and COTRs perform duties as required. Corrections of the identified preaward/postaward deficiencies will be completed by December 16, 2005. All current COTRs have completed training and the HCA will continue to monitor training. COTR memorandums were amended to include a statement stressing validation of services in accordance with contract payment terms. Internal controls have been established by the COTR to ensure workload and documentation of time and attendance through a sign-in and out procedure by all locum tenens and contract providers. Documentation is reviewed by the COTR. Resolution of the oncology services overpayment will be completed by November 10, 2005. A line count verification procedure has been put into place by the Chief, HIMS using Microsoft Word line count. The transcription service contract COTR is also verifying the turnaround time by accessing the Medscript Dictation Tracking System website and

[2] Oximetry measures the amount of oxygen in the blood.

checking the date/time of dictation and date/time of transcription of each report. The home oxygen contract is being monitored on three levels by the interactions of the medical center COTR, CO, and the vendor at monthly meetings; the VISN Prosthetic Manager and VISN Prosthetic Health System Specialist; and the VISN 1 Contracting Office. The improvement plans are acceptable, and we will follow up on implementation of planned actions.

Radiology Services – Radiology Coding Policies Should Be Reviewed and Contract Radiologists Productivity Monitored

Conditions Needing Improvement. The projected FY 2005 productivity for the medical center's staff and contract radiologists appears to be slightly low as a result of Common Procedure Terminology (CPT) coding discrepancies and a lack of technology. The coding policies at the medical center differ from other facilities within VISN 1 and may adversely affect the amount of Relative Value Unit (RVU)[3] workload credited to radiologists. As a result, radiologists at the medical center may not be receiving accurate productivity credit. Additionally, unlike several other VISN 1 facilities, this medical center does not have the digital technology that eliminates the need for radiologists to manually retrieve, handle, and read films. The absence of the technology also eliminates the possibility for the medical center to use teleradiology[4] and share radiologist resources throughout the VISN.

Productivity Benchmarks. During March 2004, the VHA Director, National Radiology Program informed the OIG[5] 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. 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.

Productivity and Cost Figures. The medical center has four full-time radiologists (three full-time staff radiologists and one full-time locum tenens) and uses the services of an

[3] RVUs are numbers established by Medicare and used in its fee formula, along with practice and malpractice expenses. The 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] Teleradiology is an enabling technology that allows radiologic and nuclear medicine studies acquired at one location to be transmitted electronically for interpretation by an imaging physician at a second location.

[5] 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).*

additional .15 FTE locum tenens radiologists as a replacement when staff radiologists take leave. The VHA Decision Support System (DSS) Labor Mapping allocates .55 FTE of the Chief, Radiology Service's time for administrative duties, which leaves the service with 3.6 FTE service line radiologists. Using productivity numbers from the first 3 quarters of FY 2005, the 2.45 FTE (3 FTE - .55 FTE for administrative duties) VA staff radiologists' projected RVU output is 10,305 RVUs, which equates to a productivity level of 4,206 RVUs per FTE (10,305 RVUs / 2.45 FTE). The projected output for the 1.15 FTE contract radiologists is 4,782 RVUs, which results in a productivity level of 4,158 RVUs per FTE (4,782 RVUs / 1.15 FTE). The total projected workload for FY 2005 is 15,087 RVUs, which would result in a productivity level for the 3.6 combined service line staff and contract radiologists of 4,190 RVUs per FTE (15,087 RVUs / 3.6 FTE).

The medical center spends approximately $271,509 per FTE for salary and benefits for a VA radiologist. The outsourcing cost is approximately $376,020 per FTE for a contract radiologist. The total cost per RVU for VA staff radiologists is $64.55, as opposed to $90.43 for the contract radiologists. The cost per RVU incorporates both cost and productivity data. The $25.88 ($90.43 – $64.55) difference between the cost per RVU for VA staff and contract radiologists is reflective of the $104,511 ($376,020 - $271,509) increased cost to the medical center for a contract radiologist compared to a staff radiologist. The productivity numbers for staff radiologists are also 48 RVUs per FTE higher than contract radiologists.

Coding Discrepancies. The productivity numbers for both VA staff and contract radiologists may also be adversely affected by discrepancies in CPT coding. In August 2002, the VISN 1 Radiology Group Manager visited the medical center and changed their radiology coding practices in order for them to be standardized with the rest of the facilities within the VISN. In August 2003, the medical center changed specific radiology codes (contrary to the August 2002 coding changes) because they believed that certain procedures were being incorrectly coded for billing purposes; thus differentiating from the other VISN 1 facilities.

VHA does not have a policy pertaining to the standardization of parenting[6] of procedures. The VHA Director, National Radiology Program advised VISN 1 personnel that the parenting of codes is left to the discretion of the facility. The VISN 1 Compliance Officer has informed us that there will be a national distribution of standardized codes related to the parenting of Computed Tomography (CT) scans by the year 2007. The VISN 1 Compliance Officer also informed us that the VISN is reviewing the coding discrepancies to determine if there is an effect on productivity numbers, and whether the medical center is the only facility within VISN 1 that is coding radiology procedures differently.

[6] Parent procedures are used to simplify the ordering process when a group of related procedures must be done. When a "parent" is created, a CPT code is not entered.

The medical center's Chief, Radiology Service estimates that the medical center's radiologists may be losing as much as 15–20 percent of the RVUs that could be generated by the parenting of codes for specific CT scans. The medical center is projected to have 5,876 RVUs from CT scans in FY 2005, without making any adjustments for coding. If the medical center standardized their coding with the rest of the facilities within the VISN, the Chief, Radiology Service's estimation of an additional 20 percent would increase their CT scan totals to 7,051 RVUs, resulting in an overall workload total of 16,262 RVUs. The average productivity for the 3.6 FTE service line radiologists would increase from 4,190 to 4,517 RVUs per FTE (16,262 RVUs / 3.6 FTE). This issue continues to be reviewed by the OIG.

Picture Communication Archive System. Because the medical center does not have a Picture Archive Communication System (PACS), radiologists cannot digitally read and verify films. Rather, they must manually handle the films, which is time consuming. Another drawback to not having PACS is that the radiologists do not have the technology to view previous films of patients, which frequently requires additional time for the retrieval of the prior examinations.

The Chief, Radiology Service informed us that he could likely take on a slightly larger workload with the addition of PACS or additional diagnostic equipment. The technology of PACS would reduce the amount of time it takes his staff to read examinations, subsequently allowing additional examinations to be read. Through the use of PACS technology, medical care providers have the capability to capture, store, view, and share radiology images. PACS also allows for the possibility of teleradiology, which could potentially allow VA facilities with excess radiologist staff to read examinations from other facilities that have a shortage of staff or a backlog of workload.

Timeliness of Examinations. VHA has recently implemented a new timeliness standard that became effective the fourth quarter of FY 2005, which requires examinations to be read and verified within 2 days. In the second quarter of FY 2005, the medical center verified 92 percent of examinations within this new performance measure and was the only facility within the VISN to be rated "Exceptional" for this performance measure. To further ensure timeliness and quality, the Chief, Radiology Service also requires radiologists to handwrite preliminary results to "stat" and "urgent" examinations, which makes findings more readily available to requesting physicians.

Recommendation 2. We recommended that the VISN Director ensure the Medical Center Director monitors contract radiologists' productivity to ensure outsourced services are cost-efficient.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that current contracted radiologists' productivity will be monitored by the Chief, Radiology Service using RVUs. The cost per RVU will also be monitored to ensure cost efficiency and the potential for cost reduction and outsourced sources. The

improvement plans are acceptable, and we will follow up on implementation of 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 collections goal of $11,638,645 by over $645,000 during the period of April 1, 2004–March 31, 2005. However, our review of statistical samples of outpatient bills, the medical center's "Reasons Not Billable (RNB) Report," and fee basis payments made during the same period identified additional opportunities to further enhance MCCF revenues. By reducing documentation errors, more closely monitoring and reviewing MCCF reports, and preventing improper coding and billing errors, we estimate that an additional $3.25 million could have been billed, and MCCF revenues could have been increased by $1,169,124 or 10 percent of $11.6 million collected.

Outpatient Billing Review. As of June 21, 2005, there were 130,164 outpatient bills valued at $20,584,322 billed to third party payers for care delivered during the period April 1, 2004–March 31, 2005. A statistical sample of 138 outpatient encounters, billed at $201,256 and collections of $81,926 was reviewed. The review identified 29 errors, which included coding, billing, and documentation of medical records errors. The 29 encounters were underbilled by $18,137 (9 percent of the total billed amount). Twenty-eight errors involved coding and billing issues, and 1 error was the result of improper follow-up on a denied payment. Examples of the errors follow.

- Two bills for an echocardiogram were not billed because the results of the test were not entered into the computerized patient record system (CPRS) until 20 days after the test was performed. Despite the documentation delay, the test was still billable for both institutional and professional fees for $1,414 and $175, respectively.

- MCCF staff had a backlog of billing, which resulted in six bills not being issued because the time to file a claim to the third party payers had expired. This resulted in missed billing opportunities of $7,503.

- Accounts Receivable staff did not follow-up with a third party payer when payment for a $270 bill was denied. The bill was inappropriately cancelled.

These missed billing opportunities resulted from both human error and internal control weaknesses. HIMS staff, MCCF staff, and the Compliance Officer need better review processes that can identify and correct for situations where charges are missed, encounters are not coded, and bills are incorrectly cancelled. Improvement in these areas will increase both billing and collections.

Projecting our sample results to the universe valued at $20,584,322, we estimate that about $1,852,589 ($20,584,322 x 9 percent) could have been underbilled. Based on the medical center's average collection rate of 35.96 percent, we estimate that an additional $666,191 could have been collected on unbilled health care services.

"Reasons Not Billable 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 represent missed billing opportunities due to poor or missing documentation by medical care providers. Coding staff review documentation such as provider progress notes, test results, and surgical reports of patient encounters. Coding staff then assign diagnoses codes from the International Classification of Diseases (ICD-9-CM) and CPT procedure codes, and if they determine that the encounter is billable, they forward the coded encounter to MCCF staff, who process the bill. If coding staff consider the encounter nonbillable, it is forwarded to MCCF staff to be listed on the "RNB Report." As of June 21, 2005, there were 351 encounters valued at $54,009 listed in the 3 segments of the outpatient "RNB Report" for treatment provided during the period of our review. There were 184 encounters valued at $28,158 in the Insufficient Documentation segment, 118 encounters valued at $22,033 in the No Documentation segment, and 49 encounters valued at $3,818 in the Nonbillable Provider (Resident) segment.

These three segments of the "RNB Report" should be used as a tool by medical center staff 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 to veterans, an additional $54,009 could have been billed for the encounters on these three segments of the "RNB Report," and based on the medical center's average collection rate of 35.96 percent, $19,422 could have been collected.

Fee Basis. The medical center paid 24,392 fee basis claims totaling $2,950,832 to non-VA providers who provided medical care to VA patients with insurance during the period April 1, 2004–March 31, 2005. Payments to fee basis providers included 611 claims for inpatient and ancillary care at a cost of $988,411, and 23,781 claims for outpatient care at a cost of $1,962,421. Fee basis staff refer claims for patients with health insurance to MCCF staff when the medical center has been billed by the provider, the services provided have been reviewed, and the fee basis claims have been paid.

To determine if fee basis care was properly billed to patients' insurance carriers, we reviewed a statistical sample of 97 outpatient claims and 84 inpatient and ancillary claims. Of the 97 outpatient claims, 76 claims were not billable to third party payers because the care provided was service-connected, the patients' insurance was not in effect on the dates care was provided, or the medical services provided were not covered by the patients' insurance. The remaining 21 outpatient claims were billable to third

party payers (average bill value $177). One claim was correctly billed for $1,590, but 20 claims were not billed by MCCF staff. Seven claims were overlooked by fee basis and MCCF staff and 13 claims were not billed because fee basis providers did not submit required documentation of the medical services provided. These 20 claims could have been billed for $2,129.

Of the 84 inpatient and ancillary claims, 41 claims were not billable to third party payers because the care provided was service-connected, the patients' insurance was not in effect on the dates care was provided, or the medical services provided were not covered by the patients' insurance. The remaining 43 inpatient and ancillary claims were billable to third party payers (average bill value of $2,352). Fifteen claims were correctly billed by MCCF staff for $88,846, but 28 claims were not billed by MCCF staff. Twenty-seven claims were not billed for $11,423 because MCCF staff did not receive the required documentation from the fee basis providers, and 1 claim was not billed for $876 because the patient's insurance was identified after the care was provided, and the facility did not have a process to identify and bill fee basis care when insurance is identified after the care occurs.

Projecting our sample results to the universe, we estimate that an additional $867,123 could have been billed for outpatient fee basis care (20.6 percent error rate x 23,781 outpatient universe x $177 average bill value) and an additional $477,456 could have been billed for inpatient and ancillary fee basis care (33.3 percent error rate x 611 inpatient/ancillary universe x $2,352 average bill value). Based on the medical center's average collection rate of 35.96 percent, we estimate that an additional $483,511 could have been collected.

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

Source	Projected Additional Billable Amount	Projected Additional Collectible Amount
Outpatient Encounters	$1,852,589	$666,191
"Reasons Not Billable" Report		
Insufficient Documentation	28,158	10,126
No Documentation	22,033	7,923
Non-Billable Provider (Resident)	3,818	1,373
Fee Basis	1,344,579	483,511
Totals	**$3,251,177**	**$1,169,124**

Conclusion. Internal controls such as compliance reviews should be expanded to include a full review of patients' records to ensure all billable patient care was coded and billed. 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 training on documentation requirements. Medical center management also needs to develop a process to obtain all documentation provided by fee basis providers and enter it into the patients' electronic medical records so that MCCF staff can appropriately bill third party payers. By strengthening controls, the medical center has the opportunity to increase MCCF revenues by about $1,169,124 annually.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director improves billing practices by taking action to: (a) establish internal controls and expand compliance reviews to capture all episodes of care that need to be coded and billed; (b) establish a monitoring system to review the "RNB Report," correct documentation deficiencies, and appropriately bill insurance carriers for health care provided; (c) follow up on missing or inadequate documentation by contacting providers and requesting that proper documentation be submitted; and (d) ensure all documentation for fee basis care is received by the medical center and entered into the patients' electronic medical records, and appropriately bill insurance carriers for fee basis care provided.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that monthly audits will be conducted to ensure all billable episodes of care have been coded and billed. A monthly monitoring system has been established to review the "RNB Report," providers will be contacted for submission of proper documentation, and billable services will be forwarded to billing for insurance claim submission. The Director also reported that if there is insufficient or missing documentation to support codes that have been entered, the person responsible for documenting the encounter is contacted by the coder. If information needed is not entered within twenty-four hours, the Chief, HIMS notifies the service chief/service line manager of action to be taken. Accounts are referred to service line manager when necessary. All authorization letters now contain the addendum stating that the report from the procedure and/or episode of care must be attached to the corresponding bill in order to ensure prompt payment from VA. The HIMS Medical Records Department will scan the fee basis care documentation into CPRS. The improvement plans are acceptable, and we will follow up on implementation of planned actions.

Equipment Accountability – Inventory Controls Should 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 July 21, 2005, the medical center had 143 active EILs listing 9,410 equipment items with a total acquisition value of $26.8 million. We identified five equipment accountability issues that required corrective action.

Equipment Inventory Procedures. VA policy requires responsible officials, such as service chiefs or their designees, to conduct annual or biennial inventories of nonexpendable equipment. These officials must evaluate the need for all equipment assigned to them and sign and date their EILs certifying that equipment was accounted for. The inventories must be completed within 10 days of notification from A&MMS for EILs with fewer than 100 items, or within 20 days for EILs containing 100 or more items. We found the following equipment inventory deficiencies.

- Responsible EIL officials did not complete 73 (82 percent) of 89 annual inventories within the required 10-day or 20-day periods after receiving notifications that the inventories were due. The 73 EILs were delinquent an average of 46 days, with delinquencies ranging from 4 days to 5 months.

- A&MMS staff did not determine whether 1,140 items (acquisition value = $3.1 million) that were classified as "out of service" were appropriately listed in this category. A&MMS officials commented that some items were improperly placed in this category by a former employee. Also, various items on the list were considered part of building services equipment (physical plant components); such equipment is not required to be included when property inventories are conducted.

Accuracy of EILs. To assess equipment accountability, we reviewed a statistical sample of 98 equipment items (combined acquisition value = $1,540,729). These items were listed in the Automated Engineering Management System/Medical Equipment Reporting System (AEMS/MERS) on the over $5,000 current inventory list. We were able to locate 96 of the 98 items. The following two items could not be located.

- A medical gas distributor (acquisition value = $10,000) unknown acquisition date.

- A transfer pump (acquisition value = $15,000) acquired in 1982.

Both items are considered building services equipment, yet are not part of the periodic physical inventories that are conducted. VA property policy does not require them to be included when the nonexpendable property inventories are conducted. However, per our discussions with A&MMS staff, we agreed that these items—most of which fall under the Facilities Management Service (FMS)—be reviewed so they can be accounted for and reported as in or out of service. Because building services equipment that does not have to be reviewed periodically to determine accountability status is listed in AEMS/MERS, the database contains items such as boilers or pumps that have been disposed, yet not deleted from AEMS/MERS.

Accountability of Firearms. We verified that all 15 Police Service firearms were listed in AEMS/MERS. Fifteen firearms were listed in the property database—12 were assigned to specific police service employees and 3 were maintained as "extras." We physically accounted for 13 of the 15 firearms, but could not view the other 2 because they were off site with 2 police officers in training.

- The sign-out sheets used by Police Service to account for firearms taken off-site were insufficient because there was no data, such as serial numbers, that specifically identified the firearms.

- The internal log maintained by Police Service to assign firearms to each police officer was inaccurate. The two firearms assigned to the police officers in training were classified as "unassigned" on the log.

- Each firearm is kept in an individual lock box when not signed-out by a police officer. Each lockbox had a bar code label affixed to it, which is supposed to identify the firearm contained inside. However, none of the bar code labels matched up to the firearms that were kept in the corresponding lock boxes. We determined that this was due to an internal Police Service practice whereby, as police officers are hired or leave VA, the lockbox order changes based on the police officers "moving up" in seniority. We believe that this practice caused the discrepancies with the bar code labels and the internal log.

Disposed Equipment. We reviewed a sample of 15 items that had been disposed of (acquisition value = $95,210) from a list of 2,546 disposed items (total acquisition value = $4,836,979) covering the period October 2003–June 2005. We received documentation showing that 13 of the items had been properly disposed. We were not provided with documentation for one item in our sample (a microwave acquired in 2003 for $121) and the status of it could not be determined. Subsequent to our on-site visit, a "Report of Survey" was prepared that appropriately addressed the loss of the item. The other item in our sample (a television acquired in 1999 for $303) was classified as turned-in; however, it was located during our review and found to be in use. A&MMS management stated

that the data for this item would be updated and the proper status and location would be entered into AEMS/MERS.

Access to Property Menu Options. We determined that 37 employees had the capability to add, edit, and dispose of (turn in) items listed in AEMS/MERS. VHA policy requires that A&MMS staff conduct a review to determine if the options for each employee are justified and needed. The integrity of the property database was vulnerable to manipulation, inaccuracies, and misuse because the reviews were not performed and 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. Medical Center management accounts for items classified as "out of service" and updates the property accountability status to reflect only inventoried items that are legitimately "out of service."
b. Responsible officials or their designees perform the physical inventories of nonexpendable property in a timely manner in accordance with VA policy.
c. Police Service strengthens controls to improve accountability for all firearms.
d. A&MMS management maintains complete and accurate documentation for all equipment that is turned in.
e. 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 the Chief, FMS will have a correct listing of equipment classified as "out of service" by November 30, 2005. Future annotations to the listing will be made timely to reflect only "out of service" equipment. A&MMS personnel will send delinquent EIL notifications to service chiefs or their designees after the 10- or 20-day due dates have elapsed. The Medical Center Director will hold service chiefs accountable for any overdue EILs. The Director also reported that sign-out sheets list the officer assigned to each firearm and the corresponding firearm serial number. The log also notes the firearms which are unassigned. Also, lock box bar code labels correspond with the stored firearms. An A&MMS supply technician has reviewed and updated documentation of disposed equipment and continues to review station equipment turned in to ensure proper record accountability. Employee access to the EIL database has been reduced from 37 to 14 employees. Only employees who need access have privileges. The improvement plans are acceptable, and we will follow up on implementation of planned actions.

Procurement of Prosthetic Supplies – Purchases Need to Comply With VA's Purchasing Hierarchy

Condition Needing Improvement. Medical center 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, and 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 FSS contracts. During the period March 2004–February 2005, the medical center purchased prosthetic supplies (hip and knees) on the open market, the least preferred source.

In the prior CAP report, we reported the same condition that purchases of hip and knee components were being made on the open market from a sole source vendor. Medical center management provided us with an implementation plan and a target date of March 1, 2004, that stated implants would be purchased from a contract source and if a non-contract implant is ordered, a waiver would be initiated and approved prior to the surgery in order to be compliant. However, the medical center did not fully comply with their implementation plan.

To determine if the medical center purchased prosthetic supplies effectively, we reviewed a sample of 35 open market purchases of total hip and knee components at a cost of $247,893. We found that procurement personnel purchased these components from one vendor and did not comply with the purchasing hierarchy. Additionally, we were not provided documentation that ordering physicians had initiated waivers to procure these items from a sole source vendor. Prior to the awarding of a national contract on June 7, 2004, procurement personnel made 30 purchases consisting of 5 total hip components purchased at a cost of $39,043, and 25 total knee components purchased at a cost of $165,736. Data obtained from the VA National Acquisition Center showed that an FSS vendor offered comparable items at lower prices. The medical center could have obtained lower prices for these items. A comparison of prices paid by the medical center to FSS prices showed that the medical center could have paid 51 percent less for hip components and 43 percent less for knee components, resulting in potential savings of $91,178 (51 percent x $39,043 and 43 percent x $165,736 = $91,178). The five open market purchases valued at $43,114 made after June 7, 2004, had proper clinical waiver documentation. We estimated the medical center could have potentially saved $91,178 by purchasing these products from an FSS vendor.

Recommendation 5. We recommended that the VISN Director ensures that the Medical Center Director requires: (a) procurement personnel to comply with the VA purchasing hierarchy and (b) controls to be established to follow-up on implementation of OIG recommendations.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that procurement personnel will comply with the purchasing hierarchy. Prosthetics has purchased items from the national contract since June 7, 2004. Further,

surgeons have requested waivers through the Chief, Surgical Service from the Chief of Staff. The Quality Manager will track action plans in response to OIG recommendations and report monthly to the Quality Leadership Team. The improvement plans are acceptable, and we will follow up on implementation of 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 Information Security Officer (ISO) was proactively writing and implementing security policies. The ISO also ensured that all employees completed an initial information security class before they were granted access to AIS, as well as completed required annual security awareness training, as required by VHA policy. The automatic session timeout feature was enabled on all medical center workstations, and the network manager was routinely monitoring system activity, vulnerabilities, and performance. The following issues required management attention.

Access to AIS Resources. VHA policy requires that physical access to AIS resources must be limited to only those personnel who have a legitimate need for access. Access to communication closets throughout the medical center was controlled by a lock and key system. FMS was responsible for issuing and monitoring keys to these closets. We found that several non-Information Resource Management (IRM) Service employees had keys allowing them access to the closets. The control of keys allowing access to the communication closets should be the responsibility of IRM Service and that access should be limited to only IRM Service personnel. The Chief Information Officer (CIO) stated that the transition of responsibility for the keys to the communication closets had already been initiated, and IRM Service would be taking over that responsibility.

Hard Drive Sanitation. VHA policy requires that all sensitive information and data must be removed from hard drives prior to the disposal of computer equipment. We selected 11 computers that had been disposed of within the past 18 months (identified by local inventory number), and requested documentation showing that the hard drives had been properly sanitized. Requested documentation could not be provided for 2 of the 11 computers. The CIO stated that the hard drives for these two computers had been removed and retained in a secure room because they were to be sent out and destroyed under a recently established VA Office of Cyber and Information Security contract. However, when the hard drives were initially removed, the local inventory numbers of the computers that they came from had not been captured. While we were on site, the CIO developed a policy requiring proper documentation of removed hard drives prior to the disposal of computer equipment.

Veterans Health Information Health Systems and Technology Architecture Menus. We reviewed the level of access and the VistA menus granted to IRM Service employees. We found that 12 employees had access to the menus for all areas throughout the medical center (e.g., Pharmacy, payroll). The CIO stated that IRM Service employees were granted this level of access for troubleshooting purposes so that any problems medical center staff encountered could be replicated and viewed by IRM Service staff. We recommend that the CIO review the level of access and VistA menus granted to all IRM Service employees to determine whether there is a continued and legitimate need for the access levels assigned.

Recommendation 6. We recommended that the VISN Director make sure the Medical Center Director takes action to: (a) transfer control of communication closet access to IRM Service; (b) limit access to AIS resources, including communication closets, to IRM Service employees; (c) properly document that all hard drives are being sanitized prior to the disposal of computers; and (d) review the access and VistA menu options for all IRM Service employees to verify that there is continued and legitimate need.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that Information Management Service Line (IMSL) policy now identifies IMSL as controlling access to the communication closets. Also, access to AIS resources will be limited to appropriate staff. Access will be available to limited FMS staff as needed. The CIO will ensure the procedure for sanitizing hard drives is followed including completion of VA Form 0751, "Information Technology Equipment Sanitization Certificate." The Director also reported VistA menu options not needed on a continual basis have been removed. Further, menu options will be assigned only on an as needed basis for technical support. The improvement plans are acceptable, and we will follow up on implementation of planned actions.

Pharmaceutical Accountability – Stock Levels Should Be Monitored and Other Controls Improved

Conditions Needing Improvement. Medical center management needed to improve controls to maintain minimum inventory stock levels, ensure accountability of controlled substances, and comply with VHA policy. Also, improvements were needed to ensure Pharmacy Service uses the prime vendor inventory management (PVIM) system and the VistA Controlled Substances Software. We identified the following issues that required management attention.

Inventory Stock Levels. VHA policy mandates the use of the PVIM system to assist medical facilities in minimizing the replenishment cost of inventory by calculating reorder points and minimum inventory stock levels.

Based on a review of 3 months activities and an ending balance on July 22, 2005, we determined that five of eight drugs tested had excess stock valued at $10,760. We found that stock levels were excessive because Pharmacy Service staff were not effectively using the PVIM system. The value of excess stock follows.

Drugs	**Amount**
Epogen (10,000 unit 1 ml)	$6,856
Oxycontin (10, 20, and 40 mg)	2,799
Lipitor (40mg)	1,105
Total	**$10,760**

Receipt of Controlled Substances. VHA policy requires that a Pharmacy Service employee and an accountable officer, or designee must witness the receipt and posting of controlled substances into inventory records. Both employees must annotate the receipt of controlled substances on the invoices. Also, an A&MMS employee must annotate on the invoices that controlled substances have been posted to the VistA Controlled Substances Software.

- Seven of 19 invoices did not contain the required 2 signatures of a Pharmacy Service employee and an accountable officer, or designee.

- Four of 19 invoices had not been annotated by an A&MMS employee to verify that controlled substances had been posted to the VistA Controlled Substances Software.

Segregation of Duties. VA policy and sound internal control practices prohibit one individual from controlling all the key aspects of a transaction such as ordering and receiving the same goods. The two Pharmacy Service procurement technicians were purchasing as well as receiving non-controlled substances.

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.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that: (a) Pharmacy Service staff use the PVIM system to ensure minimum inventory stock levels; (b) Pharmacy Service staff and an accountable officer, or designee, witness the receipt and posting of all drugs, and annotate verification on invoices; (c) segregation of duties is maintained when ordering and receiving non-controlled substances; and (d) medical center policy complies with VHA policy.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that the PVIM system will be in place and functioning by November 30, 2005. A vault employee and a pharmacy employee not assigned to the

vault receive and post all drugs and signatures will be annotated on invoices. A procurement technician will be responsible for ordering non-controlled substances and an inpatient or phone pharmacy technician will receive orders. Pharmacy Service policy concerning ordering and receiving drugs and supplies has been revised effective August 3, 2005. The improvement plans are acceptable, and we will follow up on implementation of planned actions.

Laboratory and Radiology Timeliness – Contracted Radiology Examinations Needed To Be Monitored

Conditions Needing Improvement. VISN and medical center policies defined timeliness standards for laboratory tests and radiology examinations. The turn-around-times for laboratory tests generally met the standards set by policy; and there was documentation to support reasons for scheduling routine laboratory tests beyond the designated timeframes. Also, radiology examinations performed by Radiology Service were generally completed timely. However, medical center managers needed to develop and implement processes to ensure that radiology examinations that are performed by contract radiologists are completed timely, examinations are completed prior to the contract radiologists receiving payments, and results of examinations are timely scanned into CPRS.

The medical center does not perform mammograms or magnetic resonance imaging (MRI) examinations. If these studies can not be timely scheduled at another VA facility, they are performed by contract radiologists. To expedite provider requests for contract radiologist services, the medical center established a Clinical Service Support Unit (CSSU). The functions of the CSSU are to receive examination requests from providers, schedule patients with contract radiologists, notify patients of the dates and times of their examinations, and request that the contract radiologists send the results of the examinations to the CSSU in a timely manner, so CSSU employees can notify providers of the results and scan the results into CPRS.

CSSU documentation showed that approximately 600 examinations were scheduled each month with various contract radiologists. However, the CSSU had no monitoring process in place to ensure that these examinations were actually performed, but instead relied on the contractors to notify the CSSU that examinations were completed. Without internal monitoring, the medical center could not be certain that:

- Radiology examinations performed by contract radiologists were completed timely, and the results were timely communicated to the CSSU and providers.
- The radiology services the medical center paid for were performed prior to payment.

Additionally, the CSSU had only one scanner; consequently, at the time of our visit, there was a 2-month backlog of mammogram and MRI results that had not been scanned into CPRS.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director: (a) requires that CSSU employees monitor the completion and timeliness of radiology examinations that are performed by contract radiologists, (b) ensures that contract radiology services are completed prior to the contractors receiving payments, and (c) takes action to ensure that results of mammograms and MRIs are timely placed into CPRS.

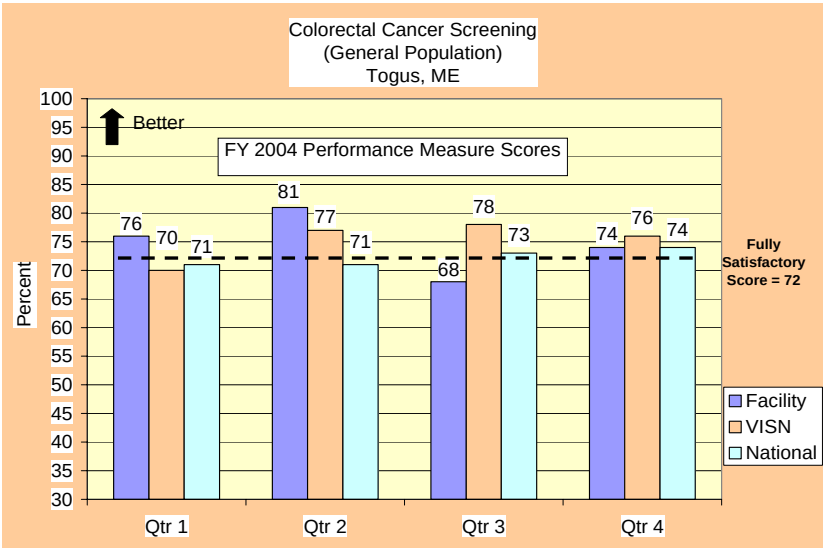
The VISN and Medical Center Directors agreed with the findings and recommendations and reported that CSSU personnel schedule the radiological examinations and monitor the date of service and the authorized date. CSSU/Fee Services Claims assistants have been directed to verify reports for community radiological examinations before payments are processed. Vendors are to attach a copy of the report to the claim or fax a copy for verification of completion of the examination. Installation of high speed scanning equipment in the CSSU will alleviate the current backlog of reports and allow the timely processing of all future reports into CPRS. The improvement plans are acceptable, and we will follow up on implementation of planned actions.

Other Observation

Colorectal Cancer Management – Processes were Timely and Appropriate

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

Figure 1



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 (Figure 2). To determine reasonableness of timeframes, we used the medical center's 120-day goal for GI evaluations (taking into consideration factors outside the medical center's control).

Figure 2

Patients appropriately screened	Patients diagnosed within 120 days	Patients appropriately notified of their diagnoses	Patients with interdisciplinary treatment plans	Patients received timely initial treatments
10/10	9/10	10/10	10/10	10/10

Appendix A

VISN 1 Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 22, 2005

From: Network Director (10N1)

Subject: **Combined Assessment Program Review of the Togus VA Medical Center**

To: 1. Attached is the response to the Draft Combined Assessment Program Review of the Togus VA Medical Center, Project number 2005-01608-R1-0137.

2. If you have any questions or need additional information, please contact John Sims, Director, Togus VA Medical Center by calling (207) 623-5756.

JEANNETTE A. CHIRICO-POST, M.D.

Attachment

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 28, 2005

From: Medical Center Director

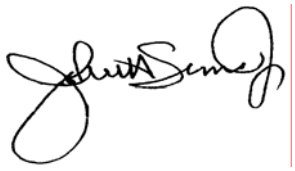
Subject: **Togus VA Medical Center, Togus, Maine**

To: Office of Inspector General, Bedford Audit Operations Division

Please find comments for the Togus VA Medical Center's OIG/CAP review on the following pages. The time, attention to detail and cooperativeness of the inspection team was most appreciated. The interactions with staff and the recommendations have afforded us the opportunity to continue to target opportunities to give unparalleled service to our veterans. We concur with the findings, recommendations, and monetary benefits presented in the report.

Concurrence with the eight recommendations is noted with specific corrective actions that have been implemented and/or will be implemented in the specified time frame.

Questions or further comments regarding our response can be directed to me with the anticipation of a complete and timely reply. Thank you.



JOHN H. SIMS, JR
Director, Togus VA Medical Center

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) COs correct the required preaward and postaward administrative deficiencies; (c) COTRs receive proper training; (d) COTRs properly monitor contracts to include validation of services and ensure payments are made in accordance with contract terms; (e) COs seek reimbursement of the overpayment for oncology services; (f) contracting officials collaborate with HIMS management to establish a process to verify billed line counts; and (g) the HCA collaborate with the CO of record to ensure the home oxygen services contract action plan is implemented.

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

(a) A check-off list, developed and implemented on October 1, 2005, signed by the HCA verifies that the HCA has completed a contract file review to ensure contracting officers and COTRs perform duties as required.

(b) The Lead Contract Specialist has implemented bi-weekly audits of contract folders by facility Contract Specialists. Corrections of the identified preaward/postaward deficiencies will be completed by December 16, 2005.

(c) On July 1, 2005, the HCA prepared a spreadsheet that lists all COTRs assigned to monitor active local/VISN contracts. Completion of COTR training is and will continue

to be tracked using this tool. All current COTRs have completed training.

(d) COTR memorandums were amended to include a statement stressing validation of services in accordance with contract payment terms. Internal controls have been established by the COTR, Chief, Medical Service, to assure workload and documentation of time and attendance through a sign-in and out procedure by all locum tenens and contract providers. Documentation is reviewed by the COTR.

(e) Resolution of the oncology services overpayment will be completed by November 10, 2005.

(f) A line count verification procedure, successfully used by the VA Connecticut Healthcare System, who has the same transcription vendor, has been put into place by the Chief, HIMS to perform a line count using Microsoft Word line count. The Medscripts web based transcription log is reviewed daily and a random selection chosen with a two-four hour window from date/time of transcription. As a result of the OIG visit, we have corrected a faulty process.

The transcription COTR is verifying the turnaround time by accessing the Medscript Dictation Tracking System website and checking the date/time of dictation and date/time of transcription of each report. If an exception to the contract terms for turnaround times is found, then a call is placed to the vendor. If the reason for a delay is not acceptable, no payment is made. To date, the contractor is meeting terms for turnaround times set forth in the contract.

(g) The Home Oxygen contract is administered by the Contracting Officer at West Haven, CT. The monitoring of the Home Oxygen contract is being accomplished through the actions on three levels: (1) by the interactions of the facility COTR, CO and the vendor at monthly meetings; (2) by the VISN Prosthetic Manager and VISN Prosthetic Health System Specialist; and (3) the VISN 1 Contracting Office.

Recommendation 2. We recommend that the VISN Director ensure the Medical Center Director monitors contract radiologists' productivity to ensure outsourced services are cost-efficient.

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

Current contracted radiologists' productivity will be monitored by the Chief, Radiology Service using RVUs. The "cost per RVU" will also be monitored to ensure cost efficiency and the potential for cost reduction and outsourced sources.

Recommendation 3. We recommend that the VISN Director ensure that the Medical Center Director improves billing practices by taking action to: (a) establish internal controls and expand compliance reviews to capture all episodes of care that need to be coded and billed; (b) establish a monitoring system to review the "RNB Report", correct documentation deficiencies, and appropriately bill insurance carriers for healthcare provided; (c) follow up on missing or inadequate documentation by contacting providers and requesting that proper documentation be submitted; and (d) ensure all documentation for fee basis care is received by the medical center and entered into the patients' electronic medical records, and appropriately bill insurance carriers for fee basis care provided.

Concur **Target Completion Date: January 31, 2006**

(a) A monthly report with a sample size of 40 will be selected from the Billing Productivity Report (or the CBI Outpatient Professional Fee Report) to ensure all billable episodes of care for that veteran’s visit have been coded and billed. Patient Accounts Manager will audit monthly, effective November 1, 2005.

(b) On September 1, 2005, HIMS established a monthly monitoring system using the RNB Report focusing on Insufficient Documentation, No Documentation, and Non-

Billable Provider (Resident) 100% sample size. HIMS will contact provider and request the proper documentation be submitted. Billable services will be forwarded to billing for insurance claim submission.

(c) On September 1, 2005, HIMS established a more aggressive process for follow up with providers if documentation is inadequate to apply the most appropriate CPT or ICD-9 code. If there is insufficient or missing documentation to support the codes that have been entered, the person responsible for documenting the encounter is contacted by the coder. If the information needed is not entered within twenty-four hours of the notification, the Chief, HIMS notifies the Service Chief/Service Line Manager for definitive action to be taken. Accounts are referred to Service Line Manager when necessary.

(d) All authorization letters now contain the addendum stating that the report from the procedure and/or episode of care must be attached to the corresponding bill in order to ensure prompt payment from VA. HIMS Medical Records Department will scan the fee documentation into the electronic medical record.

Recommendation 4. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) facility management accounts for items classified as "out of service" and update the property accountability status to reflect only inventoried items that are legitimately "out of service", (b) responsible officials or their designees perform the physical inventories of nonexpendable property in a timely manner in accordance with VA policy, (c) Police Service strengthen controls to improve accountability for all firearms, (d) A&MMS management maintains complete and accurate documentation for all equipment that is turned in, and (e) employee access to the EIL database is restricted to employees who need access.

Concur **Target Completion Date: November 30, 2005**

(a) Facility Management was sent a complete listing of Building Service Equipment classified as “out of service”. The Chief, Facility Management will have corrections made by November 30, 2005. All future annotations to the list will be made by the maintenance controller in a timely way to reflect only inventoried items that are legitimately "out of service".

(b) A&MMS sends delinquent notifications to the Service Chief or their designees after the 10 or 20 day(s) due dates have elapsed. It will be the practice of Togus VA Medical Center Director to hold accountable the Service Chief for any overdue EILs.

(c) As of July 25, 2005, sign-out sheets list each firearm’s serial number and officer assigned to the firearm. The internal log properly reflects assignment of a firearm to an officer and those firearms which are unassigned. Lock box bar code labels correspond with the stored firearm. The internal policy has been revised to reflect current practice.

(d) The supply technician has reviewed and updated documentation of disposed equipment and continues to review station equipment turned in to ensure proper record accountability.

(e) Employee access has been significantly reduced from 37 to 14. Only employees who need access have privileges.

Recommendation 5. We recommend that the VISN Director ensures that the Medical Center Director requires: (a) procurement personnel comply with the VA purchasing hierarchy and (b) controls are established to follow-up on implementation of OIG recommendations.

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

(a) Procurement personnel will comply with the purchasing hierarchy. Prosthetics has been in compliance with the national contract since its awarding June 7, 2004 with Zimmer and Smith/Nephew. All surgeons request

waivers submitted through the Chief, Surgical Services from the Chief of Staff as required by policy. The VISN Prosthetics Clinical Management Committee will monitor contract compliance.

(b) To assure monitoring of the implementation of OIG recommendations, the Quality Manager will use a systematic approach by tracking action plans on a spreadsheet and report monthly updates to the facility's Quality Leadership Team. The Surgical Service OR orientation policy is being updated to reflect the prosthetic procurement and waiver procedure.

Recommendation 6. We recommend that the VISN Director make sure the Medical Center Director takes action to: (a) transfer control of communication closet access to IRM Service; (b) limit access to AIS resources, including communication closets, to IRM Service employees; (c) properly document that all hard drives are being sanitized prior to the disposal of computers; and (d) review the access and VistA menu options for all IRM employees to verify that there is continued and legitimate need.

Concur **Target Completion Date: January 31, 2006**

(a) Information Management Service Line (IMSL) Policy 05-03, "Access to Sensitive Areas", dated April 5, 2005 identifies IMSL as controlling access to the communication closets.

(b) IMSL Policy 05-03, "Access to Sensitive Areas", states access will be available to limited FMS staff as needed. Rekeying by Facilities Management Service has been undertaken and limited to appropriate staff to control entry to automated information systems.

(c) The CIO will ensure compliance with IMSL Policy 05-05 "Policy for Safeguarding Information Stored on Automatic Data Processing during Disposal", dated April 27, 2005. This policy outlines the hard drive sanitization procedure and requires completion of VA Form 0751, Information Technology Equipment Sanitization Certificate.

(d) As of May 5, 2005, following the CAP review, menu options not needed on continual basis have been removed. Further, menu options will be assigned only on an as needed basis for technical support.

Recommendation 7. We recommend that the VISN Director ensures that the Medical Center Director takes action to ensure that: (a) Pharmacy Service staff use the PVIM system to ensure minimum inventory stock levels; (b) Pharmacy Service staff and an accountable officer, or designee, witness the receipt and posting of all drugs, and annotate verification on invoices; (c) segregation of duties is maintained when ordering and receiving non-controlled substances; and (d) medical center policy complies with VHA policy.

Concur **Target Completion Date: November 30, 2005**

(a) The McKesson program for the procurement personnel, McKesson Prime Vendor Inventory Management system, and necessary shelf labels for stock levels will be in place and functioning by November 30, 2005.

(b) Prior to completion of the CAP review, a plan was initiated where one vault employee and one pharmacy employee not assigned to the vault receive and post all drugs. Appropriate signatures will be annotated on invoices.

(c) Pharmacy Service management initiated a plan prior to completion of the CAP review to maintain segregation of duties. A procurement technician will be responsible for ordering non-controlled substances and an inpatient or phone pharmacy technician will receive orders.

(d) Pharmacy Service Policy 1-e "Ordering and Receiving of Drugs and Supplies" has been revised effective August 3, 2005.

Recommendation 8. We recommend that the VISN Director ensure that the Medical Center Director: (a) requires that CSSU employees monitor the completion and timeliness of radiology examinations that are performed by contract

radiologists, (b) ensure that contract radiology services are completed prior to the contractors receiving payments, and (c) takes action to ensure that results of mammograms and MRIs are timely placed into CPRS.

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

(a) CSSU personnel schedule the radiological examinations with community providers and monitor the date of service and the authorized date. Any irregularities are researched to determine the reason. Community radiological providers have been very responsive in scheduling urgent examinations. Monitoring of completion is accomplished by the receipt by CSSU of a faxed copy of the examination report. The scope of work in all new contracts with community providers will contain this requirement for examination report completion.

(b) CSSU/Fee Services Claims assistants have been directed to verify reports for community radiological examinations before payments are processed. Vendors are to attach a copy of the report to the claim or fax a copy for verification of completion of the examination.

(c) Installation of high speed scanning equipment in the CSSU will alleviate the current backlog of reports and allow the timely processing of all future reports scanned into CPRS.

Service Contract Administration Deficiencies

Appendix C

Contract Deficiencies	VISN Chemistry Services $6,712,935	VISN Home Oxygen Services $3,500,000	VISN Laboratory Courier Services $2,393,832	VISN Laboratory Services $720,000	Medical Officer of the Day Services $2,978,754	Transcription Services $1,377,000	Oncology Services $499,908	Radiology Services $384,800	Radiology Services $98,500	Cardiology Services $277,500	Neurology Services $277,500	Radio Pharmaceutical Services $200,000
HCA Responsibilities												
Contract was not reviewed by a contracting officer with equal or higher warrant level						X	X	X	X	X	X	
Contracting Officer Responsibilities												
Contracting authority was exceeded	X				X							
COTR responsibilities and contract terms and conditions were not fully understood						X	X				X	
Workload analysis was not conducted										X	X	X
EPLS database search was not conducted timely						X						
Background investigations were not conducted						X	X	X				
Station COTR was not appointed to monitor VISN contract	X		X	X								
COTR appointment letter was not prepared for medical center contracts											X	X
Written justification to exercise option years was not prepared				X								X
COTR was not trained					X	X						
COTR was not timely trained				X			X			X	X	X
COTR Responsibilities												
COTR did not adequately monitor contract		X				X	X			X	X	
VA employees, other than COTR, certified invoices					X	X	X			X	X	

Appendix D

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1e	Better use of funds by ensuring COTRs validate oncology services prior to certifying payments to the contractor.	$ 47,164
3b	Better use of funds by increasing MCCF collections through improved documentation of medical care and identifying and processing all billable patient healthcare services.	1,169,124
5a	Better use of funds by procurement personnel complying with the VA purchasing hierarchy.	91,178
	Total	$1,307,466

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Appendix F

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