Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Edith Nourse Rogers Memorial Veterans Hospital Bedford, Massachusetts

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VA Office of Inspector General
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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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Introduction

During the week of June 13-17, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Edith Nourse Rogers Memorial Veterans Hospital. The purpose of the review was to evaluate selected hospital 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 48 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 1.

Results of Review

This CAP review focused on 11 areas. The hospital complied with selected standards in the following areas:

- Colorectal Cancer Management
- Quality Management Program

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

- Correct environmental deficiencies.
- Improve radiology timeliness data.
- Strengthen controls to improve oversight of the contracting activity and contract administration.
- Improve oversight over the sharing agreement and evaluate the need for continuation of the agreement.
- Increase Medical Care Collections Fund (MCCF) billings and collections by improving documentation of medical care and ensuring that MCCF staff identify and process all billable patient healthcare services.
- Improve inventory procedures and controls over nonexpendable equipment.
- Strengthen controls to ensure purchase cardholders comply with the Federal Acquisition Regulation (FAR) and obtain competition for purchases exceeding $2,500.
- Improve pharmaceutical accountability controls.
- Strengthen controls for information technology (IT) security.

This report was prepared under the direction of Katherine Owens, Director, and Jeanne Martin, Associate Director, Bedford Office of Healthcare Inspections.

VISN 1 and Hospital Director Comments

The VISN Director and the Hospital Director agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendix A, beginning on page 22, for the full text of the Directors' comments.) We will follow up on the implementation of the planned actions until they are completed.

(original signed by:)
JON A. WOODITCH
Deputy Inspector General

Introduction

Hospital Profile

Organization. Located in Bedford, Massachusetts, the hospital consists of a nursing home care center, a primary care center, a domiciliary, and community-based outpatient clinics (CBOCs) in Lynn, Haverhill, Gloucester, and Fitchburg, Massachusetts. The hospital's primary service area includes Middlesex, Essex, and Worchester counties in Massachusetts.

Programs. The hospital provides nursing home and long term psychiatric care, as well as residential and primary care. It also supports programs in medicine, psychiatry, physical medicine and rehabilitation, and dentistry.

Affiliations and Research. The hospital is affiliated with Boston University (BU) School of Medicine and BU's and Harvard University's dental schools. Nursing school affiliations include the University of Massachusetts, the University of New Hampshire, Northeastern University, Regis College, Emanuel College, and Middlesex Community College.

Currently the hospital has 60 active research investigators and 143 active research projects in medicine, psychiatry, geriatrics, oncology, neuroimmunology, molecular medicine, and endocrinology. The hospital is also involved with human immunodeficiency virus research. The total research budget for FY 2004 was $10.1 million and was $9.9 million for FY 2005.

Resources. The hospital's budget for FY 2004 totaled approximately $104,728,693; the FY 2005 budget is estimated at $106,764,096. FY 2004 staffing was 941 full-time employee equivalents (FTE); FY 2005 staffing (through March) was 936 FTE, which included 34 physicians and 339 nursing FTE.

Workload. In FY 2004, the hospital treated 17,151 unique patients. During FY 2005 (through March) 13,289 unique patients were treated. The average daily census was approximately 404 in FY 2004 and 399 to date in FY 2005. The outpatient workload for FY 2004 totaled 164,473 visits. For FY 2005 (through March), workload totaled 78,778 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, quality management, 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. 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 11 areas:

Colorectal Cancer Management	Medical Care Collections Fund
Environment of Care	Pharmaceutical Accountability
Equipment Accountability	Quality Management Program
Government Purchase Card Program	Service Contracts
Information Technology Security	Sharing Agreements
Laboratory and Radiology Timeliness	

The review covered facility operations for FY 2004 and FY 2005 through March 2005, and was done in accordance with OIG standard operating procedures for CAP reviews.

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of services and the quality of care. Questionnaires were sent to all employees, and 70 responded. We also interviewed 30 patients during the review. The results were discussed with medical center managers.

During the review, we presented two fraud and integrity awareness briefings for hospital employees. These briefings, attended by 48 employees, 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.

In this report we make recommendations for improvement. The recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Results of Review

Opportunities for Improvement

Environment of Care – Areas Needed Management Attention

Conditions Needing Improvement. VHA regulations require that the medical center environment present minimal risk to patients, employees, and visitors. We found the environment of care to be generally clean and safe. However, we found conditions that required corrective action.

Inpatient Mental Health Unit. On the acute inpatient mental health unit (MHU), we found that ceiling tiles in unsupervised patient areas (such as bathrooms and patient rooms) could be removed exposing the pipes above the tiles. A patient could possibly secure a noose to a pipe in an effort to attempt suicide by hanging. This condition also allowed for the concealment of contraband items (such as drugs or weapons).

In the dining room, we found four areas where the wall boards were broken creating sharp edges. Additionally, we found a grill cover for a heating element that could be pried away from the wall. The grill cover had sharp corners and could potentially be used as a weapon.

Long Term Care. A housekeeping cart containing cleaning chemicals was unlocked and unattended on a long term care unit, which allowed easy access by patients. Managers began taking action to correct all patient safety issues while we were on site.

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Hospital Director requires that: (a) ceiling tiles on the MHU are secured, (b) walls and the grill cover in the dining room of the MHU are repaired, and (c) all housekeeping carts are secured.

The VISN and Hospital Directors agreed with findings and recommendations. They reported that the ceiling tiles were secured, the wall and grill covers were repaired, and housekeeping carts are being secured. The implementation plans are acceptable, and we consider the issues resolved.

Laboratory and Radiology Timeliness – Radiology Reporting Needed To Be Improved

Condition Needing Improvement. VISN and medical center policies defined timeliness standards for laboratory and radiology examinations. The turn-around-times for laboratory tests generally met the standards set by the policies. However, because the hospital did not employ a radiologist, it had two methods for entering radiology examination results into the hospital's computerized radiology system. This caused

potential delays in some examination results being reported to providers and resulted in inaccurate timeliness data.

The first method for entering radiology data involved routine radiology examinations (for example, chest images) that were performed in the hospital's radiology department by the technician. When the images were completed, the technician assigned an accession number to each image (this number indicated the order that the images were taken) and tele-digitally transmitted the images to the VA Boston Healthcare System's (VABHCS) radiology department for interpretation, dictation, and verification by a radiologist. Because hospital accession numbers were already assigned, the results of these examinations were transcribed by VABHCS' transcription system and entered directly into the hospital's computerized radiology system. This allowed providers timely access to the results, and the timeliness data for these examinations were accurate.

The second method involved more complicated radiology studies (for example, those that required contrast dye), and required the hospital's patients to present to VABHCS' radiology department to have the examinations performed. These examinations were assigned accession numbers by VABHCS' radiology department. Consequently, the results of these examinations were not placed into the hospital's system but into VABHCS' system. To retrieve the results of these examinations (which were the majority of the studies performed), the hospital's radiology technician had to access VABHCS' radiology system (approximately three times a week) to verify that the studies were completed. The technician then transcribed that information into the hospital's computerized radiology system and notified providers that the results were available. The hospital's radiology system automatically assigned the date that the hospital's radiology technician entered the information as the actual transcription and verification date.

This process was labor intensive for the radiology technician; and when the technician was on leave, this process did not get performed. Providers were informed that they had to access this information on their own, which potentially could cause a delay in providers and patients being notified of examination results. However, there was evidence to support that VABHCS radiologists contacted ordering providers at the hospital when examination results needed immediate attention. This practice also resulted in transcription and verification timeliness errors and skewed the performance measure data that were reported to the VISN and to VA Central Office.

Recommended Improvement Action 2. We recommend that the VISN Director and the Hospital Director develop processes to (a) ensure that results of radiology examinations performed at VABHCS are timely placed into the hospital's computerized radiology system and (b) radiology data are accurately collected and reported.

The VISN and Hospital Directors agreed with the findings and recommendations. They reported that the hospital and VABHCS has begun to use the inter-facility consult

package to reduce the time between consult referral and consult closure and will develop a collaborative monitor to collect and report radiology data. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

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

Conditions Needing Improvement. Hospital managers needed to improve the 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 5 contracts and 1 sharing agreement valued at $4.4 million from a universe of 38 contracts, sharing agreements, and leases valued at $10.1 million. We identified the following issues that required 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 can improve oversight of the contracting activity by conducting thorough and complete contract file reviews and ensuring that contracting officers and COTRs perform duties as required.

- *Contract Review*. The HCA did not conduct a thorough and complete contract file review for one contract valued at $316,000. The review and evaluation, typically conducted by the HCA, help ensure the completeness and accuracy of solicitations and contract documentation packages to ensure compliance with the FAR, the VAAR, and VA policy.

  Our review of this contract identified deficiencies that could have been identified had the HCA conducted the required review. The deficiencies included: no pricing analysis, no market research, and the solicitation was not advertised.

- *COTR Training*. The HCA did not ensure that four COTRs monitoring five contracts and one sharing agreement valued at $4.4 million, had received training before assuming responsibility for monitoring contract performance. In addition, the COTRs for three of these contracts, valued at $1.8 million, had inappropriately delegated invoice validation and certification responsibilities.

Contracting Officers Performance. Contracting officers did not take the necessary actions to ensure the COTRs carried out their assigned responsibilities, and the contracting officers did not maintain files containing records of the required preaward and postaward administrative actions.

- *Pre-Award Administrative Actions*. Contracting officers did not conduct required pre-award administrative actions, including conducting a cost/price analysis and market research for the five contracts valued at $4 million.
- *Post-Award Administrative Actions*. Contracting officers did not conduct required post-award administrative actions, including preparation of a written justification to exercise an option year for a contract valued at $2 million. We also found that the COTR redelegated validation and certification responsibilities to other VA employees for three contracts valued at $1.8 million.

COTR Performance. COTRs are responsible for monitoring contractor performance and ensuring that services are provided and payments are made in accordance with contract terms. Our review of the following contracts required management attention.

- *Telecommunication Services*. The hospital had a $2,036,000 telecommunications contract for the period April 2000–September 2005. The services included circuit maintenance, installation/modification of existing circuits, and customer service and centralized service and repair. A review of the contract showed the COTR did not validate the telecommunication services.

  To determine if the COTR properly monitored the contract, we reviewed a sample of five invoices valued at $223,021 from January 2005–June 2005. We found the COTR certified invoices for payment but did not verify usage and billing rates. The COTR indicated he reviewed the invoices only for reasonableness. The contract also specified that the hospital would receive a monthly discount of 5 percent for recurring charges and volume discounts of up to 35 percent would be applied for calling services usage. The COTR also did not verify that the hospital received discounts as identified in the contract. As a result, the hospital had no assurance that $223,021 was the appropriate amount paid for telecommunication services.

- *Telephone Maintenance Services*. The hospital had a $1,222,000 telephone maintenance contract for the hospital and its CBOCs. The contract was for the period September 1990–September 2005. A review of the contract showed the COTR did not validate the telephone maintenance services.

  To determine if the COTR properly monitored the contract, we reviewed a sample of six invoices valued at $12,700 from February 2005–May 2005. The COTR inappropriately redelegated validation and certification responsibilities to the Chief Information Officer (CIO). The CIO certified the invoices for payment but did not validate the services specified on the invoices.

  The COTR did not maintain a recordkeeping system to ensure that contracted employees actually performed the work, as required. Contract charges represented an on-site technician's hours and frequent overtime. The COTR did not require the contractor to sign a time log, post to a time clock, or post to any other type of real

time tracking system. As a result, the hospital had no assurance that $12,700 was the appropriate amount paid for telephone maintenance services.

- *Solid Waste Removal Services*. The medical center had a $396,000 contract for the removal of solid waste from April 1, 2002–September 30, 2006. A review of the contract showed the COTR did not validate waste removal services. Payments were made to the contractor based on the number of pick-ups and tonnage removed from the facility.

  To determine if the COTR monitored the contract, we reviewed a sample of six invoices valued at approximately $22,100 for waste removed from the hospital from March 2005–May 2005. We found the COTR certified payment to the contractor without knowledge of the number of pick-ups, and tonnage removed. The COTR also did not verify that the rates charged by the contractor were in accordance with contract requirements. The COTR did not ensure that pick-up slips and weight tickets from the disposal site accompanied invoices from the contractor. As a result, the hospital had no assurance that $22,100 was the appropriate amount paid for the removal of waste.

See Appendix C (page 33) for a table summarizing the types of contract services acquired, the estimated value of each contract, and contract administrative deficiencies noted.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Hospital Director requires that: (a) the HCA conducts contract file reviews to ensure compliance with the FAR and the VAAR and to detect, correct, and prevent future contract deficiencies; (b) contracting officers correct the required pre-award and post-award administrative deficiencies; (c) COTRs receive proper training; and (d) COTRs properly monitor contracts and validate services prior to certifying payments to the contractor.

The VISN and Hospital Directors agreed with the findings and recommendations. They reported that processes were implemented to ensure compliance with VA regulations, pre-award and post-award deficiencies were corrected, and a formal COTR training program was implemented. Additionally, they reported that contract services are being validated prior to payment. The implementation plans are acceptable, and we consider the issues resolved.

Sharing Agreement – Oversight Needed To Be Strengthened and Evaluation Needed To Determine Continuation of Agreement

Conditions Needing Improvement. Hospital managers needed to improve the oversight of a sharing agreement, and VISN managers needed to conduct an evaluation to ensure the agreement is in the best interests of VA. Oversight can be improved by strengthening

controls to ensure that HCA responsibilities are carried out in accordance with VA policy. VA medical facilities may enter into enhanced use sharing agreements to sell services or rent facility land or space. At the request of the Hospital Director, we reviewed a sharing agreement for the use of VA space to determine if the agreement had been properly negotiated and administered.

Background. In February 2002, the hospital entered into a non-competitive sharing agreement valued at $208,440 with a private for profit business to rent the hospital's gym, pool, and offices for an annual rent of approximately $23,000. Included in the rent were all utilities, housekeeping, and maintenance. After deducting utilities, housekeeping, maintenance and other related rental expenses, the net annual rental income to the hospital was approximately $3,200. The contractor had exclusive use of these facilities, encompassing 14,600 square feet, from 7:00 am through 6:30 pm, Monday through Saturday. Veterans and VA employees were allowed use of the gym and pool generally during extended lunch periods. The rent equaled to a rental charge of approximately $9 per hour of use, or $1.50 per square foot, per year.

Apparent Breach of Contract. The sharing agreement contract stipulated that the property used by the contractor was for the purpose of conducting rehabilitative therapies and training and education of individuals in rehabilitative techniques. No other use of the property was permitted without the prior written approval of the VA. In an apparent breach of the sharing agreement, we determined that the contractor allowed a subcontractor to engage in prohibited activities and exposed the VA to substantial liability.

The subcontractor offered competitive swim instruction to members of the general public from six months old to adults which was not within the scope of the agreement and resulted in a breach of the sharing agreement. In addition, the contractor, subtenants, and their "independent contractors," apparently lacked the necessary insurance coverage or possessed insufficient public liability, professional liability, and property damage insurance. Insurance coverage is essential for the protection of VA patients, non-VA clients who used these services, and the hospital in the event of personal injury or property damage.

Commercial Market Rates Not Considered. VA policy requires VA facilities to consider local commercial market rates for similar services. Hospital management did not consider commercial market rates when the sharing agreement was negotiated and awarded. VA policy requires VA facilities to be sensitive to private sector perceptions that Federal funds are subsidizing a private sector company. Market research disclosed that area not for profit organizations rented their indoor pool for an average of $83 per hour and their gym for $80 per hour.

Validation of Revenues and Expenses Not Conducted. Hospital managers did not validate the contractor's reported revenues and expenses that were used to establish the

annual rent (3 percent of annual net revenues). There was no assurance that the contractor's reported revenue included revenue derived from all contractor and subtenant activities at the hospital. Additionally, expenditures for patient physical and massage therapy may have been avoidable by using VA staff.

- Revenues reported to VA may have been substantially underreported. The contractor's reported revenues had declined for each of the last three years ($208,399, $182,338, and $156,094 respectively). The reported revenues equaled the revenue generated by about one FTE (i.e. $80 per hour equals $160,000 in annual revenue). The contractor charged the VA $100 per hour for physical therapy and $80 per hour for massage therapy. Records indicate that the contractor and subtenant employed 12 staff (full and part-time) to treat the general public and VA patients. Assuming that the 12 staff constituted a combined 6 FTE, annual revenues could have been as much as $960,000. In addition, projected revenues did not include any revenue generated by the swim academy.

- The hospital incurred excessive expenditures for VA patient physical and massage therapy. The contractor offered VA patients physical and massage therapy at FTE rates of $200,000 ($100/hour x 2,000 hours) and $160,000 annually ($80/hour x 2,000 hours). We determined that the hospital could have obtained these services at substantially reduced rates by using VA employees. The hospital's Physical Medicine and Rehabilitation Service was staffed with 30 FTE that included licensed physical therapists. The therapists received training in massage therapy and were compensated at an average annual salary of $55,000. If these services were provided by VA employees, the labor rate would have been significantly lower than the labor rate the contractor charged the hospital. Having VA employees provide these services also would potentially increase efficiency, evaluation, and coordination of therapies.

Recommended Improvement Action 4. We recommend that the VISN Director conduct a review of the sharing agreement to include consideration of taking action to renegotiate or terminate the agreement to ensure that it is in the best interest of VA.

The VISN Director agreed with the findings and recommendation. VISN Director reported that a work group to review the sharing agreement was appointed. The group's review will be completed by March 15, 2006. The implementation plan is acceptable, and we will follow up on the planned action until it is completed.

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

Condition Needing Improvement. Our review of statistical samples of outpatient care found instances of overbilling that were the result of documentation errors, improper coding, and billing errors. We estimate that during the period of April 1, 2004, through March 31, 2005, about $113,494 could have been overbilled and $30,473 improperly

collected. Our review of the Reasons Not Billable Report (RNB Report) and fee basis payments showed that the medical center effectively identified and billed patient services and fee basis care provided to insured patients. The review showed that few billing opportunities were missed by MCCF staff and estimated lost revenues were about $21,000.

Outpatient Billing Review. As of June 15, 2005, there were 42,100 outpatient encounters valued at $5,674,722 billed to third party payers for care delivered during the period of April 1, 2004, through March 31, 2005. A statistical sample of 137 outpatient encounters billed at $143,487 with collections of $13,252, was reviewed. The review identified 14 errors in the sample. All 14 of these encounters were overbilled by $2,879 (2 percent of the total billed amount) resulting in $464 in excess collections.

- Two bills valued at $291.11 for service connected care were erroneously submitted to the insurer and the hospital collected $58.22 on these two bills.
- Five bills valued at $2,041.30 for services provided by a student were erroneously submitted to the insurer and the hospital collected $253.58 on these five bills.
- Four encounters valued at $451.26 were erroneously billed to Medicare supplemental insurance for services provided by Licensed Practical Nurses (LPNs). The hospital collected $133.59 on these bills. Medicare would have covered 100 percent of these charges, so the supplemental insurance should not have been billed.
- Two bills were incorrectly up-coded resulting in overbilling about $8.06. The hospital collected $1.61 on these bills.
- One encounter, which was inadequately documented, was billed in the amount of $86.92 and the hospital collected $17.38 on this bill.

These errors were the result of confusion with existing regulations or human error. Hospital 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 hospital to appropriately bill the encounters. MCCF staff was not familiar with the guidelines published by the Chief Business Office stating that LPN services covered by Medicare should not be billed to Medicare supplemental insurance. Hospital management should make certain that MCCF staff receive training on guidelines that impact on billing procedures. In addition, hospital management should promptly contact providers and request that proper documentation be submitted. Projecting our sample results to the universe valued at $5,674,722 we estimate that about $113,494

($5,674,722 x 2 percent) could have been overbilled, and based on the hospital's average collection rate of 26.85 percent, $30,473 could have been improperly collected.

The Reasons Not Billable Report. We reviewed three segments, Nonbillable Provider (Resident), Insufficient Documentation, and No Documentation, of the RNB Report for the period of April 1, 2004, through March 31, 2005. We selected these segments because, with monitoring of the report, all of these reasons for not billing an encounter are avoidable. These segments represent missed billing opportunities due to poor documentation by medical care providers. As of June 10, 2005, there were 120 encounters valued at $43,186 listed in the three segments of the outpatient RNB Report for treatment provided during the period of our review.

We reviewed 63 of the 120 encounters. Our review found that 26 encounters were improperly categorized and did not belong in these report segments. These encounters were nonbillable although the documentation was sufficient. Projecting to the universe, we estimate that 70 encounters, valued at $25,393, should have been on these three segments of the RNB Report.

The RNB Report must be accurate to make the report meaningful and facilitate efforts to detect and correct documentation deficiencies. The Nonbillable Provider (Resident), Insufficient Documentation, and No Documentation 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, healthcare system management should continue to promptly contact providers and request that proper documentation be submitted timely.

If providers had appropriately documented all medical care we estimate that an additional $25,393 could have been billed for the encounters on these three segments of the RNB Report. Based on the hospital's collection rate of 26.85 percent, we estimate that an additional $6,818 could have been collected.

Fee Basis. The hospital paid 2,946 fee basis claims totaling $657,718 to non-VA providers who provided medical care to VA patients with insurance between April 1, 2004, and March 31, 2005. Payments to fee basis providers included 133 claims for inpatient/ancillary care at a cost of $536,420, and 2,813 claims for outpatient care at a cost of $121,298. Fee basis staff refers claims for patients with health insurance to MCCF staff when the hospital 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 94 outpatient claims and 56 inpatient and ancillary claims. Of the 94 outpatient claims, 91 claims were not billable to third party payers because the care provided was service-connected, the patient's insurance was not in effect on the date care was provided, or the medical service provided, such as home

health care, was not covered by the patient's insurance. The remaining three outpatient claims were billable to third party payers and correctly billed.

Of the 56 inpatient claims, 42 claims were not billable to third party payers because the care provided was service-connected, the patient's insurance was not in effect on the date care was provided, or the medical service provided, such as nursing home care, was not covered by the patient's insurance. The remaining 14 inpatient and ancillary claims were billable to third party payers (average bill value of $2,562). Five claims were correctly billed by MCCF staff for $30,815, but nine claims were not properly billed by MCCF staff, resulting in an error rate of 16.1 percent. Six claims were not billed for $4,822 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 after insurance is identified. Two claims were not billed because MCCF staff did not receive the required documentation from the fee basis providers, and one claim was not billed for $30 because the inpatient stay was improperly deemed service connected.

Projecting our sample results to the universe, we estimate that an additional $53,802 could have been billed for inpatient and ancillary fee basis care (16.1 percent error rate x 133 inpatient/ancillary universe x $2,562 average bill value). Based on the hospital's average collection rate of 26.85 percent, we estimate that an additional $14,446 could have been collected.

Conclusion. Hospital 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. Overall, we found that the hospital is effectively identifying and billing patient care and fee basis services. Our review showed that few billing opportunities were missed by MCCF staff, and estimated lost revenues were about $21,000 between April 1, 2004, and March 31, 2005.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Hospital Director improves billing practices by taking action to: (a) enhance the compliance program to correct, detect, and prevent over-billing and to identify improper collection resulting from over-billing and refund or credit insurance carriers, as appropriate; (b) provide MCCF staff additional training on the proper categorization of encounters on the RNB Report; (c) establish a monitoring system to review the RNB Report, correct documentation deficiencies, and appropriately bill insurance carriers for healthcare provided; (d) promptly follow up on missing or inadequate documentation by contacting providers and requesting that proper documentation be submitted; (e) provide additional training to healthcare providers on documentation requirements; and (f) expand compliance reviews to capture all episodes of care that need to be coded and billed.

The VISN and Hospital Directors agreed with the findings and recommendations. They reported that enhanced billing audits are being conducted by the hospital's compliance

officer, RNB report training was provided, RNB report issues will be reported quarterly to the hospital's Office of Compliance and Business Integrity (CBI), and the facility was following up on documentation issues with providers. Additionally, they reported that clinical providers are receiving training about documentation requirements, and the hospital's compliance officer has expanded billing audits to capture episodes of care that need to be coded and billed. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Equipment Accountability – Inventory Controls Needed To Be Strengthened

Conditions Needing Improvement. Hospital managers 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. A&MMS is also responsible for maintaining the accuracy and integrity of the Automated Engineering Management System/Medical Equipment Reporting System (AEMS/MERS).

As of June 15, 2005, the medical center had 91 active EILs listing 5,116 equipment items with a total acquisition value of $17.1 million. We identified six 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. VA policy requires that the inventories be completed within 10 days of notification from A&MMS if the EIL has less than 100 items; or within 20 days if the EIL contains 100 or more items. We reviewed 75 EILs from FY 2005 where A&MMS had sent the notification to the service prior to our on-site review. We found the following equipment inventory deficiencies:

- Responsible officials did not complete 21 (28 percent) of 75 annual inventories within the required 10-day or 20-day periods after receiving notification from A&MMS that the inventories were due.[1] The 21 EILs were delinquent from 5 days to 2 months.

[1] Annual inventories that were completed 5 or more days after the 10 or 20-day benchmark were considered untimely.

- Responsible officials did not complete annual inventories for 3 (4 percent) out of the 75 EILs reviewed. These EILs contained a total of 25 items valued at $138,139. One out of the three services received notification that the inventory needed to be done; however, in the other two instances notification was not sent by A&MMS.

Responsible officials need to properly conduct inventories and physically verify all equipment listed on their EILs. The review and physical verification of all items should be completed by the responsible officials before certifying the equipment as accounted for.

Accuracy of EILs. To assess equipment accountability, we reviewed a statistical sample of 98 equipment items[2] (total acquisition value = $2,264,913) listed in AEMS/MERS. We were able to locate 91 (93 percent) of the 98 items. We identified the following accountability discrepancies:

- A&MMS staff could not locate seven items (total acquisition value = $117,855) that include a nourishment station, a photomicrophic device, a muscle tension apparatus, Xerox switcher signal, two computers, and a 2005 telephone answering service (acquisition value = $4,623.) The total current value of the seven items, which were acquired between 1982 – 2005, was $28,088. Reports of Survey need to be completed in order to delete the items from AEMS/MERS.
- Thirteen items had the wrong locations listed.
- Three items had no locations recorded.
- Eight items had the wrong serial numbers listed.
- Eight items had no serial numbers listed.

In summary, we estimated that 32 items, with an acquisition value of $1,022,331 (estimated current value of $243,649), could potentially be unaccounted for. The statistical sample projection is based on a 90 percent confidence level, 10 percent error rate, and a margin of error of 5 percent.

We also judgmentally selected 12 of the 91 EIL inventory folders, maintained by A&MMS, to assess whether the FY 2005 physical inventories were properly conducted and documented in accordance with property policy. A&MMS management did not provide requested supporting documentation and sufficient explanations to our inquiries for the 12 EILs. As a result, we were unable to verify whether the nonexpendable equipment was properly accounted for and recorded in the accountability records.

We concluded the accuracy and completeness of the AEMS/MERS property database was questionable. Equipment cannot be properly safeguarded and accounted for without being accurately recorded on the appropriate EILs and in the property database. Responsible officials should also review their EIL listings and report incomplete or

[2] The 98 items were selected from the equipment list of nonexpendable property with each item having an acquisition value over $5,000.

inaccurate information (i.e., serial number, location) to A&MMS for correction in the database.

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 of controls of sensitive equipment, we judgmentally selected 20 sensitive IT items (total acquisition value = $73,302) and assessed the accuracy of the EIL data. We were unable to account for 7 (35 percent) of the 20 items.

- Three of the items were IBM Think Pad laptops (purchased in 2000 for $2,899 each) and had a total current value of $4,350.
- One of the items was a Dell Computer Workstation (purchased in 2000 for $4,076) and had a current value of $2,038.
- One of the items was a Gateway 2000 laptop (purchased in 1997 for $4,310) and had a current value of $862.
- Two of the items were desktop computers and that were more than ten years old and had no current value.

We reviewed the EIL folder for the IRM Service to determine if these items were accounted for in the past; however, there was no documentation of any past annual inventories having been completed. The EIL inventory for FY 2005 had not been completed prior to our review. The Chief, ALS stated that a 100 percent inventory of sensitive equipment had never been completed.

Loaned Property. VA policy requires that loans of VA-owned personal property must be approved by facility directors and processed and documented by A&MMS. The Acquisition/Logistics Manager for the medical center did not provide any documentation in response to our request for copies of documents covering equipment on loan to VA employees. Sensitive IT equipment, such as laptop computers, is typically recorded on a facility loan form or a revocable license. As a result, the controls for accountability over loaned equipment (which is removed from the facility) by VA employees are weak and renders the property vulnerable to theft and misuse. As noted above, the medical center could not account for 7 of the 20 sensitive IT items in our audit sample. Also, we reviewed a "Report of Survey" recently filed showing 115 IT items valued at $309,929 could not be accounted for. Documenting loaned equipment might improve the facility's problems with accounting for IT equipment.

Out of Service Equipment. Prior to our review, A&MMS personnel did not determine whether 1,996 items (acquisition value = $3.5 million) that were classified as "out of service" were appropriately listed in this category. Of these items, 832 (42 percent) were acquired within the past 10 years and potentially still have useful life and current value. Information maintained in the property database regarding these "out of service" items, noted below, was incomplete.

- 276 (14 percent) items did not have an acquisition value.
- 631 (32 percent) items did not have an acquisition date.
- 136 (7 percent) items did not have a current location.
- 322 (16 percent) items did not have a serial number.

We recommend that A&MMS personnel make a good faith effort to account for all items listed as "out of service," and limit the use of this status to legitimate items.

Access to Property Menu Options. We determined that 39 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 are justified and needed. If too many people have access to the property database, it is possibly vulnerable to manipulation, inaccuracies, and misuse.

Recommended Improvement Action 6. We recommend that the VISN Director ensure that the Hospital Director requires that: (a) controls are strengthened to track and account for all nonexpendable property; and physical inventories are completed in an efficient, timely, and accurate manner; (b) a wall to wall inventory be completed and documented for all sensitive equipment; (c) service chiefs are held accountable for computers and other sensitive IT equipment in their respective services; (d) controls be established to track and document loaned equipment; (e) A&MMS managers account for all items classified as "out of service" and update the AEMS/MERS accountability status to reflect only inventoried items that are legitimately "out of service"; and (f) access to AEMS/MERS is restricted to employees with a legitimate need.

The VISN and Hospital Directors agreed with the findings and recommendations. They reported that policies were revised to strengthen property accountability and inventory completion, a computer equipment inventory will be completed by April 30, 2006, and responsible officials are now accountable for nonexpendable property in their control. They also reported that controls on loaned equipment have been strengthened, property classified as "out of service" is being reviewed, and databases have been updated. Additionally, access to AEMS/MERS was restricted to employees who require access. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Government Purchase Card Program – Compliance with the Federal Acquisition Regulation Needed To Be Improved

Condition Needing Improvement. Hospital managers needed to strengthen controls to ensure that Government purchase cardholders seek competition for open market purchases exceeding $2,500. For the period from October 1, 2003, to April 30, 2005, the hospital had 77 cardholders and 30 approving officials processing 16,101 transactions totaling $6.2 million. The universe of transactions greater than $2,500 totaled 190

transactions valued at approximately $1.1 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 purchasing 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 hospital purchased supplies in accordance with the FAR, we reviewed 32 prosthetic open market purchases with a total cost of $175,291. It should be noted that Boston Healthcare System employees purchase prosthetic supplies on behalf of the Hospital. These purchase cards were issued by the Hospital. We found that two cardholders did not obtain bids from three sources or document sole source justifications for all 32 purchases totaling $175,291. The 32 purchases consisted of 14 outdoor ramps valued at $70,712, 4 stair glides valued at $34,399, 10 scooter lifts valued at $32,465, 3 porch lifts valued at $28,215 and 1 scooter $9,500.

We obtained pricing from a vendor that offered comparable items at lower prices. A comparison of prices paid by the hospital to prices offered by a competing vendor showed that the hospital could have paid nine percent less for scooter lifts. We estimated that the hospital could have potentially saved $2,922 (9 percent x $32,465) by seeking competition for this prosthetic item.

Recommended Improvement Action 7. We recommend that the VISN Director ensures that the Hospital Director develop processes to review all Bedford purchase card transactions over $2,500 for documentation of competition and/or sole source justification and to hold the cardholder accountable, through their supervisor, regardless of the duty location of the cardholder.

The VISN and Hospital Directors agreed with the findings and recommendation. They reported that compliance with Government purchase card regulations was strengthened. The implementation plans are acceptable, and we consider the issues resolved.

Pharmaceutical Accountability – Inspection Deficiencies Needed To Be Corrected and Stock Level Monitoring and Other Controls Needed To Be Improved

Conditions Needing Improvement. Hospital managers needed to improve controls to address weaknesses in controlled substances inspections, maintain minimum inventory stock levels, and comply with VHA policy. Also, improvements were needed to ensure that Pharmacy Service uses the Veterans Integrated Systems Technology Application (VistA) Controlled Substance Package and the prime vendor inventory management (PVIM) system. 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 inspection reports for the 6-month period of November 2004–April 2005, interviewed inspectors and the Controlled Substances Coordinator, reviewed 72-hour inventories, 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 controlled substances held for destruction were turned over quarterly to a destruction company. In addition, drugs held for destruction were being reviewed quarterly rather than monthly.
- Documentation was not maintained for 10 (23 percent) of 37 72–hour inventories conducted from February 2005–April 2005.
- The Director did not appoint in writing 6 (43 percent) of 14 controlled substances inspectors.

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

We determined that, as of August 26, 2005, 8 of 9 drugs tested had excess stock valued at $9,831, based on a review of 3 months activities. We found that stock levels were excessive because Pharmacy staff were not effectively using the PVIM system. The value of excess stock follows:

Oxycontin (10, 20, 40 mg)	$4,988.00
Lipitor (20, 40 mg)	3,988.00
MS Contin (30, 60 mg)	823.00
Vicodin (5/500 mg)	32.00
Total	$9,831.00

Receipt of Controlled Substances. VHA policy requires that a pharmacy 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. Further, an Acquisition and Materiel Management Service (A&MMS) employee must annotate on the invoices that controlled substances have been posted to the electronic inventory and reconcile Schedule II drugs against the Drug Enforcement Agency (DEA) Form 222 entitled *US Official Order Forms– Schedule I and II.*

- A review of 22 (96 percent) of 23 invoices disclosed the lack of signatures of a pharmacy employee and the accountable officer, or designee. This was an issue in the prior CAP review and corrective action has not been fully implemented.

- A&MMS staff did not annotate on invoices that controlled substances had been posted to the electronic inventory. Also, Schedule II drugs were not reconciled to the DEA Form 222. A&MMS staff were unaware of these requirements.

Pharmacy Electronic Records. VHA policy requires that Pharmacy Service use the PVIM system 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.

- Pharmacy staff did not use the PVIM system to automatically record the purchase of 7 (50 percent) of 14 controlled substances. Pharmacy staff manually entered the 7 controlled substance purchases into the VistA Controlled Substances Package without an invoice number.

- Pharmacy staff did not record the purchase of 12 (86 percent) of 14 controlled substances on the date received in the perpetual inventory. They were recorded from 1 to 46 days after receipt.

- We noted that 10 (83 percent) of 12 purchases of non-controlled substances were not electronically entered into the VistA Drug Accountability Package when received.

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.

Recommended Improvement Action 8. We recommend that the VISN Director ensure that the Hospital Director requires that: (a) controlled substances inspectors conduct inspections in accordance with VHA policy; (b) Pharmacy Service staff use the PVIM system to ensure minimum inventory stock levels and accountability of drug receipts; (c) Pharmacy Service staff and an accountable officer, or designee, witness the receipt and posting of all drugs, and annotate verification on invoices; (d) Pharmacy Service staff use the VistA Controlled Substance Package for timely updating of perpetual inventories; and (e) hospital policy identify the job titles of those employees who have the authority to order, receive, post and verify controlled substances orders.

The VISN and Hospital Directors agreed with the findings and recommendations. They reported that controlled substances inspectors are in compliance with VHA policies, use of the PVIM system has been implemented, and the receipt and posting of drugs is being appropriately witnessed and documented. Additionally, they reported that perpetual inventories are being appropriately updated, and the hospital's policy governing inspection of controlled substance has been revised to reflect current VA Central Office policy. The implementation plans are acceptable, and we consider the issues resolved.

Information Technology Security – Controls Needed To Be Strengthened

Conditions Needing Improvement. Hospital 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 access to the computer room and communication closets was limited to those with a need for access, system backups were being performed daily and stored in a separate building, and testing of the back-up generator that supplied power to the computer room was being done on a weekly basis. The following issues required management attention.

Security Awareness Training. VHA policy requires that all facilities establish AIS security awareness and training programs. The Information Security Officer (ISO) is responsible for overseeing the security training program. All individuals who manage, operate, program, maintain, or use AIS should be trained prior to being granted access to AIS resources. All individuals must also be provided annual refresher training. VA Handbook 6210 outlines approved computer security training procedures. We found that annual refresher training was completed by only 59.4 percent of all permanent employees with user accounts during FY 2004. The ISO needs to work with each service to make sure all employees complete the required annual security awareness training.

Automatic Session Timeout. Microsoft Windows operating systems have a built-in security feature that will time-out after a workstation has been left idle for a specific period of time. This feature can be set to require the current user to re-enter their username and password before they can return to their current session, thus adding a higher level of security. This feature improves the protection of sensitive patient, employee, and financial information in the event an employee walks away from their workstation leaving sensitive information displayed on the monitor. VHA policy requires the automatic session time-out be implemented on all VHA AIS. The automatic session time-out feature was not activated on facility workstations.

Recommended Improvement Action 9. We recommend that the VISN Director ensures that the Hospital Director takes action to (a) work with each service chief to make sure all employees with access to AIS resources complete the annual refresher training each fiscal year and (b) implement the automatic session time-out feature on all facility workstations.

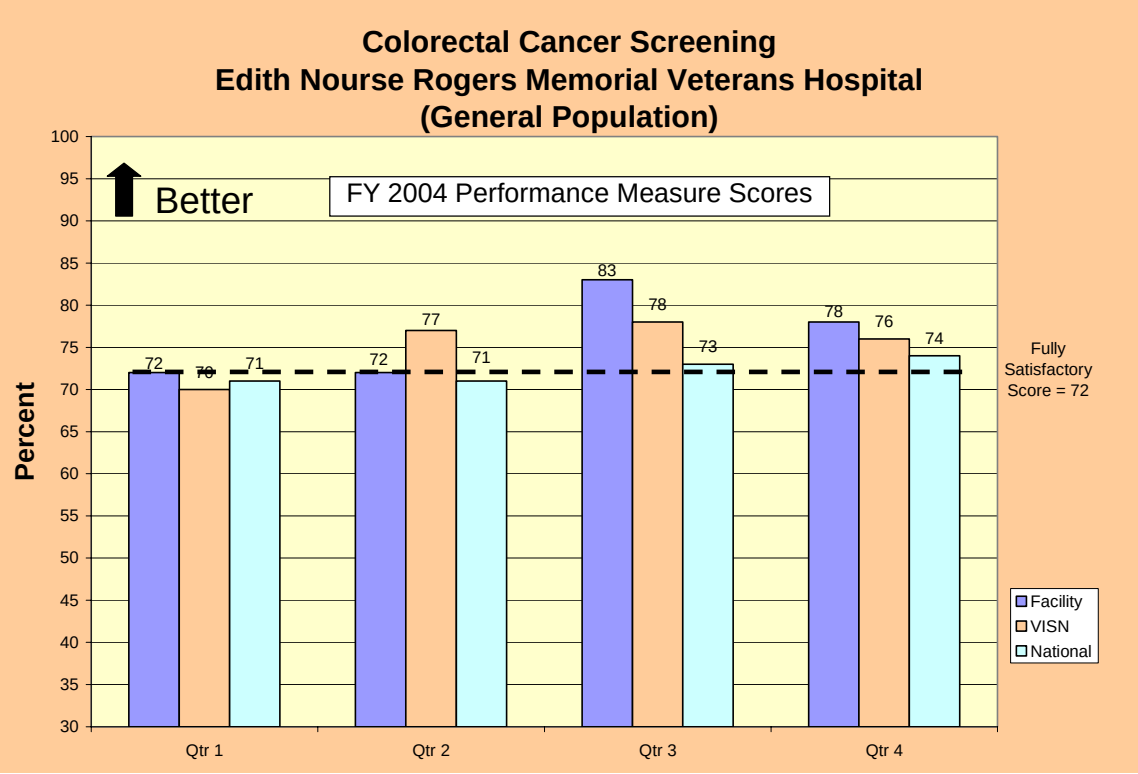
The VISN and Hospital Directors agreed with the findings and recommendations. They reported that 97 percent of employees received training by December 31, 2005, and automatic time-out features have been implemented. The implementation plans are acceptable and we consider the issues resolved.

Other Observations

Colorectal Cancer Management - Screening Processes were Timely

The hospital met or exceeded the VHA performance measure for colorectal cancer screening in FY 2004. The VHA colorectal 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. The hospital does not perform colonoscopies or provide surgical or oncology treatment services but refers all patients who have positive results from colorectal cancer screening to other VA facilities for further evaluation and treatment. Consequently, only the hospital's ability to screen for colorectal cancer could be assessed. We reviewed a sample of 10 patients who were diagnosed with colorectal cancer during fiscal year 2004 (refer to figure A).

Figure A



Findings: There was evidence of routine colorectal screening in 6 of 10 patients in our sample. The remaining four patients had not received previous care from the VA prior to their diagnosis of colorectal cancer and therefore, were screened in the community.

Recommended Improvement Action: None

Department of Veterans Affairs **Memorandum**

Date: February 13, 2006

From: VISN 1 Director

Subject: **Edith Nourse Rogers Memorial Veterans Hospital Bedford, Massachusetts**

To: Office of Inspector General (50)

1. Attached is the response to recommendations noted in most recent Combined Assessment Program Review of the VA Medical Center, Bedford, Massachusetts conducted in June 2005.

2. If you have any questions or need additional information, please contact Karen Y. Waghorn, Director, VAMC Bedford by calling (781) 687-2201.

(original signed by:)
JEANNETTE A. CHIRICO-POST, M.D.

Attachment

Department of Veterans Affairs **Memorandum**

Date: February 7, 2006

From: Medical Center Director

Subject: **Edith Nourse Rogers Memorial Veterans Hospital Bedford, Massachusetts**

To: VISN 1 Director

Office of Inspector General, Bedford Audit Operations Division

Attached you will find a narrative response to the recommendations noted in your most recent OIG CAP Audit, conducted in June 2005. We have indicated our specific concurrence with the nine recommendations given in your report in the following pages.

We concur with the recommendations. Specific timelines and corrective actions are detailed in our response. We concur with the single item listed in Appendix D, Monetary Benefits in Accordance with IG Act Recommendations.

Your audit staff proved very helpful in their analysis. This will have a positive effect on the high quality health care delivered at this facility and will ultimately improve the lives of the veterans we serve.

Specific follow-up questions should be directed to George R. Poulin, Associate Hospital Director, at (781) 687-2202.

(original signed by:)

Karen Y. Waghorn

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 Recommendation(s)

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Hospital Director requires that: (a) ceiling tiles on the MHU are secured; (b) walls and the grill cover in the dining room of the MHU are repaired; and (c) all housekeeping carts are secured.

Concur **Target Completion Date:** Completed

(a) Ceiling tile identified during OIG CAP review has been secured.

(b) Wall and radiator grill cover have been repaired.

(c) Housekeeping carts are being secured when not attended.

Recommended Improvement Action 2. We recommend that the VISN Director and the Hospital Director develop processes to (a) ensure that results of radiology examinations performed at VABHCS are timely placed into the hospital's computerized radiology system and (b) radiology data are accurately collected and reported.

Concur **Target Completion Date:** June 30, 2006

a) VA Bedford and VA Boston will utilize the VistA Interfacility Consult package which should reduce the time between consult referral and consult closure.

(b) Pending use of the VistA Interfacility Consult package, VA Bedford and VA Boston will develop a collaborative monitor for radiology data.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Hospital Director requires that: (a) the HCA conducts contract file reviews to ensure compliance with the FAR and the VAAR and to detect, correct, and prevent future contract deficiencies; (b) contracting officers correct the required pre-award and post-award administrative deficiencies; (c) COTRs receive proper training; and (d) COTRs properly monitor contracts and validate services prior to certifying payments to the contractor.

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

(a) The Contract Review process was expanded in July, 2005 to include renewal of existing contracts. To ensure compliance with the FAR and the VAAR, checklists, similar to those utilized for initial contract awards, are now being completed by the Contracting Officer for renewals/extensions, are then reviewed by a higher level Contracting Officer and then filed within the contract file.

(b) Contracting Officers will correct deficiences which can be corrected. Future pre-award requirements have been addressed through the contract checklist system previously established. Post-award requirements have been addressed through the expansion of the Contract Review process to cover existing contracts.

(c) A formal COTR training program has been implemented. Initial training for current COTRs has been completed. In the future initial training for newly appointed COTRs will occur at the time of their appointment and refresher training for all COTRs will occur as required.

(d) Fiscal Service's contract payment audit procedure has been enhanced to include their replicating the COTR review and certification process to include verification of contract, adherence to contract prices and mathematical accuracy. Discrepancies are resolved prior to the bill being processed for payment. Results of these audits will be shared with the HCA and facility QMB.

Recommended Improvement Action 4. We recommend that the VISN Director conduct a review of the sharing agreement to include consideration of taking action to renegotiate or terminate the agreement to ensure that it is in the best interest of VA.

Concur **Target Completion Date:** April 30, 2006

The Network Director has appointed a work group to review the sharing agreement. The review will be completed by March 15, 2006. The charge to the workgroup will include:

(a) Perform an analysis of revenue and cost benefit from the sharing agreement.

(b) Evaluate if the lease space rate charged by VA and revenues received by VA from the contractor are both reasonable and verifiable.

(c) Any assignment of interest, sublet, sub-lease, sub-contract, or separate agreement between the contractor and a third party is fully disclosed and receives prior written approval from VA Regional Counsel.

(d) Evaluate the terms and conditions by which assignees occupy VA space are clearly specified, any liabilities resulting from the agreement are fully insured by the contractor(s).

(e) Evaluate the appropriateness of credentials of contractor providers treating VA patients.

(f) Evaluate the reasonableness of the prices VA pays for services received from the contractor.

(g) Verify that any treatment provided to VA patients by the contractor and paid for by VA is ordered as medically necessary by a physician.

Based on the evaluation of the workgroup, the Hospital Director will take appropriate action with regard to the sharing agreement by April 30, 2006.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Hospital Director improves billing practices by taking action to: (a) enhance the compliance program to correct, detect, and prevent over-billing and to identify improper collection resulting from over-billing and refund or credit insurance carriers, as appropriate; (b) provide MCCF staff additional training on the proper categorization of encounters on the RNB Report; (c) establish a monitoring system to review the RNB Report, correct documentation deficiencies, and appropriately bill insurance carriers for healthcare provided; (d) promptly follow up on missing or inadequate documentation by contacting providers and requesting that proper documentation be submitted; (e) provide additional training to healthcare providers on documentation requirements; and (f) expand compliance reviews to capture all episodes of care that need to be coded and billed.

Concur **Target Completion Date: April 30, 2006**

(a) All cases identified in this audit as billed in error were refunded. Expanded breadth of billing audits, coordinated by the Compliance Officer, began October 2005.

(b) Training on the RNB Report was provided to the billing staff during OIG review. In November 2005 commenced monthly distribution of RNB grid to MCCR staff for their review and appropriate action.

(c) RNB report, delineating No Documentation, Insufficient Documentation, and Non-Billable Provider (Resident), will be provided to the facility CBI on a quarterly basis commencing January 2006 for their oversight.

(d) MCCF is including cases that fall into the RNB categories referenced in RIA 5c above in the Quadramed Code Me Report to HIMS. HIMS is providing email notification within Quadramed to providers requesting the needed documentation and will suspend case for one week. If necessary documentation is not provided within that time frame, HIMS manager will notify appropriate supervisor for further follow-up.

(e) Coders are now including the Quadramed E&M Reason for Change Report in the monthly documentation review conducted with clinical providers to assist with their training.

(f) Billing audits, conducted by the facility Compliance Officer, have been expanded to include billings identified as not billed due to insufficient documentation, lack of documentation and non-billable provider.

Recommended Improvement Action 6. We recommend that the VISN Director ensure that the Hospital Director requires that: (a) controls are strengthened to track and account for all nonexpendable property and that physical inventories are completed in an efficient, timely, and accurate manner; (b) a wall to wall inventory be completed and documented for all sensitive equipment; (c) service chiefs are held accountable for computers and other sensitive IT equipment in their respective services; (d) controls be established to track and document loaned equipment; (e) A&MMS managers account for all items classified as "out of service" and update the AEMS/MERS accountability status to reflect only inventoried items that are legitimately "out of service;" and (f) access to AEMS/MERS is restricted to employees with a legitimate need.

Concur **Target Completion Date:** April 30, 2006

(a) Medical Center Memorandum Nos. 90.05, 90.21 and 90.25 have been revised to strengthen procedures for tracking and accounting for all nonexpendable property, for completion of physical inventories in an efficient, timely, and accurate manner and to provide oversight of the nonexpendable property management process.

(b) A wall-to-wall inventory of computer equipment will be completed by 4/30/06.

(c) Medical Center Memorandum Nos. 90.05, 90.21 and 90.25 have been revised to strengthen accountability by the Responsible Officials for the nonexpendable property in their control.

(d) Medical Center Memorandum Nos. 90.05, 90.21 and 90.25 have been revised to strengthen controls on management of equipment taken off-station through establishment of multi-level reviews/approvals.

(e) All non-expendable property currently listed as "Out of Service", will be reviewed to determine actual status and the AMES/MERS database will be amended accordingly

(f) The AMES/MERS system has been purged of nonessential users to only those necessary.

Recommended Improvement Action 7. We recommend that the VISN Director ensures that the Hospital Director develop processes to review all Bedford purchase card transactions over $2,500 for documentation of competition and/or sole source justification; and to hold the cardholder accountable, through their supervisor, regardless of the duty location of the cardholder.

Concur **Target Completion Date:** April 15, 2006

A process will be implemented by January 30, 2006 where, on a monthly basis, Fiscal Service will identify all purchase card transactions exceeding $2500 and furnish that listing to AMMS. AMMS will review the individual transactions on this listing to determine whether competition was obtained or sole source justification documented and provide a summary report to the Hospital Director. The Hospital Director will determine appropriate further action.

Recommended Improvement Action 8. We recommend that the VISN Director ensure that the Hospital Director requires that: (a) controlled substances inspectors conduct inspections in accordance with VHA policy; (b) Pharmacy Service staff use the PVIM system to ensure minimum inventory stock levels and accountability of drug receipts; (c) Pharmacy Service staff and an accountable officer, or designee, witness the receipt and posting of all drugs, and annotate verification on invoices; (d) Pharmacy Service staff use the VistA Controlled Substance Package for timely updating of perpetual inventories; and (e) hospital policy identifies the job titles of those employees who have the authority to order, receive, post and verify controlled substances orders.

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

(a) Controlled substances inspectors are conducting inspections in accordance with VHA policy. In addition, Hospital Memorandum 119.05 "Inspection of Controlled Substances", Section IV, Implementation, Subsection 7d, has been updated to reflect current VACO policy.

(b) Pharmacy staff has commenced utilization of the PVIM system to to ensure minimum inventory stock levels and accountability of drug receipts.

(c) Procedures have been modified to insure that Pharmacy staff and the Accountable Officer, or designee witness, post and annotate invoices to properly record reciept.

(d) Pharmacy service has commenced utilization of the VISTA Controlled Substance Package to insure timely updating of perpetual inventories.

(e) Hospital Memorandum 119.05 "Inspection of Controlled Substances", Section IV, Implementation, Subsection 7d, has been updated to reflect current VACO policy with respect to identification of the job titles of those employees who have the authority to order, receive, post and verify controlled substances orders.

Recommended Improvement Action 9. We recommend that the VISN Director ensures that the Hospital Director takes action to: (a) work with each service chief to make sure all employees with access to AIS resources complete the annual refresher training each fiscal year and (b) implement the automatic session time-out feature on all facility workstations.

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

(a) The process has been strengthened with oversight provided by the facility Quality Management Board. Annual Automated Information Security refresher training was provided to 97 percent of all employees, students and WOC's last cycle. With renewed efforts to provide mandatory training to staff members on non-regular shifts as well as part-time staff, we expect 100 percent this coming cycle.

(b) Automatic time-out features have been implemented for individual users through software features within VISTA and Microsoft. Automatic time-out features for specific hardware devices have been implemented through software for thin clients and is in process for personal computers as replacements or additional units are deployed.

Service Contract Administration Deficiencies

Contract Deficiencies	Telecommunications Services $2,036,000	Telephone Maintenance Services $1,222,000	Waste Removal Services $396,000	Psychiatric Services $316,000	General Medical Services $191,000	Sharing Agreement $208,440
HCA Responsibilities						
Contract file reviews not thorough and complete				X		
Contracting Officer Responsibilities						
Workload analysis not conducted	X	X	X			
Pricing analysis not conducted	X	X	X	X		
Market research not conducted	X	X	X	X		X
Legal/technical review not conducted	X					
COTR was not timely trained	X	X	X		X	X
Written justification to exercise option year was not prepared	X					
Solicitation not advertised	X	X		X		
Sharing agreement certification not complete						X
Liability insurance coverage not maintained						X
COTR Responsibilities						
COTR redelegated validation and certification responsibilities to other VA employees		X	X		X	
VA employees, other than COTR, reviewed and certified invoices		X	X		X	

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
3c,f	Better use of funds by increasing MCCF billings and collections by improving documentation of medical care and identifying and processing all billable patient healthcare services.	$21,264
5	Better use of funds by purchasing prosthetic supplies according to the purchasing hierarchy.	2,922
	Total	$24,186

OIG Contact and Staff Acknowledgments

OIG Contact	Katherine Owens, Director, Bedford Office of Healthcare Inspections (781) 687-2317
Acknowledgments	Annette Acosta Maureen Barry Stephen Bracci John Cintolo Nick Dahl Maureen Hamilton Jeffrey Joppie Mathew Kidd Jeanne Martin James McCarthy Philip D. McDonald Amy Mosman Steven Rosenthal Joseph Vivolo Hope Watt

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