Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center White River Junction, Vermont

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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 August 22-26, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the White River Junction VA Medical Center. The purpose of the review was to evaluate selected hospital operations focusing on patient care administration and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 28 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 1.

Results of Review

The CAP review covered 11 operational activities. The medical center complied with selected standards in the following activities:

- Colorectal Cancer Management
- Procurement of Prosthetic Supplies

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

- Strengthen controls to improve oversight of the contracting activity and contract administration.
- Use Relative Value Units (RVUs) to review the department's workload and monitor contract radiologists' productivity to ensure outsourced services are cost-efficient.
- 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.
- Test the alarm system on the inpatient psychiatric unit and place the system on a preventative maintenance schedule.

- Improve radiology timeliness reporting.

This report was prepared under the direction of Ms. Katherine Owens, Director, Bedford Office of Healthcare Inspections.

Director Comments

The VISN Director and the Medical Center Director agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendix A, beginning on page 25, for the full text of the Directors' comments.) We will follow up on the implementation of planned actions until they are completed.

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

Introduction

Medical Center Profile

Organization. Located in White River Junction, Vermont, the medical center is a primary and secondary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four community-based outpatient clinics located in Bennington, Colchester, and Rutland, Vermont; and Littleton, New Hampshire. The medical center serves a veteran population of about 89,750 in a primary service area that includes 14 counties in Vermont and 4 counties in New Hampshire.

Programs. The medical center provides medical, surgical, psychiatric, geriatric, primary, and critical care; it has 60 operating beds. It also provides a broad range of diagnostic and therapeutic services that include nuclear medicine, orthopedics, podiatry, hospice, optometry, neurology, rehabilitation medicine, and oncology.

Affiliations and Research. The medical center is affiliated with the Dartmouth Medical School and shares a primary care affiliation with the University of Vermont School of Medicine. The medical center supports approximately 170 resident positions annually. It also has nursing affiliations with the University of Vermont, University of New Hampshire, Northeastern University, Boston College, and Rivier College.

During Fiscal Year (FY) 2004, the medical center's research program had 114 active projects with a budget of $6.4 million. The program included projects focused on medical and health services research and research clinical trials.

Resources. The medical center's budget for FY 2004 was $104.4 million, an increase of 13 percent from FY 2003. FY 2004 staffing was 632 full-time equivalent employees (FTE), which included 64 physician and 148 nursing FTE.

Workload. In FY 2004, the medical center treated 22,705 unique patients, a 3.8 percent increase from FY 2003. In FY 2004, the average daily census was 44.7, an increase of 2.7 percent from FY 2003. The FY 2004 outpatient workload was 171,397 visits, an increase of 2.8 percent from FY 2003.

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 healthcare facility and regional office operations focusing on patient care, quality management (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 and general management controls. Patient care administration is the process of planning and delivering patient care. 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. We also followed up on recommendations that were made in the CAP report published March 16, 2005.[1] The review covered the following activities:

Colorectal Cancer Management	Medical Care Collections Fund
Environment of Care	Pharmaceutical Accountability
Equipment Accountability	Procurement of Prosthetic Supplies
Government Purchase Card Program	Radiology Services
Information Technology Security	Service Contracts
Laboratory and Radiology Timeliness	

A review of the medical center's QM Program was not conducted because the CAP report cited above did not identify deficiencies in that program. The review covered facility operations for FY 2004 through June 2005, and was done in accordance with OIG standard operating procedures for CAP reviews.

As part of the review, we used interviews to survey patient satisfaction with the timeliness of services and the quality of care. We interviewed 30 patients during the review. The results were discussed with medical center managers.

During the review, we also presented two fraud and integrity awareness briefings for hospital employees. These briefings, attended by 28 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.

[1] *Combined Assessment Program Review of the VA Medical Center, White River Junction,* Report Number 04-02592-107.

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

Results of Review

Organizational Strengths

The medical center received the 2005 VA Circle of Excellence Award. Only previous Robert W. Carey Trophy Award recipients (the medical center received the trophy in 2004) are eligible to apply for the award. Additionally, the medical center applied for the Malcolm Baldrige National Quality Award and received a first stage site review on October 18-20, 2004. In 2004, there were a total of 60 applicants nationally for the Malcolm Baldrige National Quality Award. Twenty-two of the applicants were healthcare organizations. Of those 22 healthcare organizations, only 4, including the medical center, received site reviews. The medical center received a stage two site review on October 23-29, 2005.

Opportunities for Improvement

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

Conditions Needing Improvement. Medical center managers needed to improve contracting activity performance by strengthening controls to ensure that the Head of the Contracting Activity (HCA), contracting officers, and contracting officer technical representatives (COTRs) perform their responsibilities in accordance with FAR, Veterans Affairs Acquisition Regulation (VAAR), and VA policy. To evaluate the effectiveness of the contracting activity, we reviewed 10 contracts valued at $3.4 million from a universe of 57 contracts (over $50,000) valued at $28 million.

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

- *Contract Reviews.* The HCA did not conduct contract file reviews of four contracts valued at $1.5 million. The review and evaluation, typically conducted by the HCA, helps ensure the completeness and accuracy of solicitations and contract documentation packages and ensures compliance with FAR, VAAR, and VA policy.

  Our review of these four contracts identified deficiencies that could have been prevented had the HCA conducted required contract file reviews. The type of deficiencies included potential conflicts of interest on two contracts valued at $850,000, the absence of a legal/technical review for a $740,000 contract, the absence of documentation of medical liability insurance for one contract anesthesiologist and one contract nurse anesthetist, and the failure to ensure tuberculosis testing of two contract physicians.

Contracting Officer Performance. Contracting officers did not take necessary actions to avoid potential conflicts of interest and to maintain files containing required records of pre-award and post-award administrative actions. In addition, contracting officers needed to ensure that COTRs are trained before assuming responsibility for monitoring contractor performance.

- *Potential Conflict of Interest.* We determined that the Deputy Executive Director of the National Center for Post Traumatic Stress Disorder (PTSD) and the Director of VISN I Patient Safety Center of Inquiry (PSCI) had potential conflicts of interest involving two contracts valued at approximately $850,000 with the medical center's affiliate, Dartmouth College. The Deputy Executive Director of the National Center

PTSD holds a non-remunerative appointment with the affiliate as Professor of Psychiatry. The Director of PSCI who holds two appointments as Associate Professor of Psychiatry and as Associate Professor of Community and Family Medicine received reimbursement of expenses totaling $10,262 for services provided to the affiliate. Generally, if a VA physician has a faculty appointment and receives any compensation, or is under the direction of the school, the VA physician has at least an imputed financial interest in the VA contracts with the school. No VA physician who has a financial interest, including an imputed financial interest, in a contract may lawfully participate in the contract. Prohibited action regarding these contracts included acting as a COTR, monitoring contractor performance, and validating contract deliverables. VHA policy requires a written opinion from VA Regional Counsel that an affiliated physician may lawfully participate in the contract before participation occurs. In the contracts under discussion, the medical center did not obtain an opinion from VA Regional Counsel.

In the prior cited CAP report, we determined that contracting officers did not conduct a number of required pre-award and post-award administrative actions. Required actions not performed included market research, VA employees other than COTRs certifying payments, background investigations, and COTR designation letters. The medical center submitted an implementation plan to address the recommendations. However, our review of service contracts on the current CAP review continued to identify service contract administrative deficiencies. We found the following contract deficiencies for 6 of 10 contracts reviewed.

- *Required Pre-Award Administrative Actions.* A contracting officer did not forward the patient safety research contract for legal/technical review valued at $740,000. Contracting officers did not maintain evidence of current medical liability insurance for two contracts valued at $660,000.

- *Required Post-Award Administrative Actions*. A contracting officer did not prepare written justifications and amendments to exercise option years for the psychiatric research contract valued at $109,000.

- *COTR Training*. A contracting officer did not ensure a COTR, responsible for monitoring two locum tenens[2] contracts valued at $659,000, had received training before assuming responsibility for monitoring contractor performance. The training identifies COTR duties, responsibilities, limited authority, and prohibited actions which include the delegation of certification responsibilities. The COTR for these two contracts inappropriately delegated certification responsibilities to the Chief of Staff's (COS) administrative assistant (AA).

[2] A Latin term literally meaning "place holder"; it means a person who substitutes temporarily for another member of the same profession.

COTR Performance. COTRs are responsible for monitoring contractor performance, ensuring that services are provided, and payments are made in accordance with contract terms and conditions. Our review showed COTRs did not ensure that physicians providing anesthesia and radiology services had received a negative tuberculosis (TB) test result prior to commencing work at the medical center. COTRs also did not ensure that physicians and researchers providing anesthesia, vascular surgery, and psychiatric research services signed in and out when coming on duty and leaving duty as required. As a result**,** the medical center lacked assurance that payments made for billed services were appropriate.

- *TB Testing of Contracted Physicians*. The medical center had two locum tenens contracts valued at $879,092 for Anesthesiologist and Radiologist services. The contracts required that "all personnel providing services under this contract shall provide evidence of current TB testing. Evidence of such testing shall be submitted prior to commencing work at the facility." The medical center did provide evidence that the anesthesiologist was administered the test; however, she did not return to have the test read and no evidence was provided showing the radiologist was tested. The anesthesiologist provided services from January 31–March 18, 2005 and April 4–July 1 and the radiologist from October 1, 2004–February 11, 2005 and March 7–September 1. COTRs need to require evidence of a negative test result to reduce the risk of exposure to VA patients and medical center staff before physicians commence work at the medical center.

- *Anesthesiology Services*. The medical center had a $403,200 locum tenens contract to provide anesthesiology services from July 2004–September 2005. The contract required that a recordkeeping system, to include time and attendance logs, be established to demonstrate that services have been received by VA. The Medical Service secretary was required to maintain time and attendance logs. Providers were required to sign in and out with the Medical Service secretary.

  The COTR, who was the Chief of Anesthesia and responsible for monitoring contractor performance, did not have an anesthesiologist sign in and out from April–June 2005, as required. While time and attendance logs were not maintained, we were informed the AA to the COS and not the COTR monitored performance. The AA conducted personal visits to the Surgical Service and reviewed patient medical records and operative and anesthesia reports for a few cases each month. However, this methodology did not fully account for the number of hours billed by the contractor and paid for by the medical center. A review of operative and anesthesia reports for June showed the anesthesiologist provided approximately 136 hours of services while the contractor billed the medical center for 178.25 hours at a cost of $35,751. As a result, the AA authorized payment for 42.25 hours totaling $8,450 without documentation to support that the anesthesiologist rendered services.

- *Vascular Surgeon Services*. The medical center had a $455,244 contract to provide vascular surgery services from December 2004–November 2005. The contract required that a recordkeeping system, to include time and attendance logs, be established to demonstrate that services have been received by VA. The Surgical Service secretary was required to maintain the time and attendance logs. Providers were required to sign in and out with the Surgical Service secretary. The COTR, who was the AA to the COS, did not have vascular surgeons sign in and out as required. As a result, the COTR authorized payments totaling $220,937 from December 2004–May 2005 without sufficient documentation to ensure the surgeons rendered the services billed by the contractor and paid for by the medical center.

- *Psychiatric Research Services*. The medical center awarded a $109,046 contract to the affiliate to provide psychiatric research services for the National Center for PTSD from October 2002–June 2005. The contract required that a record keeping system, to include time and attendance logs, be established to demonstrate that services were received by the medical center. The PTSD AA was required to maintain the time and attendance logs. Providers were required to sign in and out with the PTSD AA. The COTR, who was the Associate Director for Operations, did not have researchers sign in and out as required. Also, the COTR certified invoices that did not include the number of hours worked or the hourly rate, just the total amount owed. As a result, the COTR authorized payments totaling $152,287 from October 2002–June 2005 without sufficient documentation to ensure researchers rendered the services billed by the contractor and paid for by the medical center.

See Appendix C, page 37, for a table summarizing the types of contract services acquired, the estimated value of each contract, and contract administrative deficiencies noted.

Recommended Improvement Action 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 FAR, VAAR, and VA policy and to detect, correct, and prevent future contract deficiencies; (b) contracting officers request legal/technical reviews when required; (c) contracting officers strengthen controls to prevent conflicts of interest and, if required, seek VA Regional Counsel opinions; (d) contracting officers correct the required pre-award and post-award administrative deficiencies; (e) COTRs receive proper training; (f) COTRs obtain evidence of a negative TB test result before contracted physicians commence work at the medical center; and (g) COTRs maintain time and attendance logs for contract personnel when required.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that contract file reviews are being conducted, required legal/technical reviews will be requested when required, Regional Counsel will be consulted to prevent conflicts of interest, and contract deficiencies were remedied. A template was developed and contract officer training was conducted to reduce or eliminate future deficiencies.

Additionally, the Directors reported that a COTR training module was developed; COTRs are verifying TB test result information before new physicians begin working at the medical center, and as of October 1, 2005, attendance logs are maintained for contract personnel. The implementation plans are acceptable, and we consider the issues resolved.

Radiology Services – Relative Value Units Should Be Used To Measure and Monitor Workload and Staffing Levels

Conditions Needing Improvement. The FY 2005 productivity for the medical center's contract radiologists appeared to be low as a result of limited workload. The projected productivity level for contract radiologists in FY 2005 was considerably lower than their FY 2004 productivity. The lower productivity could be attributed to a decrease of workload from FY 2004 to FY 2005 and a staffing level increase (contract and VA staff) in FY 2005. Additionally, unlike several other VISN 1 medical facilities, this medical center did not have the digital technology that eliminates the need for radiologists to manually retrieve and handle films. Because the medical center did not have digital technology, they were unable to take advantage of teleradiology and share radiologist resources throughout the VISN, which would potentially enhance their productivity.

Productivity Benchmarks. During March 2004, the Director of the VHA National Radiology Program informed the OIG[3] that there were no productivity standards for VA radiologists, and he advocated the use of Relative Value Units (RVUs)[4] to assess their productivity. He stated that 5,000 RVUs would be a reasonable 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.

VA Staff Radiologists Productivity. The productivity figures for staff radiologists were slightly below the 5,000 RVU per FTE mark but compared favorably to most facilities within VISN 1–especially considering that the medical center did not have digital technology. In FY 2004 the medical center had 2.05 FTE service line staff radiologists who completed 9,483 RVUs, which equated into a productivity level of 4,626 RVUs per FTE (9,483 RVUs / 2.05 FTE). We used productivity figures for quarters 1-3 of FY 2005

[3] 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).*

[4] 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.

to estimate annual workload and productivity levels of staff and contract radiologists. In FY 2005 the medical center had 2.37 staff radiologists who were projected to produce 10,851 RVUs and have a productivity level of 4,578 RVUs per FTE–which was in line with their FY 2004 productivity level of 4,626 RVUs per FTE.

Contract Radiologists Productivity. In FY 2004, the medical center used the services of .74 locum tenens. Their total workload output was 6,501 RVUs, which equated to a high productivity level of 8,785 RVUs per FTE (6,501 RVUs / .74 FTE). The estimated productivity level for Quarters 1 through 3 in FY 2005 was 4,346 RVUs per FTE (4,346 RVUs / 1 FTE), which was considerably lower than their FY 2004 level of 8,785 RVUs per FTE.

Contract Cost per RVU. In FY 2004, the medical center spent an average of $204 per hour for locum tenens contract services; the total cost for the .74 FTE radiologists was $300,236. The medical center's FY 2005 average hourly cost for locum tenens services was $239 and the projected FY 2005 total cost was $478,000 for 1 FTE. The cost per RVU incorporated both cost and productivity data. The cost per RVU for contract services increased from $46 per RVU in FY 2004 to $111 per RVU in FY 2005. The dramatic increase of $65 ($111 - $46) per RVU was a result of an increase in cost (from $204 per hour to $239 per hour) and a considerable decrease in productivity (from 8,851 RVUs per FTE in FY 2004 to 4,346 RVUs per FTE in 2005).

The Acting Chief of Radiology told us that the department experienced a backlog of exams in FY 2004, which provided the contract radiologists with a workload that was higher than the norm. The total workload in FY 2004 was 15,945 RVUs, compared to a projected workload of 15,201 in FY 2005. In comparison, the FY 2005 workload was lower because there was no backlog, and a CT scanner had been inoperable for several weeks. Consequently, the medical center outsourced CT exams via fee basis. The Acting Chief of Radiology believed that .8 FTE contract services could cover the medical center's current needs, but most locum tenens providers will only contract services at 1 FTE. Also, the medical center anticipates acquiring additional equipment during FY 2006 that will increase the total workload for the radiologists.

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

The Acting Chief of Radiology said that the addition of PACS would increase productivity levels immediately. Through the use of PACS technology, medical service providers have the capability to capture, store, view, and share radiology images. PACS also allows for the possibility of teleradiology, which potentially allows VA facilities

with available radiologists to read exams from other facilities that have a shortage of staff or a backlog of workload.

The FY 2005 productivity figures for contract radiologists supported the speculation that the current workload could possibly be completed with a reduction of .2 FTE contract radiologists. However, due to the anticipated acquisition of additional diagnostic equipment in FY 2006, and FTE contract limitations, it may not be reasonable to reduce the amount of contract radiologist services the medical center is currently receiving. However, if the medical center acquires PACS that would be compatible with other facilities' systems within VA, available staff could be utilized to read exams and possibly help other facilities that have a shortage of radiologists or a backlog of workload.

Recommended Improvement Action 2. We recommended that the VISN Director ensure the Medical Center Director: (a) monitor the radiology department's workload and productivity by using RVUs and (b) take steps to ensure contract radiology services are cost-efficient.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that as of January 1, 2006, radiology workload will be monitored by using RVUs, and the cost per RVU will be monitored to ensure cost efficiency. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Medical Care Collections Fund – Some Improvements Could Further Enhance Revenue

Condition Needing Improvement. The medical center's MCCF program collected $7,063,325 between April 1, 2004, and March 31, 2005, missing its collections goal by almost $500,000. They will not meet their collections goal for FY 2005. Our review of statistical samples of outpatient care found instances of underbilling that were the result of documentation errors and billing errors. The medical center also needed to prevent underbilling by validating and reviewing the Reasons Not Billable Report (RNB Report) and identifying and billing all patient services and fee basis care provided to insured patients. We estimate that during the period of April 1, 2004, through March 31, 2005, an additional $581,410 could have been billed; also MCCF revenues could have been increased by about $158,027 (2.2 percent of $7.06 million) collected during this period.

Outpatient Billing Review. As of July 28, 2005, there were 71,249 outpatient encounters valued at $11,458,696 billed to third party payers for care delivered during the period of April 1, 2004, through March 31, 2005. A statistical sample of 138 outpatient encounters billed at $322,427, with collections of $72,051, was reviewed. The review identified 33 errors valued at $10,896 in the sample, an error rate of 3.4 percent.

- Seventeen encounters, valued at $8,227, were overlooked by MCCF staff. Examples of these missed billing opportunities follow:

a. Four encounters totaling $686 were not billed by a contract billing agency. The medical center had no system in place to detect missed bills by the contractor.

b. One encounter for $1,950 was never billed to the insurance company because MCCF staff incorrectly thought the insurance filing time had expired.

c. Three encounters, valued at $144, were underbilled as the result of coding errors.

- Thirteen encounters, valued at $2,111, were not billed due to confusion caused by incorrect interpretations of billing rules by the medical center's compliance office. Examples of these missed opportunities follow:

  a. Pathology charges of $1,585.02 related to a colonoscopy were not billed because medical center staff believed these charges were included in the colonoscopy.

  b. Psychiatric and mental health care provided by residents was not billed, even though the care was properly supervised by attending physicians, and thus billable at $415.

These 33 errors were the result of human error or confusion with existing regulations. Medical center management needs to correct, detect, and prevent coding and billing errors and clarify billing criteria. Projecting our sample results to the universe valued at $11,458,696, we estimate that about $389,596 ($11,458,696 x 3.4 percent) could have been under billed; based on the medical center's average collection rate of 27.18 percent, $105,892 could have been collected.

Reasons Not Billable Report. We reviewed three segments—Non-Billable Provider (Resident), Insufficient Documentation, and No Documentation—of the RNB Report for the period of April 1, 2004-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. Coding staff review documentation such as provider progress notes, test results, and surgical reports of patient encounters. Coding staff assign diagnoses codes from the International Classification of Diseases (ICD-9-CM) and procedure codes from Common Procedural Terminology (CPT); if they determine that the encounter is billable, they forward the coded encounter to MCCF staff, who process the bill. If they consider the encounter nonbillable it is forwarded to MCCF staff to be listed on the RNB Report. As of July 26, 2005, there were 768 encounters valued at $157,024 listed in the three segments of the outpatient RNB Report for treatment provided during the period of our review. We reviewed a judgment sample of each segment to determine whether the report was accurate and to ensure encounters were billable had they been sufficiently documented.

- *Non-Billable Provider (Resident).* There were 462 encounters valued at $80,332 on this segment of the RNB Report. We reviewed a judgment sample of 46 encounters, and found that this segment was not accurate. In 9 of 46 (19.6 percent) encounters reviewed, the medical care was provided by non-billable providers and should not have been placed on this segment of the RNB Report. We estimate that the actual

number of encounters that should have been on this segment was 371 (462 x 80.4 percent actually resident-provided care) with a value of $64,266. Additionally, in 16 of the 46 encounters in our sample, residents provided mental health services. These were not billed due to the medical center's compliance office instructions that these events were not billable even though the visits were appropriately supervised. In all other instances, the care was not billed because the level of supervision was not adequately documented to bill professional charges. Had resident supervision been properly documented and compliance office instructions been corrected, the medical center could have billed an additional $64,266; based on the medical center's collection rate of 27.18 percent, $17,468 could have been collected.

- *No Documentation.* We reviewed a judgment sample of 19 encounters from a universe of 185 valued at $38,931 for this segment of the RNB Report and found the segment to be accurate. Had documentation been properly completed, the medical center could have billed $38,931; based on the medical center's collection rate of 27.18 percent, $10,581 could have been collected.
- *Insufficient Documentation.* We reviewed a judgment sample of 12 encounters from a universe of 121 valued at $37,761 for this segment of the RNB Report and found the segment to be accurate. Had documentation been properly completed, the medical center could have billed $37,761; based on the medical center's collection rate of 27.18 percent, $10,263 could have been collected.

Medical center staff was not following up on these three segments of the RNB Report. As a result, report inaccuracies went undetected. Additionally, the RNB Report was not being used as a tool to monitor and obtain provider documentation. Medical center management needs to assign responsibility for reviewing and following up on the RNB Report. When there is no documentation or an encounter is inadequately documented, they should promptly contact providers and request that proper documentation be submitted timely. If providers had appropriately documented all medical care we estimate that an additional $140,958 ($64,266 + $38,931 +$37,761) could have been billed for the encounters on these three segments of the RNB Report. Based on the medical center's collection rate of 27.18 percent, we estimate that an additional $38,312 could have been collected.

Fee Basis. The medical center paid 5,062 fee basis claims totaling $889,172 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 225 claims for inpatient/ancillary care at a cost of $413,866 and 4,837 claims for outpatient care at a cost of $475,305. 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 96 outpatient claims and 68 inpatient and ancillary

claims. Of the 96 outpatient claims, 91 claims were not billable to third party payers because the treatment was for a service-connected disability, Medicare supplements do not cover the service provided, or the veteran did not have the proper insurance coverage. The remaining five outpatient claims were billable to third party payers (average bill value $140). One claim was correctly billed by MCCF for $12, but four claims were not billed by MCCF staff. The four claims were overlooked by MCCF staff, resulting in an error rate of 4.2 percent. These four claims could have been billed for $687.

Of the 68 inpatient claims, 34 claims were not billable to third party payers because the medical service provided, such as nursing home care, was not covered by the patient's insurance, the veteran did not sign a release form, or because the fee basis provider was not credentialed as a provider for the medical center by the third party payer. The remaining 34 inpatient and ancillary claims were billable to third party payers (average bill value of $284). Ten claims were correctly billed by MCCF staff for $5,482, but 24 claims were not properly billed by MCCF staff, resulting in an error rate of 35.3 percent. All 24 claims, which could have been billed for $4,159, were overlooked by MCCF staff.

Projecting our sample results to the universe, we estimate that an additional $28,420 could have been billed for outpatient fee basis care (4.2 percent error rate x 4,837outpatient universe x $140 average bill value) and an additional $22,436 could have been billed for inpatient and ancillary fee basis care (35.3 percent error rate x 225 inpatient/ancillary universe x $284 average bill value). Based on the medical center's average collection rate of 27.18 percent, we estimate that an additional $13,823 could have been collected.

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

Source	Projected Additional Billable Amount	Projected Additional Collectible Amount
Outpatient	$389,596	$105,892
Reasons Not Billable Report		
Non-Billable Provider (Resident)	64,266	17,468
No Documentation	38,931	10,581
Insufficient Documentation	37,761	10,263
Fee Basis	50,856	13,823
Totals	**$581,410**	**$158,027**

Conclusion. 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 healthcare services. Internal controls such as compliance

reviews or other monitors should be expanded to include a full review of patients' records to assure all billable patient care was coded and billed. Medical center management needs to enhance the compliance program to ensure coding and billing errors are detected, corrected, and prevented. 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. Healthcare providers should receive continuing training on documentation requirements. By strengthening controls, the medical center has the opportunity to increase MCCF revenues by about $158,027 annually.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director improves billing practices by taking action to: (a) enhance the compliance program to ensure coding and billing errors are detected, corrected, and prevented; (b) establish internal controls and expand compliance reviews to capture all episodes of care that need to be coded and billed; (c) establish a monitoring system to review the RNB Report, correct documentation deficiencies, and appropriately bill insurance carriers for healthcare provided; and (d) follow up on missing or inadequate documentation by contacting providers and requesting that proper documentation be submitted.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that actions were taken to ensure coding and billing errors are detected and corrected, the Patient Accounts Office expanded compliance reviews, The Patient Accounts Manager expanded the monitoring of the RNB Report, and coders are notifying providers of missing or incomplete documentation. The implementation plans are acceptable, and we consider the issues resolved.

Equipment Accountability – Inventory Controls Needed To Be Strengthened

Conditions Needing Improvement. Medical center managers needed to improve procedures to ensure that nonexpendable 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 were responsible for coordinating the EIL inventories, which included notifying all services when inventories are due and following up on incomplete or delinquent inventories. A&MMS was also responsible for maintaining the accuracy and integrity of the Automated Engineering Management System/Medical Equipment Reporting System (AEMS/MERS).

As of August 10, 2005, the medical center had 49 active EILs listing 934 equipment items with a total acquisition value of $22.9 million. We identified four 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. We found the following equipment inventory deficiencies.

- Responsible officials did not complete 15 (31 percent) of 49 annual inventories within the required 10 or 20 day periods after receiving notification that the inventories were due. These 15 inventories accounted for 446 items with a total value of $6.4 million. As of August 17, 2005, the pending inventories were from 9 to 101 days overdue.
- Responsible officials did not complete 9 (18 percent) of 49 annual inventories in a timely manner[5] – which accounted for 111 items with a total value of $7.6 million. The completed inventories were conducted from 5 to 29 days after their due dates.

Accuracy of EILs. To assess equipment accountability, we reviewed a statistical sample of 98 items[6] (combined acquisition value = $1.8 million). We were able to account for 97 out of the 98 items; however, we found the following accountability discrepancies:

- A Gateway 2000 Pentium Tower Computer Workstation (acquired in 1997 for $7,612), which was assigned to the Information Resource Management (IRM) Service, could not be located.
- A DuPont Centrifuge Rotor (acquired in 1991 for $7,220) was improperly listed in the current inventory database. Documentation was provided showing that it was turned in on May 20, 2005. Corrective action was taken while we were on-site to place the rotor into "turned-in" status and removed from the active inventory list.
- There were several inaccuracies recorded in AEMS/MERS regarding the sample of 98 items: Six items had no serial number recorded, and one item had an inaccurate serial number; five items had the wrong location listed; and two items did not have a manufacturer listed.

Out of Service Equipment. Prior to our review, A&MMS personnel did not determine whether 299 items (acquisition value = $558,744) that were classified as out of service were appropriately listed in this category. A&MMS management stated that the number of items classified as out of service was due to the fact that so many employees had access to AEMS/MERS and had the ability to place items in that status. Data recorded in AEMS/MERS regarding these items was also incomplete:

- 157 (53 percent) of the items did not have an acquisition date.
- 70 (23 percent) of the items did not have an acquisition value.

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

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

- 23 (8 percent) of the items did not have a serial number listed.
- 8 (3 percent) of the items did not have a physical location listed.

During our on-site review, A&MMS management began identifying and accounting for all items classified as out of service, and they began limiting the use of this status to items that are legitimately out of service.

Access to Property Menu Options. We determined that 29 employees had access to add, edit, and dispose (turn in) items in AEMS/MERS. A&MMS staff need to conduct a review to determine if the options for each employee were justified. The integrity of the property database was vulnerable to manipulation or misuse because so many employees had access to the system.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) responsible officials or their designees perform the physical inventories of nonexpendable equipment and ensure that property data entered into AEMS/MERS is complete and accurate, (b) A&MMS management accounts for items classified as out of service and updates this status to reflect only inventoried items that are legitimately out of service, and (c) 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. They reported that physical inventories are being completed, and timeliness of completion will be monitored and reported to senior management. Additionally, the status of out of service items will be conducted by February 28, 2006, and access to the EIL database was restricted. 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

Conditions Needing Improvement. Medical center managers needed to strengthen controls to make sure Government purchase cardholders seek competition for open market purchases exceeding $2,500. For the period from July 1, 2004, to June 30, 2005, the medical center had 73 cardholders and 36 approving officials processing 19,595 transactions valued at approximately $7.5 million. The universe of transactions greater than $2,500 totaled 508 transactions valued at approximately $3.3 million. We identified the following condition that required corrective action.

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

To determine if the medical center purchased supplies in accordance with the FAR, we reviewed 19 purchase card transactions consisting of stair lifts, scooter lifts, home oxygen, and prosthetic legs valued at $260,679. We found that cardholders for 4 (21 percent) of 19 purchases valued at $27,687 did not comply with the FAR; they purchased stair-lifts on the open market without documenting bids from three sources or documenting a justification for using a sole source. The cardholder stated the vendor used was the sole vendor serving the area.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Medical Center Director requires cardholders to consider three sources of competition for purchases over $2,500 or document the justification for using a sole source.

The VISN and Medical Center Directors agreed with the findings and recommendation. They reported that effective February 28, 2006, random reviews will be performed ensure compliance with the requirement to consider three sources of competition for purchases over $2,500. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Pharmaceutical Accountability – Stock Levels Needed To Be Monitored and Other Controls Needed To Be Improved

Conditions Needing Improvement. Medical center managers needed to improve controls to maintain minimum inventory stock levels and address weaknesses in controlled substances inspections. Also, improvements were needed to ensure Pharmacy staff uses the prime vendor inventory management (PVIM) system. 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 total replenishment cost of inventory by calculating reorder points and minimum inventory stock levels.

Based on a review of 3 months activities ending July 31, 2005, we determined that 8 of 8 drugs tested had excess stock valued at $5,280. We found that stock levels were excessive because Pharmacy staff were not effectively using the PVIM system. The value of excess stock follows.

Zoloft (50, 100 mg)	$2,733.00
Viagra (50, 100 mg)	1,713.00
Methadone (5, 10 mg)	666.00
Oxycodone (5/325 mg)	428.00
Acetaminophen (30, 300 mg)	280.00
Total	$5,280.00

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

- Inspectors did not inventory Schedule III through Schedule V controlled substances as part of monthly inspections.
- Inspectors did not inventory all controlled substances in the Pyxis dispensing machine. Inspectors did not have the correct menu options to perform the inventory.

Separation 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 pharmacy procurement technician was purchasing as well as receiving non-controlled substances.

Recommended Improvement Action 6. 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 levels, (b) separation of duties is maintained when ordering and receiving non-controlled substances, and (c) controlled substances inspectors conduct inspections in accordance with VHA policy.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that implementation of the PVIM was completed September 30, 2005. Separation of duties was established, and controlled substances inspectors are conducting inspections in accordance with VHA policy. The implementation plans are acceptable, and we consider the issues resolved.

Information Technology Security – Controls Needed To Be Strengthened

Conditions Needing Improvement. Medical center managers 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 the automatic session timeout feature was activated on all facility workstations, the information security officer (ISO) was properly documenting that hard drives were being sanitized prior to disposal, and that the ISO had initiated appropriate full background investigations on IRM staff. The following issues required management attention.

Security Awareness Training. VHA criteria requires that all facilities establish AIS security awareness and training programs to ensure all individuals who manage, operate, program, maintain, or use AIS are trained prior to being granted access to AIS resources. The ISO is responsible for overseeing the security training program. All employees 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 65.5 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.

Physical Security. Proper controls and safeguards must be in place to protect each facility's AIS resources from unauthorized access or destruction. As noted in a previous CAP review, physical security of AIS communication equipment needed to be improved. We found AIS communication equipment and components located in open areas in the basement of two medical center buildings. In another building, we found AIS communication equipment stored in an unlocked metal cabinet. While these three buildings had limited traffic and were not typically accessed by the public, VHA criteria requires that network infrastructure components be stored in secured facilities or locked inside containers to prevent unauthorized access.

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) make sure all employees complete the annual security awareness training and (b) secure AIS communication equipment from unauthorized access and possible malicious destruction.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that 95 percent of employees completed annual security awareness training by September 30, 2005. Additionally, actions are in progress to ensure that AIS communication equipment is secured. All planned actions will be completed by April 30, 2006. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed

Environment of Care – The Alarm System on the Inpatient Psychiatric Unit Needed To Be Tested and Placed on a Preventative Maintenance Schedule

Condition Needing Improvement. A follow-up inspection was performed of environment of care areas identified as needing attention in the previously cited CAP report. One area continued to require corrective action.

The removable ceiling tiles in the acute psychiatric unit were equipped with an alarm system that sounded if the ceiling tiles were tampered with. In the previous CAP report, the OIG recommended that the system be tested on a regular basis. The VISN and Medical Center Directors agreed with the recommendation. The Directors' response to the recommendation indicated that nursing employees were required to perform periodic

operational checks of the alarm system and that the system was placed on a preventative maintenance schedule.

The follow-up inspection found that nursing employees were not testing the system on a regular basis, but they were annotating on the unit blackboard when the system alarmed spontaneously (apparently the system was sensitive, and spontaneous alarming happened frequently). However, these annotations were erased daily by nursing employees, leaving no permanent record that the system was tested and functioning. Additionally, the alarm system was not placed on a preventative maintenance schedule. Medical center managers took actions to correct these conditions while we were on site.

Recommended Improvement Action 8. We recommended that the VISN Director ensure that the Medical Center Director implements planned actions for testing the ceiling alarm system and place the system on a regular preventative maintenance schedule.

The VISN and Medical Center Director agreed with the finding and recommendation. They reported that the alarm system was placed on a testing and preventative maintenance schedule during the CAP review. The implementation plans are acceptable, and we consider the issues resolved.

Laboratory and Radiology Timeliness – Radiology Reporting Needed To Be Improved

Conditions 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, and there was documentation to support reasons for scheduling routine laboratory tests beyond the designated timeframe (for example, patient preference). Also, radiology examinations performed in the medical center's radiology department were generally completed timely and the results were available to ordering providers.

Medical center managers needed to develop and implement processes to ensure that radiology examinations (for example, bone density studies and magnetic resonance imaging [MRI] studies) done either in the community or at another VA Medical Center were completed timely, were scanned timely into the computerized patient record system (CPRS), and verification and transcription times were accurate.

If the results of radiology examinations performed outside of the medical center needed the immediate attention of an ordering provider (for example, an abnormal MRI study), we were told that the outside radiologist contacted the ordering provider directly with the results, and a copy of the results was sent to the provider. However, other examination results were sent to the medical center's radiology department by facsimile. A radiology employee then transcribed, verified, and scanned the reports into CPRS to ensure that

examination results were available to ordering providers. At the time of our visit, there was a backlog of bone density and MRI study results, dating back to March 2005, that were not yet scanned into CPRS. We were also told that providers frequently needed to contact the outside radiology department (often at the request of the patient) to find out the results of a study when it was unavailable in CPRS.

Additionally, inaccurate verification and transcription times were established when the medical center's radiology department employees transcribed and verified reports performed outside of the facility. This happened because the radiologists who originally read the examinations entered verification and transcription dates and times into their respective computer systems. However, when that information was entered into the medical center's computer system (typically on dates later than the original), new dates and times were automatically assigned. Consequently, documentation showed erroneous turns around times for these studies and skewed the performance measurement data reported to the VISN. We have found and reported similar situations at other VISN 1 facilities that rely on community or other VA radiology departments to perform examinations that the facilities do not have the capability to perform. VISN managers have been responsive to these findings and are working toward rectifying the situation so data can be accurately collected and reported.

Recommended Improvement Action 9. We recommended that the VISN Director ensure that the Medical Center Director: (a) requires that processes be established and implemented to monitor the completion and timeliness of radiology examinations performed outside of the facility, (b) takes action to ensure that the results of bone density and MRI examinations are timely placed into CPRS, and (c) that VISN managers ensure that radiology timeliness data are accurately collected and reported.

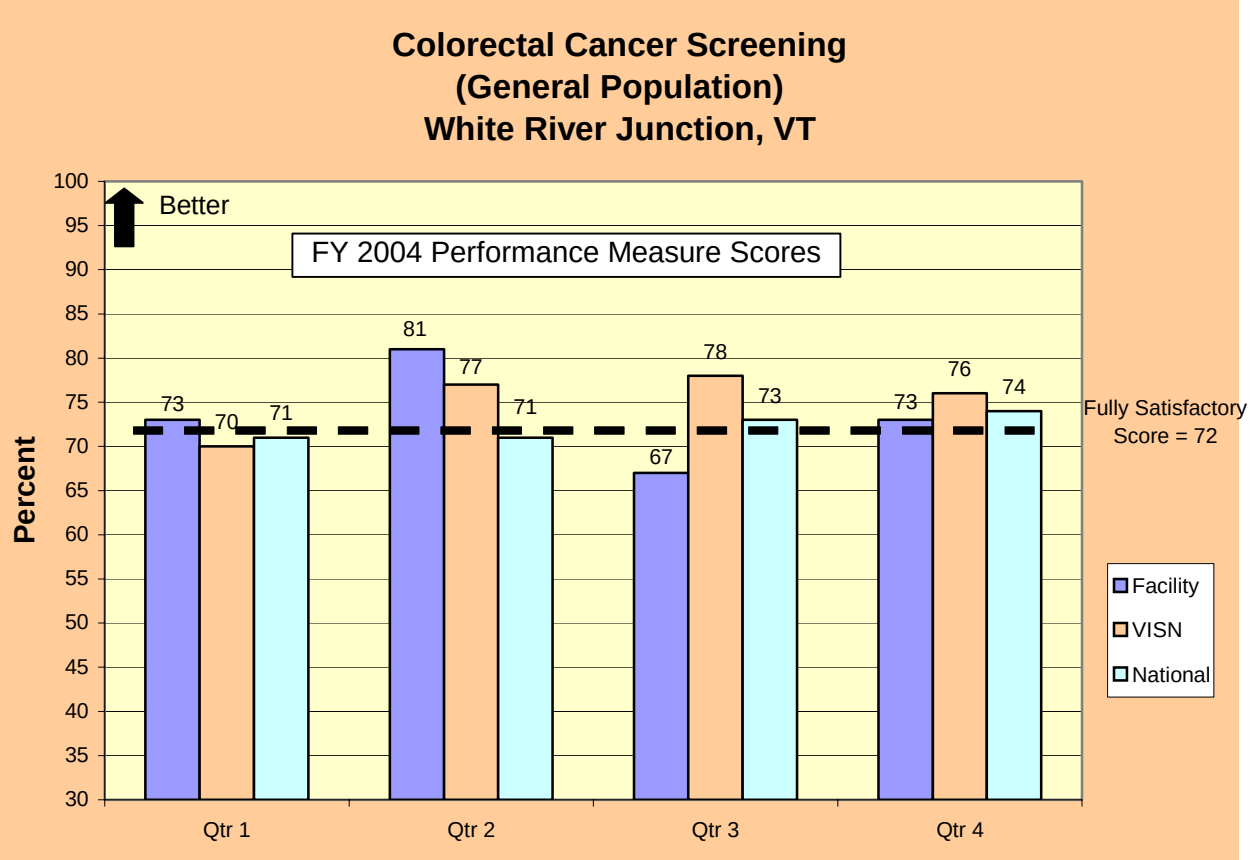
The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that processes were implemented to monitor timeliness of examinations performed outside of the facility and ensure timely notification of results to ordering providers. Additionally, the Network Information and Data Management Committee and the Chiefs of Radiology are examining the timely entry of radiology data. They will complete their review and make recommendations by April 30, 2006. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Other Observations

Colorectal Cancer Management - Screening and Treatment Processes were Timely

The medical center generally met the VHA performance measure for colorectal cancer screening (graph), 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.

Graph



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 fiscal year 2004 and 2003 (table). To determine reasonableness of timeframes, we used the 120-day VHA guideline for GI evaluation when patient demand exceeds current clinical capacity (taking into

consideration factors outside the facility's control). The GI clinic's patient demand exceeded the clinic's capacity, but patients were actually seen within 60 days.

Table

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

Appendix A

VISN 1 Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 5, 2006

From: VISN 1 Director

Subject: **VA Medical Center White River Junction, Vermont**

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 White River Junction, Vermont conducted in August 2005.

2. If you have any questions or need additional information, please contact Mr. Gary M. De Gasta, Director, VAMC White River Junction by calling (802) 295-9363 x5400.

(original signed by:)

JEANNETTE A. CHIRICO-POST, M.D.

Attachment

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 5, 2005

From: Medical Center Director

Subject: **VA Medical Center White River Junction, Vermont**

To: 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 August, 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. The local staff interactions with the audit staff, combined with the data analysis conducted by all parties, served as a foundation for several corrective actions that have been or will be undertaken. All of 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 Ryan Lilly, Chief Fiscal Officer, at 802-295-9363 x 5034.

(original signed by:)
Gary M. De Gasta, Director

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)

Concur **Target Completion Date:**

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director requires: (a) the HCA to conduct contract file reviews to ensure compliance with FAR, VAAR, and VA policy and to detect, correct, and prevent future contract deficiencies; (b) contracting officers request legal/technical reviews when required: (c) contracting officers strengthen controls to prevent conflicts of interest and, if required, seek VA Regional Counsel opinions; (d) contracting officers correct the required preaward and postaward administrative deficiencies; (e) COTRs receive proper training; (f) COTRs obtain evidence of a negative TB test result before contracted physicians commence work at the medical center; and (g) COTRs maintain time and attendance logs for contract personnel when required.

Concur **Target Completion Date:** As Noted

(a) We concur with the need to have a review by a contracting officer of equal or higher warrant. However, since the facility has so many contracts, we feel assigning this role to one single person may become inefficient. Therefore, we propose to share the responsibility for a second-level review between all contracting officers. We discussed this alternative proposal with the OIG Auditor on 12/6/05 and he concurred with the strategy. We will implement this proposal no later than December 31, 2005.

(b) The trigger for legal and technical review is based on a dollar amount of the entire contract and for this particular contract the contracting officer considered only the dollar value of a single option year. This was an oversight by the Contracting Officer and remedial training was conducted during the August, 2005 site visit.

(c) Contracting Officers have been instructed to solicit a formal opinion from Regional Counsel whenever a faculty member may have an inherent conflict of interest (defined as whenever a faculty member has a faculty appointment or other similar business arrangement with a potential contractor). Previous controls did not incorporate this step. Training was completed in November, 2005. Conflict of interest concerns will also be included in the higher-level contract review discussed in recommendation 1a.

(d) The specific contract issues identified were remedied where appropriate during the site visit. A contract review sheet template was created and training was conducted in September, 2005 to remind contracting officers of the need to complete the template for every contract. The template contains a checklist of requirements to complete on each contract, which should reduce or eliminate many of the oversights discovered by the auditors.

(e) A COTR training module was developed to incorporate all required training elements as required by either the FAR or VA policy. All COTR training has been completed and properly documented, effective September 1, 2005.

(f) TB test documentation will be reviewed at the time of technical submission by Contracting Officers. Remedial training on this requirement was conducted during the August, 2005 site visit. Whenever locum staff change, COTRs will verify TB test information before the new staff begin seeing patients.

(g) Effective 10/1/05, all COTR's will maintain attendance logs for contract personnel. Contracting Officers spot review five contracts per month to verify COTR performance with record-keeping standards.

Recommended Improvement Action 2. We recommend that the VISN Director ensure the Medical Center Director: (a) monitor the radiology department's workload and productivity by using RVUs and (b) take steps to ensure contract radiologists' services are cost-efficient.

Concur **Target Completion Date:** 1/1/06

(a) The Chief of Radiology will continue to monitor RVU workload and performance on a quarterly basis, effective 1/1/06. Summary information will be presented to the CEB on a schedule determined by the Chief of Staff. The facility will utilize the Class III RVU software provided by OIG during the site visit to conduct this analysis.

(b) Contracted radiologists' performance 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.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Medical Center Director improves billing practices by taking action to: (a) enhance the compliance program to ensure coding and billing errors are detected, corrected, and prevented; (b) establish internal controls and expand compliance reviews to capture all episodes of care that need to be coded and billed; (c) establish a monitoring system to review the RNB Report, correct documentation deficiencies, and appropriately bill insurance carriers for healthcare provided; and (d) follow up on missing or inadequate documentation by contacting providers and requesting that proper documentation be submitted.

Concur **Target Completion Date:** As Noted

(a) Billing staff were trained on changes to previous compliance instructions which resulted in underbilling in August, 2005. In addition, all billing staff had UB-92 and HCFA 1500 claims scrubbers installed on their PCs to screen for incorrect billing in September, 2005. Effective 10/1/05, the VISN-wide billing contract was rewritten to include the claim scrubber requirement. All of these elements serve to ensure that coding and billing errors are detected and prevented. The Compliance Officer reports audit findings at a monthly CBI meeting, the Patient Accounts manager receives the feedback and provides training to staff, and reports on follow-up actions at future meetings. This ensures that any errors that were not prevented are properly corrected.

(b) The Patient Accounts office has expanded reviews to include a review of the ONSC list sixty days after the date of service, with distribution for appropriate coding and billing action. This new process began 10/1/05 and ensures that workload is appropriately captured for billing.

(c) The Patient Accounts Manager expanded monitoring of the RNB report to include areas highlighted by the OIG inspectors, effective 10/1/05. This includes areas such as Non-billable Provider, Insufficient Documentation, and No Documentation. The Compliance Officer presents summary RNB data to the CBI Committee on a monthly basis, with appropriate follow-up action assigned to the Patient Accounts Manager at the meeting. The Patient Accounts Manager reviews the incomplete documentation findings, validates inclusion on the RNB report, and works with Coding to educate providers on required documentation improvements necessary to appropriately bill for care.

(d) Coders now notify providers of any missing or incomplete documentation via email. Summary tracking data is coordinated through the Chief, HIMS. Summary data on incomplete record closeout is presented at the monthly Data Validation Commiteee meeting, with follow-up action on indivdiual providers assigned to clinical Service Chiefs or the Chief of Staff. This process was effective 10/1/05.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) responsible officials or their designees perform the physical inventories of nonexpendable equipment and ensure that property data entered into AEMS/MERS is complete and accurate, (b) A&MMS management accounts for items classified as "out of service" and updates this status to reflect only inventoried items that are legitimately "out of service", and (c) employee access to the EIL database is restricted to employees who need access.

Concur **Target Completion Date:** As Noted

(a) Responsible Officials or their designess perform physical inventories of nonexpendable equipment. A/LS staff perform a 10% spot check of all accountable items to ensure that property data entered is complete and accurate. Timeliness of inventory completion is being monitored and reported to senior management, effective 11/14/05.

(b) The AEMS/MERS program is a shared program between A/LS, FMS, and Clinical Engineering. Historically, the "out of service" field has been used by each service for different purposes. A/LS will conduct an analysis of all items in the system listed as "out of service" and update the status to reflect only items that are truly out of service. This will be conducted by 2/28/06.

(c) This program is used by both ALS and Facilities Management. During the August, 2005 review, program access was reviewed and only specifically designated individuals from ALS, FMS, IRM, and Clinical Engineering have access. Each has access to separate portions of the program and utilize the program based on their job resonsibilities. Management determined that the number of employees and level of access for each was appropriate and that each needed access to properly perform their job.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Medical Center Director requires cardholders to consider three sources of competition for purchases over $2,500 or document the justification for using a sole source.

Concur **Target Completion Date:** 02/28/06

Cardholders are reminded of the requirement to consider multiple sources for purchases over $2500 during annual training. A file search will be developed to identify all purchases over $2500. Random reviews will be performed quarterly by the Purchase Card Coordinator to review for compliance, effective 2/28/06.

Recommended Improvement Action 6. We recommend 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 levels, (b) separation of duties is maintained when ordering and receiving non-controlled substances, and (c) controlled substances inspectors conduct inspections in accordance with VHA policy.

Concur **Target Completion Date:** 12/06/05

(a) The Pharmacy Prime Vendor (PPV) provided the White River Junction Inventory Manager/Procurement Technician with necessary training in the use of McKesson's (PPV) inventory management tools and reports on August 30, 2005, per prearranged training rollout scheduled by the PPV. Implementation of the Prime Vendor Inventory Management System (PVIM) was completed September 30, 2005 as evidenced by TURNS report that indicates White River Junction Pharmacy turned "A" item inventory 18 times during the past twelve months, exceeding the standard of 12 turns per year. Pharmacy management use the PVIM system on an ongoing basis to ensure minimum inventory levels.

(b) Pharmacy management assigned order receiving duties and responsibilities to staff not involved with order placement on August 30, 2005. This process is current practice.

(c) Effective August 30, 2005 inventory assessment for all controlled substances, at all storage sites, including pharmacy and points of care, has been incorporated into the narcotic inspection processes, in full accordance with the most current edition of VHA's Controlled Substances Handbook.

Recommended Improvement Action 7. We recommend that the VISN Director ensure that the Medical Center Director takes action to: (a) make sure all employees complete the annual security awareness training and (b) secure AIS communication equipment from unauthorized access and possible malicious destruction.

Concur **Target Completion Date:** As Noted

(a) WRJ Management took an active approach, assigning a Quadrad-level "champion" to enforce the mandatory training requirement in FY05. Each service also had staff trained on how to run monthly reports on mandatory training completion. Senior management reviews the reports quarterly and holds service chiefs accountable for individual completion in their sections. This was done to ensure users participated in the annual Information Security Training and resulted in 95% of WRJ users completing the training by September 30, 2005.

(b) The metal industrial equipment rack in Building 37 will have it's lock core changed to allow the cabinet to be locked. This will be completed by February 28, 2006.

For the AIS equipment in Building 6 and 7, each is a low-traffic building used by staff and not generally accessible to the public. Any construction project on either building would likely bring environmental concerns (asbestos, etc.). Further, since the buildings are converted residences, there are not simple solutions to create new access points to basement storage areas. For Building 7, the ISO will draw up documentation for WRJ management to make a Risk Based Decision (RBD) to accept the conditions as traffic in the IM equipment area can be minimized. The cost associated with correcting the deficiencies is prohibitive. For Building 6, the ISO will draw up an RBD document to accept the residual risk again due to the limited traffic in the outer building. The RBD will consider the residual risk associated with installing a cage around the equipment. Each action will be completed by April 30, 2006.

Recommended Improvement Action 8. We recommend that the VISN Director ensure that the Medical Center Director implements planned actions for testing the ceiling alarm system and place the system on a regular preventative maintenance schedule.

Concur **Target Completion Date:** 12/06/05

The alarm system was placed into the preventive maintenance system while the auditors were on site. The motion detector alarm system on the inpatient psychiatry ward (Ground East) is tested to ensure that the system is operational in the following schedule. At the beginning of each tour of duty, it is the responsibility of the charge nurse to observe that the system is functioning. In addition, random testing of ceiling areas by nursing staff takes place on a weekly basis. At least four (4) areas served by the system are tested. All testing (daily and weekly) is recorded and a log maintained on the nursing unit. Any malfunctions are reported to the Safety Officer for timely evaluation and repair. All components of the new process were implemented by 12/06/05.

Recommended Improvement Action 9. We recommend that the VISN Director ensure that the Medical Center Director: (a) requires that processes be established and implemented to monitor the completion and timeliness of radiology examinations performed outside of the facility, (b) takes action to ensure that the results of bone density and MRI examinations are timely placed into CPRS, and (c) that VISN managers ensure that radiology timeliness data are accurately collected and reported.

Concur **Target Completion Date:** As Noted

(a) As noted by the auditors, the process for immediate notification of abnormal test results was sufficient. For "normal" test results, the elimination of backlogs by 12/1/05 has ensured that results are entered timely into the system. The backlog present during the inspection prohibited local staff from entering information timely into the system. Radiology staff use the internal software to notify ordering providers of study completion and enter the date of the study as reported by the private facility whenever that information is included as part of the study results (local staff assign a study completion time based on receipt of reports if it is not provided).

(b) The backlog of reports present during the site visit was addressed through a redistribution of workload amongst office staff. The backlog has been eliminated effective 12/1/05. A weekly review to identify all outstanding reports is performed and all reports received are scanned into the patient's record.

(c) The Network Information and Data Management Committee and the Chiefs of Radiology are examining the timely entry of radiology data. They will complete their review and make recommendations by April 30, 2006.

Service Contract Administration Deficiencies **Appendix C**

Contract Deficiencies	Psychiatric Research Services $109,046	Radiology Services $475,892	Vascular Surgeon Services $455,244	Anesthesiology Services $403,200	CRNA Services $256,056	Patient Safety Research Services $739,172	Quality Scholars Teaching Services $804,604	Clinical Services (Sell) $52,000	Educational Services (Sell) $26,000	Educational Services (Sell) $71,720
HCA Responsibilities										
Contracts not reviewed by contracting officer of equal or higher warrant authority	X			X	X	X				
Contracting Officer Responsibilities										
Potential conflict of interest	X					X				
Contract not forwarded for legal/technical review						X				
Evidence of current medical liability insurance not in files				X	X					
Amendment to exercise option year not prepared	X									
Written justification to exercise option years not prepared	X									
COTR not trained timely				X	X					
Physicians not tested for TB		X		X						
COTR Responsibilities										
COTR did not maintain time and attendance log	X		X	X						
VA employees, other than COTR, reviewed and certified invoices				X	X					

Appendix D

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
3b,c	Better use of funds by increasing MCCF billings and collections by improving documentation of medical care and ensuring MCCF staff identify and process all billable patient healthcare services.	$158,027
	Total	$158,027

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 Mathew Kidd Jeanne Martin James McCarthy Philip D. McDonald Amy Mosman Steven Rosenthal Jackie Stumbris Joseph Vivolo Hope Watt

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