Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the John J. Pershing VA Medical Center Poplar Bluff, Missouri

Report No. 05-01230-195

August 21, 2006

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

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

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high-quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

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

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Contents

Executive Summary

Introduction

During the week of September 12–16, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the John J. Pershing VA Medical Center, Poplar Bluff, Missouri, which is part of Veterans Integrated Service Network (VISN) 15. The purpose of the review was to evaluate selected operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 107 medical center employees.

Results of Review

The CAP review focused on 12 areas. The medical center complied with selected standards in the following eight areas:

- Colorectal Screening Management
- Controls Over Prescription Drugs
- Environment of Care
- Government Purchase Card Program
- Information Technology Security
- Laboratory and Radiology
- Quality Management Program
- Unliquidated Obligations

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

- Improve Medical Care Collections Fund (MCCF) procedures.
- Strengthen procedures for billing and collection efforts for accounts receivable and collection efforts for debts owed by separated employees.
- Improve contract administration.
- Improve supply inventory management.

We also made an observation concerning colorectal screening management.

The report was prepared under the direction of Mr. Freddie Howell, Jr., Director, and Mr. Walter Pack, Audit Manager, Chicago Audit Operations Division.

VISN 15 and Medical Center Director Comments

The VISN and Medical Center Directors agreed with all recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 10–18, for the full text of the Directors' comments.) We will follow up on the implementation of planned improvement actions.

(original signed by:)

JON A. WOODITCH
Deputy Inspector General

Introduction

Facility Profile

Organization. Located in Poplar Bluff, Missouri, the medical center is a primary care facility that provides inpatient and outpatient health care services. The medical center operates four community-based outpatient clinics located in Cape Girardeau, Farmington, and West Plains, Missouri; and in Paragould, Arkansas. Tertiary care support is provided by VA medical centers (VAMCs) in St. Louis and Columbia, Missouri, and Memphis, Tennessee; and at the Healthcare System (HCS) Little Rock, Arkansas. The medical center is part of VISN 15 and serves about 70,000 veterans in a primary service area that includes 24 counties in Missouri and 6 counties in Arkansas.

Programs. The medical center provides inpatient and outpatient mental health and substance abuse treatment. It operates 18 internal medicine hospital beds and 40 long-term care beds.

Affiliations and Research. The medical center does not have a medical school affiliation or a research program.

Resources. In fiscal year (FY) 2004, the medical center's expenditures totaled $47.2 million. The FY 2005 medical care operating budget was $48.8 million. FY 2005 staffing was 420 full-time equivalent employees (FTE), including 20 physician FTE and 96 nursing FTE.

Workload. In FY 2004, the medical center treated 18,796 unique patients, a 3.7 percent increase over FY 2004. Inpatient workload totaled 1,604 patients. The average daily census was 16 for internal medicine care beds and 36 for long-term care beds. The medical center reported 131,587 outpatient visits during FY 2004.

Objectives and Scope of the CAP Review

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

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

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

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. 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 organization goals are met.

We also followed up on recommendations and suggestions included in our previous CAP report of the medical center (*Combined Assessment Program Review of the John J. Pershing VA Medical Center, Poplar Bluff, Missouri,* Report No. 01-02120-20, July 22, 2002). We found that medications were properly secured and stored, excessive inventory levels of controlled substances had been reduced, and staff with Government purchase card limits in excess of $2,500 had appropriate warrants.

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

Accounts Receivable	Information Technology Security
Colorectal Screening Management	Laboratory and Radiology
Contract Administration	Medical Care Collections Fund
Controls over Prescription Drugs	Quality Management Program
Environment of Care	Supply Inventory Management
Government Purchase Card Program	Unliquidated Obligations

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

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 Strength

The medical center has received four national VA Office of Nursing Service Innovation awards within 3 years. This is the highest number of awards received by any VA facility in the country. These awards were given for programs that resulted in positive outcomes and successfully dealt with the challenges of planning and providing care to patients in a rural environment. The programs demonstrated innovative and cost effective ways to provide patient care.

One award was for the Multi-Point Diabetic Education Program that increased patient participation in diabetic education to 99 percent and reduced hemoglobin A1C (blood sugar levels) in the targeted patient population by 22 percent. The program uses video conferencing to provide diabetic patient education in outpatient clinics. The patient safety program, "Across the Continuum of Care," won an award for reducing falls within the medical center and patients' homes by 71 percent. Through use of consistent screening processes, patients at risk are given increased safety training and video phones. Nurses can view patients' homes for safety and reinforce safety teaching for approximately one-eighth of the cost of traveling to the patients' homes. A third award was given to the Tele-Major Medical Evaluation Clinics for using technology and long distance collaboration with VAMC Kansas City to assess patient appropriateness for lift chairs and electric mobility devices. This has resulted in 40,000 miles of reduced patient travel, a 33 percent decrease in waiting times, a less than 10 percent no show appointment rate, and 96 percent patient satisfaction scores. The final award was for Tele-Dermatology, which is a collaborative program linking a VAMC St. Louis dermatologist with medical center nurses to visualize, diagnose, and treat skin problems. This program eliminates the 300-mile round trip between the VAMCs and has increased patient satisfaction and compliance.

Opportunities for Improvement

Medical Care Collections Fund – Fee-Basis Billing Procedures and Medical Record Documentation Needed Improvement

Condition Needing Improvement. VA is authorized by Federal law to bill health insurance carriers for certain costs related to the treatment of insured veterans. During FY 2004, the medical center collected $2,219,235 from insurance carriers, or 94 percent of its VISN 15 goal of $2,368,879. However, MCCF managers could increase collections by strengthening billing procedures for fee-basis care, improving medical

record documentation, and by ensuring that medical record coding and billing staff identify all opportunities to bill insurance carriers.

Fee-Basis Billing. VA facilities are required to obtain reimbursement from third party insurance carriers for fee-basis care provided to insured veterans. To determine if the medical center had billed insurance carriers for fee-basis care provided to patients with insurance coverage, we reviewed a random sample of 12 outpatient fee-basis payments and 6 inpatient fee-basis payments made during the first quarter of FY 2005. Of the 12 outpatient cases, MCCF staff appropriately billed 2 cases, and the remaining 10 were not eligible for billing because the patients did not have insurance or the types of services provided were not billable. However, MCCF staff had not billed insurance carriers $54,081 for four of the six inpatient fee-basis payments.

- In three cases, totaling $44,435, fee-basis staff had not entered fee-basis billing information into the Veterans Health Information Systems and Technology Architecture system, which prevented MCCF staff from identifying these cases as billable episodes.

- In one case, totaling $9,646, MCCF staff delayed billing because they needed to determine what medical record documentation was required by the insurance carrier to bill for multiple fee-basis payments incurred on behalf of one veteran.

During our review, MCCF staff prepared bills for three of these claims totaling $44,435. The fourth case was not billed because of the lack of medical record documentation. Once the needed documentation is obtained for this case, MCCF staff can bill the insurance carrier for $9,646.

Medical Record Documentation and Coding. Veterans Health Administration (VHA) policy requires clinicians to enter documentation into medical records for each outpatient encounter so that MCCF staff can bill insurers for the care provided. The "Reasons Not Billable" report for the period October 1 through December 31, 2004, included 189 potentially billable cases totaling $25,270 that were not billed because of insufficient or no medical record documentation. A sample of 50 cases showed that 44 (88 percent) totaling $5,390 should have been billed.

- In 32 cases, MCCF staff could have billed $3,290 for patient care if the providers had documented the care in patients' medical records. MCCF management informed us that this occurs because some providers do not dictate the patient care notes required by insurance carriers to document the care provided.

- In 10 cases, MCCF staff were unable to issue bills totaling $1,914 that resulted from insufficient documentation of care in medical records. While the patients' medical records contained some documentation, it was inadequate for billing purposes.

- In two cases, MCCF staff had not billed $186 because of medical coding errors.

Improved billing procedures for fee-basis care and better documentation and coding in medical records would enhance revenue collections. Our review identified additional billings totaling $59,471 ($54,081 + $5,390) that MCCF staff needed to submit to insurance carriers. Based on the medical center's FY 2005 accounts receivable collection rate of 40 percent, we estimate that $23,788 ($59,471 x 40 percent) could be collected by processing these missed billing opportunities.

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director (a) improves billing for fee-basis care provided to insured veterans and (b) improves medical record documentation and coding practices.

The VISN and Medical Center Directors agreed with the findings and recommendations. The Medical Center Director improved monitoring of billable cases and took steps to improve medical record documentation to improve billing performance. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Accounts Receivable – Billings, Collections, and Clearance Procedures for Separated Employees Needed To Be Improved

Condition Needing Improvement. Fiscal Service staff established accounts receivable in accordance with VA policy and used appropriate follow-up and collection procedures for current employees and vendor accounts receivable. However, Fiscal Service staff needed to improve billings and collections of accounts receivable and clearance procedures for separated employees.

Billings and Collections of Accounts Receivable. VA policy requires that Fiscal Service staff prepare bills promptly and perform prompt and aggressive follow-up collection actions on accounts receivable by sending initial collection letters within 30 days of the establishment of debts. We reviewed 17 accounts receivable totaling $25,590 as of June 30, 2005. These included nine vendor accounts receivable totaling $5,272 and eight employee accounts receivable totaling $20,318. As of September 2005, Fiscal Service staff had collected eight of the nine vendor accounts receivable and had performed appropriate follow-up on the remaining accounts receivable.

The eight employee accounts receivable consisted of three current employee accounts receivable totaling $5,306 and five separated employee accounts receivable totaling $15,012. Fiscal Service staff had established repayment plans for two of the three current employee accounts receivable and had performed appropriate follow-up action on the third. In addition, Fiscal Service staff took appropriate actions in two of the five

separated employee accounts receivable. However, they had not prepared bills or issued collection letters timely for the other three accounts.

Fiscal Service staff did not perform timely billing or collection actions on one separated employee accounts receivable for $5,041. The employee resigned on August 23, 2004, but Fiscal Service did not establish the accounts receivable until January 27, 2005, and did not send the initial collection letter until May 1, 2005. According to the Fiscal Service budget analyst, Fiscal Service staff had not established the accounts receivable timely because they did not know how to process a bill resulting from a breach of contract. Then, they did not send the initial collection letter timely because they thought one had been sent by VAMC St. Louis staff.

Clearance Procedures. VA policy requires notification of Fiscal Service staff when employees separate. Medical center staff allowed one separated employee to complete the separation process and did not apply a lump sum payment of $646 to a $5,041 debt. According to the Fiscal Service budget analyst, this occurred because the medical center's Coordinator for the National Nursing Education Initiative, who is responsible for Nursing Service training programs, did not notify Fiscal Service staff that the employee had failed to fulfill a financial obligation incurred when the Government paid for the employee's nursing training.

Fiscal Service staff did not timely prepare bills for $4,648 ($306 and $4,342), owed by another separated employee. The employee separated on August 31, 2004, and staff did not prepare the bills until March 14, 2005, and March 22, 2005. According to the Fiscal Service budget analyst, this occurred because Human Resources Management Service staff had not notified Fiscal Service staff that the employee was separating.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director take action to (a) aggressively pursue delinquent accounts receivable and (b) ensure that clearance procedures are followed when employees terminate their employment.

The VISN and Medical Center Directors agreed with the findings and recommendations. The Medical Center Director took steps to aggressively pursue delinquent accounts receivable and to ensure that indebted employees were identified before separation. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Contract Administration – Contracting Activities Needed Improvement

Condition Needing Improvement. The Federal Acquisition Regulation requires VA contracting staff to justify and document contracting actions and decisions. In addition, VA Acquisition Regulations require nursing homes that have contracts with VA to have a minimum of $1 million in medical liability insurance.

VISN 15 contracting staff located at VAMC Leavenworth, Kansas, solicits, negotiates, and administers contracts for all facilities in the VISN. We reviewed 15 contracts that included 5 contracts for physician services totaling $5.1 million annually, 5 service contracts totaling $3.5 million annually, and 5 community nursing home contracts where payments are based on Medicaid's per diem rate, and found that contracting staff did not adequately verify actions taken for 3 of the 15 contracts. A review of contract files showed three community nursing homes did not have medical liability insurance coverage for at least $1 million at the time the contracts were issued. One nursing home only had $500,000 in liability coverage and the other two only had $250,000 each.

Recommendation 3. We recommend that the VISN Director ensures that contracting staff verify that all contract nursing homes have the required medical liability insurance.

The VISN Director agreed with the finding and recommendation and took actions to ensure that contract nursing homes had the required liability insurance. The improvement plan is acceptable, and we will follow up on planned actions until they are completed.

Supply Inventory Management – Inventory Reporting Needed Improvement and Stock Levels Needed Reduction

Condition Needing Improvement. VHA policy mandates the use of the Generic Inventory Package (GIP) and Prosthetics Inventory Package (PIP) to manage supply inventories. These automated inventory control systems assist staff in monitoring inventory levels, analyzing usage patterns, and facilitating orders. VHA policy also requires maintenance of 30-day stock levels for all items to control inventory costs. Medical center inventory management staff adequately controlled medical supply inventory. However, they needed to take steps to ensure the accuracy of GIP and PIP and to reduce excess engineering and prosthetics supply inventories.

Accuracy of GIP and PIP. Inventory levels reported in GIP and PIP were not accurate. As of September 14, 2005, the value of 21 engineering supply items reported in GIP was $5,015. We reviewed 10 engineering supply items in GIP valued at $4,012 and found errors in reported stock levels that resulted in a net understatement of $313. As of September 15, 2005, the value of 126 prosthetics supply inventory items reported in PIP was $23,545. We reviewed 10 items valued at $6,649 and found errors in reported stock levels that resulted in a net overstatement of $524.

According to the Logistics Section inventory management supervisor, the misreporting of both engineering and prosthetics inventory occurred in part because staff using the supplies did not notify inventory management staff when items were removed from or returned to inventory.

Engineering and Prosthetics Inventory Levels. Eight of the 10 sampled engineering supply items exceeded a 30-day supply, ranging from 36 to 700 days, and the value of the excess stock was $2,392. Five of the 10 prosthetics items sampled exceeded a 30-day supply, ranging from 33 to 417 days, and the value of the excess stock was $1,116.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director require that: (a) staff using engineering and prosthetics supplies notify staff in the Logistics Section when items are removed from or returned to inventory and (b) Logistics Section staff reduce engineering and prosthetics inventories to a 30-day stock level.

The VISN and Medical Center Directors agreed with our findings and recommendations. The Medical Center Director took steps to improve inventory controls and reduce stock levels. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

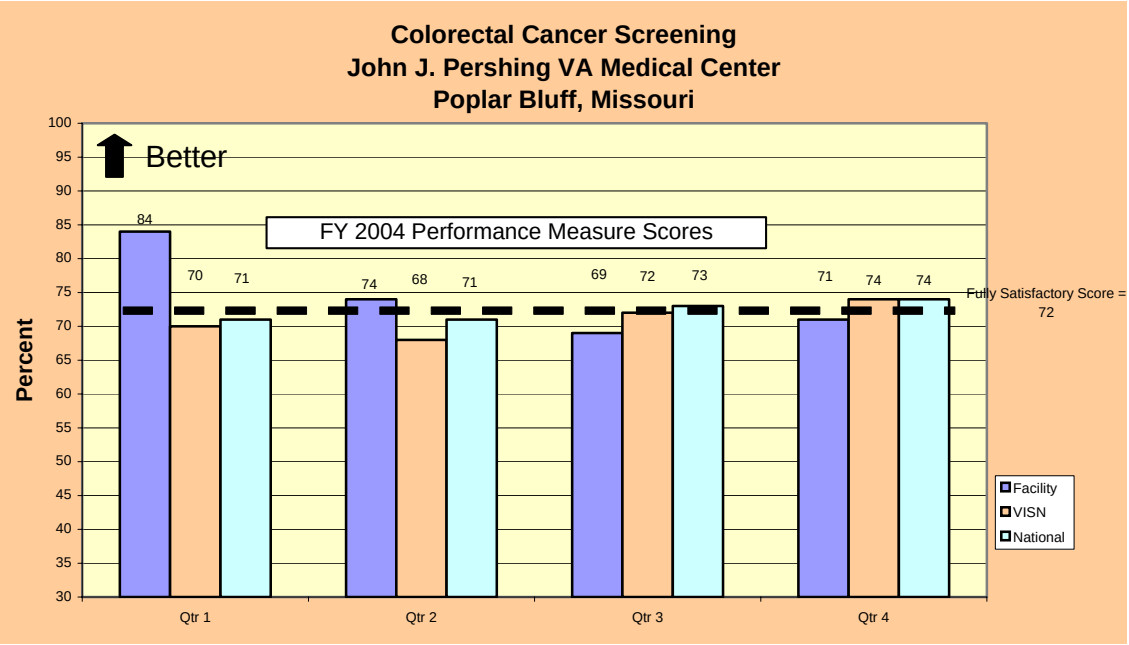
Other Observation

Colorectal Screening Management – Colonoscopy Waiting Times Have Improved

Gastroenterology (GI) physicians did not provide timely consultation responses or diagnostic colonoscopies in FY 2004, but senior management recognized the deficiency and put corrective actions in place. As a result, FY 2005 data showed continual improvement in timeliness. Timely diagnosis is essential to appropriate management of colorectal cancer (CRC) and optimal patient outcomes.

The VHA CRC screening performance measure assesses the percent of patients screened according to prescribed timeframes. The medical center provided appropriate CRC screening, and primary care providers promptly referred patients for further evaluation when indicated. Physicians informed patients of diagnoses and treatment options within reasonable timeframes and provided timely surgery and hematology/oncology referrals. Treatment was timely after patients were diagnosed. However, delays in response to initial GI consultation requests and completion of diagnostic colonoscopies caused significant delays from initial presentation to diagnosis.

The table on the following page illustrates the medical center's overall fully satisfactory performance score in FY 2004 for CRC screening:



We reviewed records for 10 patients who were diagnosed with colorectal cancer during FY 2004 and found that in 7 cases, delays occurred between presentation of symptoms and CRC diagnosis. These delays ranged from 118 to 346 days.

The medical center chartered a performance improvement project in early FY 2004 and implemented recommendations that resulted in improved timeliness for GI consultation and completion of colonoscopies. The current waiting time for colonoscopies is less than 14 days.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 30, 2006

From: Director, VISN 15 (10N15)

Subject: Combined Assessment Program Review of the John J. Pershing VA Medical Center Poplar Bluff, Missouri

To: Assistant Inspector General for Audit

Attached is our response to the subject draft report.

In addition to the response that follows, it should be noted that the Facility Profile contained in the report's introduction, does not accurately describe the facility's affiliations. While Poplar Bluff does not have a medical school affiliation, it is affiliated with multiple educational institutions covering a wide range of healthcare occupations.

Peter L. Almenoff, M.D., FCCP

VISN Director Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1: We recommend that the VISN Director ensure that the Medical Center Director: (a) improves billing for fee-basis care provided to insured veterans and (b) improves medical record documentation and coding practices.

Concur **Target Completion Date:**

See facility response.

Recommendation 2. We recommend that the VISN Director ensure that the Medical Center Director takes action to: (a) aggressively pursue delinquent accounts receivable and (b) ensure that clearance procedures are followed when employees terminate their employment.

Concur **Target Completion Date:**

See facility response.

Recommendation 3. We recommend that the VISN Director ensures that contracting staff verify that all contract nursing homes have the required medical liability insurance.

Concur **Target Completion Date:**

See response under facility section.

Recommendation 4. We recommend that the VISN Director ensure that the Medical Center Director requires that (a) staff using engineering and prosthetics supplies notify staff in Logistics Section when items are removed from or returned to inventory and (b) Logistics Section staff reduce engineering and prosthetics inventories to a 30-day stock level.

Concur **Target Completion Date:**

See facility response.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

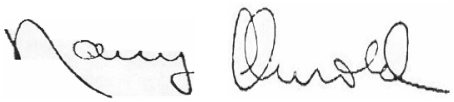
Date: January 27, 2006

From: Director, John J. Pershing VA Medical Center (647/00)

Subject: Combined Assessment Program Review of the John J. Pershing VA Medical Center Poplar Bluff, Missouri

To: VISN Director, VA Heartland Network (10N15)

Final draft of Combined Assessment Program Review of John J. Pershing VA Medical Center, Poplar Bluff, Missouri



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

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

OIG Recommendations

Recommendation 1: We recommend that the VISN Director ensure that the Medical Center Director: (a) improves billing for fee-basis care provided to insured veterans and (b) improves medical record documentation and coding practices.

Concur **Target Completion Date:** Completed 10-1-05

Response: Concur that process for MCCF collection needs to be strengthened.

During FY 05, the Medical Center initiated 183 fee bills to insurance companies for services provided. The audit revealed four (4) episodes of care had not been billed which reflects 2% of the billable episodes.

During the months of October/November 2005, 8,992 third party bills were processed. Thirty (30) episodes of care were not billable due to insufficient documentation which reflects less than ½% of third party bills.

The following steps were implemented to strengthen MCCF collection procedure:

a. The MCCF Lead prints monthly the Potential Cost Recovery Report and distributes to billing for review. This report has all patient entries for fee patients seen and is for both outpatient and inpatients. Beginning October 1, 2005, this report is now being reviewed by billing and for those patients who are not indicated as billed are annotated by billing staff with the reason the service date is not billable.

b. If the reason not billable is "no" insurance indicated with a registration prompt of "unanswered", the Supervisory Health Systems Specialist will be notified, who will then direct staff to contact veterans to update status of insurance. Any instances for reason not billable is that the inpatient fee-basis information has not been entered into the Veterans Health Information Systems and Technology Architecture (VISTA) system, then the fee clerk will be notified and request that the information be forwarded to coding for input. The MCCF Lead will follow up on these fee episodes of care to ensure that the information is collected and input for billing of these dates of services.

c. Pre-registration menu will be utilized to update all patient information and the pre-registration call list will be followed with patient demographics updated every six months via telephone. The initial program will start with the Medical Administrative Assistants and will eventually be phased in with clerks who specifically have this responsibility.

d. Fee staff will review incoming UB-92's, HCFA 1500's for patients who have an insurance indicator of "unknown" or for patients who have demographics updates required when checking on patient eligibility. An alert will be processed and sent to the Supervisory Health System Specialist, who will direct enrollment and eligibility staff to update these portions of the registration package utilizing the "pre-registration" menu.

e. Fee staff will ensure documentation supporting charges on UB-92's and HCFA 1500's are reviewed by coding prior to payment to ensure that charges are supported by diagnostic documentation. If there is insufficient documentation to support the payment of the episode of care or insufficient documentation to support billing the episode of care to the third party insurance, the fee staff will contact the vendor for proper documentation to proceed.

f. The Reasons not Billable report was run quarterly in FY 05. All episodes of care noted as insufficient documentation was identified and the results were sent to the

providers and their supervisors requesting this be corrected. This report will be run monthly beginning FY 06 for more current review by the providers.

g. Our medical center Leadership Council has encouraged and supported counseling of providers that are consistently in violation of not providing sufficient documentation to support billing to insurances for care given. There was one provider last FY that was consistently on the reasons not billable report for lack of documentation. This provider has been counseled and steps to improve their performance have been implemented. This had been completed prior to the CAP visit. On the latest reasons not billable report ran for the first two months of FY 06, this provider is not on the list.

Recommendation 2. We recommend that the VISN Director ensure that the Medical Center Director takes action to: (a) aggressively pursue delinquent accounts receivable and (b) ensure that clearance procedures are followed when employees terminate their employment.

Concur **Target Completion Date:** Completed 10-1-05

Response: Concur that process for Accounts Receivable needs to be strengthened.

The three bills referred to in the audit as not being timely billed or timely collected were identified by fiscal staff prior to the audit and corrected.

The following steps were implemented to strengthen the accounts receivable process:

a. The clearance sheet of separated employees is maintained by the Payroll Liaison in Human Resources at our facility and the Payroll Department (NBO) in Leavenworth. NBO has begun e-mailing lists of final checks of separated employees to our Finance Service. The Budget Analyst reviews the list, along with the Gains and Losses report, each pay period for separating Poplar Bluff employees. If a Poplar Bluff employee is listed, an e-mail will be sent to the Payroll Liaison and/or NBO requesting information for need of bills

of collection for LWOP, Advanced Leave, Lost Keys, and Uniforms, etc. Also the names of the separated employees will be compared to the list of NNEI recipients received from the NNEI Coordinator to determine if any breach of contract exists. At this point, action will be taken to establish the bills of collection. Once this information is received and a bill of collection is needed, the Budget Technician will input the bill of collection and implement the collection procedures. If this information is provided and the bill of collection set before the last check is given to the employee, the procedure will be to deduct any outstanding amounts due on bill of collections from the final pay before the employee is given their final check. If, however, this information comes from the NBO or NNEI Coordinator after the final check has been given to the employee, then the collection procedures will take place.

b. The input of bills for non-MCCF bills and the follow-up process will be transferred from the Revenue Coordinator/MCCF Lead to the Budget Technician. Follow-up will be accomplished when the statements are mailed on a monthly basis. The employee and ex-employee bills are reconciled monthly and we will implement the same follow-up procedures as we presently have on the vendor bills immediately. We will begin calling along with sending statements out to the responsible party. As bills age and it is determined that we have exhausted all our resources locally and through the TOP offset program, we will refer these bills to Regional Counsel for collection.

c. The set up of billing for NNEI was initially referred to Finance Service for set up of the amount of payment for education to the educational institute. The gap of time from date of terminated employment to set up of bill of collection was due to information not provided to Finance Service due to lack of communication of the breach of contract. Upon review by the MCCF Lead, it was discovered that a formula was to be used to determine amount of reimbursement to seek from the ex-employee.

After contact with Central Office, the bill was re-established with the correct amount. The statements did not initially go to the ex-employee on this bill due to all statements for non-

MCCF statements print at the St. Louis VA. It was discovered that the statements had not been sent out and that a manual printing of the statement of account would need to be processed in order to mail to the recipient. This discovery has been reviewed and the process for future input of NNEI bills and statement mailing has been revised to keep this from reoccurring.

Recommendation 3. We recommend that the VISN Director ensures that contracting staff verify that all contract nursing homes have the required medical liability insurance.

Concur **Target Completion Date:**

Response: Concur. The VISN Contracting Office concurs with the findings and immediately took action to require contractors to provide liability coverage. This issue has been completely resolved.

Recommendation 4. We recommend that the VISN Director ensure that the Medical Center Director requires that (a) staff using engineering and prosthetics supplies notify staff in Logistics Section when items are removed from or returned to inventory and (b) Logistics Section staff reduce engineering and prosthetics inventories to a 30-day stock level.

Concur **Target Completion Date:** 12-30-05

Response: Concur that process for inventory control in prosthetics and engineering should be strengthened.

The two items in engineering GIP that were not accurate were due to a posting error. The errors were corrected before the Office of Inspector General exit from the medical center. Prosthetics stock is no longer sent to the CBOC before it is issued to a patient. All stock levels have been reviewed with prosthetics and engineering and stock has been reduced to a 30-day stock level.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1	Ensuring all billable fee-basis care is billed would increase MCCF collections.	$23,788
4	Reducing stock levels would make funds available for other uses.	3,508
	Total	$27,296

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Freddie Howell, Jr. (708) 202-2667
Acknowledgments	Donald Bunce Dorothy Duncan Mary Ann Fitzgerald Tom Foley Kevin Gibbons Raymond Jurkiewicz Jennifer Kubiak Cynnde Nielsen Walter Pack Reba Ransom James Seitz Virginia Solana William Wells

Appendix E

Report Distribution

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Director, John J. Pershing VA Medical Center (647/00)

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