



# **Department of Veterans Affairs Office of Inspector General**

---

## **Healthcare Inspection**

### **Quality of Care, Administration, and Contracting Issues VA Sierra Nevada Health Care System Reno, Nevada**

**To Report Suspected Wrongdoing in VA Programs and Operations  
Call the OIG Hotline – (800) 488-8244**

## Executive Summary

The Office of Inspector General (OIG) received allegations regarding several aspects of care and administration at the VA Sierra Nevada Health Care System. The complainant made a total of 12 allegations in the following five areas:

- Quality of care in vascular surgery and gastroenterology services.
- Medical information security.
- Emergency airway management.
- Administration.
- Contracting.

We substantiated allegations in four of the five areas above and recommended that management ensure that:

1. Invasive procedure complications are properly identified and thoroughly reviewed and that problems are addressed within reasonable timeframes.
2. Actions are taken to secure patient medical information, including revising the system policy to address the process for making changes in electronic health record entries and routinely monitoring practices for compliance.
3. Provision of emergency airway management complies with regulations.
4. Training on proper contract formation and administration is provided (including training on VA Directive 1663, *Health Care Resources Contracting - Buying*) to all Contracting Officers, contract administrators, Contracting Officers' Technical Representatives, Team Leaders, Chief Logistics Officers, Directors, Chiefs of Staff, and others involved in the award and administration of contracts for services.
5. Appropriate action is taken to address the scheduling and other administrative issues that were the basis of the request by the neurosurgery group to increase pricing for the last option year.
6. All contracts awarded under the provisions of 38 U.S.C. 8153 are reviewed to ensure compliance with VA Directive 1663.

Management concurred and had already implemented actions that addressed the issues in Recommendations 1, 2, 3, 5, and 6. They submitted acceptable action plans for Recommendation 4, which included providing training for contracting personnel and managers at the facility and network levels. We find the actions and plans acceptable and will follow up until all action plans have been implemented.



**DEPARTMENT OF VETERANS AFFAIRS**  
**Office of Inspector General**  
**Washington, DC 20420**

**TO:** Veterans Integrated Service Network 21 Director

**SUBJECT:** Healthcare Inspection – Quality of Care, Administration, and Contracting Issues, VA Sierra Nevada Health Care System, Reno, NV

## **Purpose**

The Department of Veteran Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections reviewed allegations regarding several aspects of care and administration at the VA Sierra Nevada Health Care System (the system) in Reno, NV. The complainant wrote letters and/or e-mail messages to the Under Secretary for Health, the OIG, and Representative Harry Mitchell to request a review of the allegations.

## **Background**

The complainant made a total of 12 allegations in five areas: (1) quality of care issues in vascular surgery and gastroenterology (GI), (2) patient medical information security, (3) emergency airway management support, (4) several administrative issues, and (5) sub-specialty contracts.

The allegations originated from a dispute that began in 2004 regarding endovascular procedures,<sup>1</sup> which generally can be performed by specially trained vascular surgeons, interventional radiologists, or cardiologists. Clinical privileges to perform endovascular procedures were granted to both the vascular surgeon and the interventional radiologist employed by the system. The two individuals began to disagree regarding techniques, patient selection, and acceptable outcomes. In September 2005, the radiologist reported 14 patient cases where the surgeon had allegedly provided sub-standard care. The system's Chief of Staff (COS) and Director, with the support of the Veterans Integrated Service Network (VISN) 21 Director, issued a moratorium on endovascular procedures until the allegations of poor quality could be investigated. The Director also requested peer reviews on the 14 cases by a vascular surgeon and an interventional radiologist from another facility within VISN 21.

---

<sup>1</sup> Insertion of a catheter to perform procedures within blood vessels, such as placement of stents.

The complainant objected to the moratorium, as well as to a number of management issues. He complained to the OIG, the Veterans Health Administration's (VHA) Chief Surgical Consultant, and the Under Secretary for Health. The Under Secretary for Health referred the complaint to VHA's Office of the Medical Inspector (OMI). The complaint to the OIG was deferred because OMI staff had begun to review the quality of care issues.

The complainant continued to request a review of the allegations that the OMI did not include in their review. This report provides conclusions about 10 allegations made by the complainant from November 8, 2005, through March 2, 2007.

The system is a 56-bed acute care medical and surgical facility that also includes a 60-bed nursing home and two outpatient clinics. The system has affiliations with the University of Nevada School of Medicine and the University of California, San Francisco (UCSF) School of Medicine. The system had one senior general surgery resident at a time from the UCSF program.

## **Scope and Methodology**

We reviewed documents submitted by the complainant, relevant patients' medical records, system policies, and other pertinent documents and conducted interviews with the complainant, OMI staff, and relevant personnel at the system and at the VISN. We conducted a site visit on March 23, 2007.

We also reviewed three contract files related to procurement of health care services on a sole-source basis to non-affiliated entities. On or about March 1, 2005, the VISN 21 Consolidated Contracting Activity (CCA) awarded contract V261P-2351 to a neurosurgery group for neurosurgical services. In December 2005, the CCA awarded two contracts for GI physician services, V261P-2753 and V261P-2756. All three contracts were for a base period of 1 year plus 2 option years. We reviewed the contract files to evaluate the awards, modifications, and administration.

Two allegations that we did not pursue were timekeeping irregularities related to a former employee and dissatisfaction with the former COS, who retired in July 2006.

We conducted the inspection in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

## Inspection Results

### Issue 1: Quality of care issues were not acted upon appropriately.

A. Endovascular Procedures. We did not substantiate the allegation that the system's clinical leaders responded inappropriately to the poor quality of care claims by the interventional radiologist.

We reviewed patients' medical records and the peer reviews that were performed and concluded that enough serious questions were raised to merit the moratorium. One of the 14 patients did not have an endovascular procedure and was not included in the peer reviews. Over a period of approximately 18 months, the 13 patients had endovascular procedures performed by the same physician, and 7 patients experienced complications that resulted in additional procedures, lengthened hospitalization, and/or death. In accordance with VHA policy,<sup>2</sup> peer reviewers chose from three standard judgments:

Level 1 – Most experienced, competent practitioners would have handled the case similarly in all respects listed.

Level 2 – Most experienced, competent practitioners might have handled the case similarly in all respects listed.

Level 3 – Most experienced, competent practitioners would have handled the case differently in one or more of the respects listed.

The OMI's reviewers judged the 13 cases as follows:

Level 1 – 4 cases.

Level 2 – 1 case.

Level 3 – 8 cases.

A peer reviewer from another VISN 21 facility reviewed the nine cases judged to be Level 2 or 3 by the OMI reviewers and made the following judgments:

Level 1 – 4 cases.

Level 2 – 4 cases.

Level 3 – 1 case.

Only one case received a judgment of Level 3 from both reviews.

The system's Medical Executive Board (MEB) analyzed all the peer reviews of the 13 cases, plus additional case reviews, and interviewed the physician involved. The

---

<sup>2</sup> VHA Directive 2004-054, *Peer Review for Quality Management*, September 29, 2004.

MEB concluded that differences in peer review results were most likely due to variations in regional approaches and poor medical record documentation. On June 22, 2006, the MEB made the following recommendations regarding endovascular procedures:

- Improve medical record documentation.
- Adhere to the guidelines in the Memorandum of Understanding dated December 22, 2005.
- Increase senior vascular surgeon involvement in complex cases.
- Continue all involved practitioners' clinical privileges.

The complainant also alleged that the moratorium resulted in unnecessary costs and delays in patient care. On September 15, 2005, the COS directed the Chief of Surgical Service to prioritize the needs of patients who were appropriate for endovascular procedures and to refer urgent cases either to another VISN 21 facility or to appropriate providers in the community. Patients with non-urgent needs were placed on waiting lists at other VISN 21 facilities. We reviewed the spreadsheet maintained by the Surgical Service Administrative Officer and found it to reflect adequate tracking of these patients. While some costs were incurred when patients received procedures by non-VA providers, the VISN and system Directors told us that these costs were justified in order to provide needed care while resolving the poor quality of care claims.

We did not substantiate an allegation that the system's peer review process was ineffective. We reviewed the peer review process and found it to be in compliance with VHA directives. We found the decision to request outside peer reviews on the endovascular procedure cases in question to be appropriate because these procedures are specialized and review required objective practitioners with similar skills and privileges.

We did not substantiate an allegation that one of the outside peer reviewers was not competent. This individual was recommended by the VHA Chief Surgical Consultant and had the skills and privileges in endovascular procedures to provide peer reviews. Although the peer opinions differed significantly in several cases, the MEB did not recommend administrative actions against any providers.

**B. Gastroenterology Procedures.** Between July 2005 and January 2007, eight complications that resulted in additional procedures, lengthened hospitalization, and/or death were associated with procedures performed by four GI practitioners. We substantiated that reporting, reviewing, and taking corrective actions could have been more timely.

We reviewed the complications compiled by provider and by procedure. The system providers' colonoscopy complication rates ranged from 0.00–16.66 percent, with an overall complication rate of 0.79 percent (5/631). A large 2003 study showed an

incidence rate of colonoscopy perforations of 0.0196 percent.<sup>3</sup> The practitioner with the 16.66 rate had two perforations out of 12 colonoscopies performed. Another practitioner had two perforations out of 238 colonoscopies performed (0.84 percent), as well as two complications out of 501 esophago-duodenoscopy<sup>4</sup> procedures performed (0.40 percent). Both practitioners were temporary employees whose services were terminated.

The system had an informal process for reporting complications. The expectation was for the GI nurse who assisted with procedures to alert the quality management (QM) office regarding complications that occurred during the procedures. The nurse who called patients 3 days after every procedure was to alert the QM office regarding complications patients experienced after procedures. Five of the eight cases appeared to be reported appropriately. One case occurred in April 2006 but was not reported and a review initiated until March 5, 2007. The Chief of the Medical Service acknowledged that the complications were not all reported properly, and he told us that he had initiated a 100 percent review of all invasive procedures at 3 days and again at 30 days to ensure that complications are identified and reviewed and any trends acted upon. We recommended that procedure complications be properly identified, reported, and thoroughly reviewed.

## **Issue 2: Patient medical information was inappropriately altered.**

We substantiated that a physician inappropriately altered entries in the computerized patient record system (CPRS) of two patients. We reviewed the original notes and the altered notes for the two identified patients. We also reviewed the report from the VISN 21 Compliance Officer who reviewed the situation in July 2006. The altered notes were found to be inappropriate, the cause was identified, and proper action was taken to prevent reoccurrences.

We further analyzed the business rules that govern all CPRS entries and found that some inappropriate processes were still allowed. We concluded that seven CPRS business rules were not in compliance with VHA guidance and needed to be removed. The Chief of Health Information Management (HIM) deleted these seven rules on March 21, 2007.

Because new guidance may be issued in this area, we recommended that the Chief of HIM review all CPRS business rules on a regular, periodic basis. Also, because the CPRS business rules do not address “stand-alone” computer packages, such as the radiology and lab packages, we recommended that the Chief of HIM revise the system’s policy to clarify the processes and prohibitions regarding changing entries in all areas.

---

<sup>3</sup> Nicolle M. Gatto et al., “Risk of Perforation After Colonoscopy and Sigmoidoscopy: A Population-Based Study,” *Journal of the National Cancer Institute*, Vol. 95, No. 3, February 5, 2003, pp. 230–6.

<sup>4</sup> Insertion of a scope to view the esophagus and small intestine.



### **Issue 3: Emergency airway management support was inadequate.**

We substantiated that, during the 2<sup>nd</sup> quarter of fiscal year (FY) 2007, there were no practitioners on duty with documented competence in emergency airway management on 48 out of 90 days. VHA policy requires that appropriate individuals who are trained and qualified provide emergency intervention in the event any patient loses the ability to breathe.<sup>5</sup> The system's clinical leadership chose to designate the physicians who worked in the emergency room (ER) to provide emergency airway management each day from 4:30 p.m. until 8:00 a.m. the following morning. The system's ER coverage is provided through a contract. However, the contract allowed for physicians to work in the ER without documented competence in emergency airway management.

The system's Chief of the Medical Service had identified this issue on February 22, 2007. He told us that he and the Chief of the Anesthesiology Service had developed a plan to evaluate, train, and/or proctor all the current contract ER physicians to demonstrate competence in emergency airway management by July 1, 2007. Between February 22 and July 1, the staff ICU physicians provided emergency airway management coverage. We found this response and plan adequate and recommended full implementation.

### **Issue 4: Several administrative and resource issues needed attention.**

A. Veterans Health Administration Chief Surgical Consultant. We did not substantiate the allegation that the Chief Surgical Consultant did not fulfill his responsibilities. The Chief Surgical Consultant, when asked, provided two sets of names of relevant providers to utilize as peer reviewers. The VISN 21 Director indicated that this was the appropriate response of the Chief Surgical Consultant in this complaint.

B. Emergency Care Contracting Issue. Non-VHA acute inpatient care is currently obtained in the community and paid at the Medicare rate. This care includes both emergency cardiac surgeries and inpatient admissions when the system lacks bed space. We were told that in FY 2006, 148 patients received inpatient care at community hospitals. Currently, there is no contract in place for this care. We suggested that the system's COS work with the VISN 21 contracting office to consider developing a contract for inpatient care that specifies the rate of payment, as well as sets forth terms and conditions to improve clarity. These terms could include coordination of post-operative care; coordination of medical records; and procedures and documentation requirements for determining when patients are to be sent back to the system, if patients are not to remain at the community hospitals from admission to discharge home.

---

<sup>5</sup> VHA Directive 2005-031, *Out-of-Operating Room Airway Management*, August 8, 2005.

C. Low Employee Satisfaction. We substantiated that the system's two most recent sets of employee satisfaction scores (FYs 2004 and 2006) indicated employee satisfaction with senior management that was significantly lower than VHA and VISN 21 averages. A different management team was in place at the time of the 2004 survey. The current system Director had acknowledged the low scores and had initiated a plan, which included increasing communication opportunities, taking strong actions to address identified problems, and developing a goal-sharing program.

We did not substantiate the related allegation that sub-specialist physicians had left because of their dissatisfaction with the system's senior management. The Chief of Human Resources confirmed that six specialists had left over the past 2 years and that they gave the reasons detailed in the table below in their informal exit interviews. In addition, two neurologists resigned their staff appointments but continued to provide services under contract/fee basis at the system.

	<b>Specialty</b>				<b>Total</b>
	Radiology	GI	Vascular Surgery	Cardiology	
Departed for any reason	3	1	1	1	6
Transferred to another VHA facility	0	0	1	0	1
Retirement	1	0	0	0	1
More money	1	0	0	1	2
Contract expired	1	0	0	0	1
No reason given	0	1	0	0	1

### **Issue 5: Sub-specialty contracts were not awarded appropriately.**

We substantiated that three contracts were not awarded appropriately. The complainant alleged that private gastroenterologists had received inappropriately higher compensation under system contracts than had private neurosurgeons. Annual expenditures under the two GI and one neurosurgery contracts were approximately \$680,000, and we found that none of them were awarded based on an adequate determination of price reasonableness by the Contracting Officer (CO). Furthermore, our review found that contract formation was inadequate to protect VHA's interests.

We found the following common elements relating to the award of all three contracts:

- The VISN 21 CCA made no determination of price reasonableness except to state that the offerors are the only source of the service, and so, VA is obliged to pay whatever the offeror wants. There was no indication that any requests were made of the offerors to support what they were paid for the same services by other third party payors or why an up-charge to Medicare was appropriate. For services

provided at the system, the negotiated price, including any increase over the Medicare rates, should have been limited to the provider and malpractice components of the Medicare rate.

- The contracts were negotiated prior to the development of the solicitation. This is indicated by the inclusion of the name of the offeror on pages 2–3 of each solicitation and the percent of Medicare representing the contract pricing in the “Pricing Schedule/Statement of Work” section.
- The benchmark used to establish the rate was the current Medicare rate for the procedures to be performed without regard to the place of performance or making appropriate adjustments to the payment rate to account for the resources provided by the system.
- The CCA did not identify the type of contract for the neurosurgical services contract and inappropriately designated the GI physician services contracts as firm-fixed-price. As a commercial item acquisition, the contract type is limited to firm-fixed-price or firm-fixed-price with economic price adjustment. All three contracts should have been designated as firm-fixed-price with economic price adjustment since all three were based on a percentage of a price that changes yearly and not on a fixed price for the duration of the contract term. The GI physician services contracts expressed the “price” as a percentage of Medicare, which changes each year. Although the percentage was “fixed,” the price to which it was applied changed during the term of each contract period. By definition in the Federal Acquisitions Regulations (FAR) 16.201, adjustable prices can only be adjusted by operation of contract clauses providing for equitable adjustment or other revision of the contract price under stated circumstances. The neurosurgical services contract did not include clause 52.216-1, Type of Contract, as required by FAR 16.105, Solicitation Provision, which states, “The CO shall complete and insert the provision at 52.216-1, Type of contract, in a solicitation unless it is for—(a) A fixed-price acquisition made under simplified acquisition procedures,<sup>6</sup> or (b) Information or planning purposes.”

As indefinite delivery, the contracts were required to be further defined as definite-quantity, requirements, or indefinite-quantity. Both GI physician services contracts were inappropriately defined as requirements contracts, which means that by definition, all requirements for the services being procured were to go to the entity awarded the contract (see FAR 16.503), which was not the case. Furthermore, had a requirements contract been appropriate, the CO did not use Alternate I of clause 52.216-21 because some of the requirements were to be fulfilled by a VA-employed physician (see FAR 16.506(d)(2)). This action exposes VA to potential liability because either awardee would have a valid claim

---

<sup>6</sup> The procurement was not made using simplified acquisition procedures.

against VA, since each is entitled to all of the required services in accordance with the clause.

- The contracts contained no monitoring procedures and no instructions for submitting invoices other than the standard instruction found in 52.212-4(g), Contract Terms and Conditions – Commercial Items.
- The pricing schedules did not contain a contract line item, estimated quantity, unit type, price, or extended amount, as required. Consequently, none of the contracts had an estimated contract value. Additionally, the invoicing instructions contained in the contracts under 52.212-4(g) specify invoicing in accordance with the schedule, which contained no pricing or unit of measure.
- The contracts were not executed properly. One GI contract was effective prior to signature by either party. The other GI contract was effective prior to the date of negotiations and 2.5 months prior to the signing of the contract. The neurosurgery contract was effective prior to the date the CO signed the contract.

Issues specific to the award and administration of the two GI physician services contracts were:

- According to the “Justification for Other Than Full and Open Competition” (justification), the CO’s intent was to issue the contracts on a sole-source basis, which is an incorrect statement since two firms were contracted with to provide the same services. It appears that the actual condition that warranted the sole-source procurements was that neither of the groups could handle all of the system’s volume. The justification memorandums<sup>7</sup> contained numerous conflicting statements and should not have been approved by the Team Leader of the Professional/Clinical Team. In the first paragraph, the CO states that there are two GI physician groups with sufficient capabilities to provide the services required by the system. However, in paragraph 2, the CO states that neither group has sufficient physician staff to handle all of the services required. He states in his request that, “It is my intention to contract with both physician groups on a sole source basis.” The justification was approved by the Team Leader without comment. The procurement should have been issued competitively with the intent to award one or more contracts to responsive/responsible offerors. The solicitation should have identified the estimated requirements and asked the offerors to specify what percentage of the stated needs they could provide.

---

<sup>7</sup> The memorandums were identical for both GI physician services contracts except for the solicitation number and the vendor name.

- One of the contracts is with the physician group.<sup>8</sup> However, both contracts refer to two entities (a physician group and a facility), and all four entities have distinct corporate numbers. Both the contracts include a facility charge and a professional services charge. Coincidentally, they are both at the same up-charge to Medicare (110 percent for facility and 170 percent for professional in the base year). In our opinion, either four contracts should have been negotiated for the services required, or the contracted party should have been required to disclose the agreement between them and the subcontractor in order to determine price reasonableness. There is no specific requirement for subcontracts to be disclosed in a commercial item acquisition, but because patient care services are being procured, we question whether the standard malpractice and security clauses should be applied to all entities involved.
- Neither contract was clear as to what and when services were to be performed at the system versus those that were to be performed at the contractors' locations.
- Neither contract appears to address the differences between Medicare Part A for facilities' charges and Medicare Part B for physicians' charges. The contracts did not contain a schedule of prices. As such, there was no clear understanding between the parties of the actual Medicare rates that were the basis of the contract prices. The facilities' charges should have been based on Medicare's Ambulatory Payment Classification system, which applies to outpatient procedures done in a non-hospital setting. However, if any of the procedures performed included a technical component and a professional component, the technical component serves as the reimbursement rate under the Medicare system. We did not find evidence in the contract file that establishes the appropriate Medicare rate to use as a benchmark for determining whether invoices were submitted for the proper amount using the appropriate rate.
- Neither GI physician services contract file contains documents indicating any knowledge by the CO of the volume of services expected to be or actually purchased. There are no invoices or other documents that support the amount of funding requested for the contracts, and there is no justification to support the sharp increase in funding from FY 2006 to FY 2007. Both contracts were funded with \$116,100 in December 2005. The first option year was executed in December 2006 for both contracts at which time funding increased to \$585,000 each. There is nothing in the files to support this increase. One e-mail from the CO's Technical Representative (COTR), in response to a request from the CO for FY 2006 expenditures, provides an estimate of \$268,700 for one facility and \$206,664.34 for the physician services. Since these amounts cover roughly a 9-month period, the annualized amount should have been roughly \$358,000 for the

---

<sup>8</sup> The services required are physician services, which can't be provided by the contracted party.

facility and \$275,000 for the physician services. There are no documents in the files that show that additional funding was added to the contracts prior to the December 2006 addition of \$585,000 to each contract.

- Both modifications exercising the first option year were issued as unilateral change orders and indicated as a supplemental agreement (SA) pursuant to FAR 52.217-9, Option to Extend the Term of the Contract. FAR 2.101 defines a change order as a written order, signed by the CO, directing the contractor to make a change that the changes clause authorizes the CO to order without the contractor's consent. Conversely, an SA is defined as a contract modification that is accomplished by mutual consent of the parties. In accordance with FAR, this contracting action should have been issued on a bilateral (signed by both parties) basis as either an SA, as indicated on the "Standard Form 30," or as simply a modification exercising the option period.

Issues specific to the award and administration of the neurosurgery contract were:

- The pricing schedule included three columns of prices by procedure, but there were no estimated quantities and no way to determine the total estimated value of the contract. In addition, the pricing schedule did not include any provision for providing services in the neurosurgery clinic at the system, as described on pages 2–4 of the contract.
- There were two un-numbered pages, listing procedures and prices, inserted generally where a pricing schedule should be, but they were not otherwise identified as part of the contract.
- Documents in the file, especially those that are related to funding issues, intermingle the contractual requirement and the procedures that are to be done on a fee basis by the same vendor. Fee basis procedures are not relevant to the contract and should not have been included in the file.
- Amendment SA #1 was executed by the CO on February 23, 2006, exercising option period 1. The copy in the file is not executed by the contractor, even though it is identified as a bilateral modification to the contract.
- Modification SA #2 was executed by the CO on February 28, 2007, with an effective date of March 1, 2007. This modification exercised option year 2, increased pricing by 75 percent, and added services to the entire statement of work. If the system was willing to increase the amount paid for the services to be performed by almost double, it would seem prudent that another effort to find alternative sources or an effort to correct the problem identified by the contractor as the reason for the requested increase would have been attempted. The history of Modification SA #2, exercise of option year 2, is as follows on the next page:

- As documented in an e-mail from the COTR to the contract administrator, the neurosurgery group required “equitable consideration before they would extend the option years which prompted the escalation as noted.”<sup>9</sup> The equitable consideration of an increase to 175 percent of Medicare had been proposed on February 13, 2007, attached to an e-mail from the neurosurgery group to the contract administrator. They also wanted to be compensated for office visits, as well as for reviewing radiological images. It seems apparent that they had been uncompensated for office visits not resulting in a surgical procedure. However, it was unclear whether they had been reviewing radiological images during the contract period or why the addition of reviewing radiological images was essential. Additionally, the neurosurgery group expressed their concerns about “non-productive” time spent at the system,<sup>10</sup> which is a valid concern for a contractor who is being paid on a procedure basis and not being compensated for clinic duty. The Price Negotiation Memorandum (PNM) states that the increase proposed by the neurosurgery group was to offset the impact to their private practice capabilities caused by the system’s increased patient workload. The neurosurgery group’s letter cites longer turn around times in surgery that were as much as two times what area hospitals were experiencing, which resulted in non-productive time for their physician that supports the system. Neither the CO’s notes or the PNM specifically address the issues raised by the neurosurgery group as the basis for requesting an increase. We interpreted the concerns raised by the neurosurgery group to mean that the issue was caused by the system’s scheduling processes and was beyond the control of the neurosurgery group. The increase appears to be designed to cover their costs for the time unbillable services are provided at the system. In other words, they would expect to see a certain number of patients during a clinic session to evaluate and refer for surgery in their private practice, and that level of productivity was not materializing at the system, which resulted in decreased compensation.

The modification makes no provision for services offsite, but the PNM states that reimbursement will be at the Diagnosis Related Group (DRG) rate and the Resource Based Relative Value Schedule (RBRVS) rate. According to the COTR,<sup>11</sup> all professional fees are paid for under the contract, whether performed on- or off-station, inclusive of film reads, consults/office visits, and procedures. The key is the term “professional.” The contract is for physician services, Medicare Part B, and makes no provision for the payment of any facility charges that are covered under Medicare Part A. Furthermore, if offsite professional services are to be covered under the contract, a provision should

---

<sup>9</sup> COTR, e-mail message, addressed to the contract administrator, February 26, 2007, 5:07 p.m.

<sup>10</sup> Neurosurgery group, letter, addressed to the VA contract administrator, February 13, 2007.

<sup>11</sup> Based on an e-mail exchange dated April 25, 2007, and a clarifying phone call on April 26, 2007.

be included that states that the neurosurgery group will not bill any third-party insurers for the system's patients that they see offsite.

- Even though the CO had the information to do so, the modification does not include a schedule listing procedures, estimated quantities, or extended estimated costs.
- The PNM<sup>12</sup> for the modification states the Government pricing objective as "DRG at the RBRVS rate (approximately Medicare)." The offered and accepted rate was "Patient DRG times 175 percent." This statement is significant because of the increase in the rate and because DRGs are used to reimburse hospitals for inpatient facility services. Current Procedural Terminology (CPT) codes under Medicare Part B are used to pay for provider services. Because the contract is for physician services only, it should not include any reference to facility charges.
- The contract's statement of work (as modified) does not include any clear statements regarding billing procedures. However, we discussed this with the COTR and were assured that the procedures he implemented in conjunction with certification of invoices are adequate to protect the system's interests. Bills are reconciled with operating room records and system nurse practitioner records. These procedures should have been included in the contract; therefore, the contract should be modified to articulate the current procedures.
- The PNM appears to mix the terms of the fee basis payments and the contractual payments. There was no pricing schedule. Although e-mail documentation included a spreadsheet, the spreadsheet was not incorporated into the contract. The statement of work for the modification only adds radiological readings to the scope of work. It does not include any referral work under fee basis. Yet, it appears that both the contract administrator and the COTR thought that the fee basis procedures were to be performed and funded under this contract. If that was the case, we reiterate that the contract had made no provision for the facilities' portion of the procedures to be performed off-station.
- The PNM justifies the increased cost by stating that in order to cover the system's needs, two neurosurgeons would have to be hired. However, the current services were performed only 2 days a week, and according to the neurosurgery group, there is still down time because of inadequate scheduling on the system's part. The PNM goes on to justify the cost of the contract by using comparisons, such as salary survey data from the Medical Group Management Association and the Association of American Medical Colleges,

---

<sup>12</sup> The PNM for the modification was written prior to the stated date of negotiations.



- as well as hourly rates from the Federal Supply Schedule services contracts. First, comparing payment for a procedure-based contract to salary data is inappropriate. Second, it appears that there was no attempt to determine price reasonableness by asking the neurosurgery group to provide support for what they receive for the same services, under the same terms and conditions, from other third party payors.
- Documents show that the CCA made decisions relating to Modification SA #2, not because they were legally sound and in the interest of the system, but specifically to avoid compliance with VA Directive 1663.<sup>13</sup> For example:
    - The neurosurgery group offered to reduce the rate to 150 percent of Medicare for additional option years. First, this was not possible because the “Option to Extend” clause in the contract limited total duration to 3 years, which would expire on February 29, 2008. Nevertheless, the contract administrator presented the offer to the Team Leader of the Professional/Clinical Team, who declined the offer. She declined not because it was not allowable but because she did not want the contract value to exceed the audit threshold, which would have required a pre-award audit of the neurosurgery group’s offer under the provisions of VA Directive 1663.
    - The contract administrator, upon accepting the offer, explained that the system could not extend the contract beyond the last option year because VA policy would require an audit that would take “months.” Additionally, the contract administrator made reference to the additional layers of approval required by the directive and stated that the system did not have time to do that prior to the expiration of option year 2.
    - In an e-mail to the COTR on February 25, 2007, the contract administrator stated, “If VA Directive 1663 gets in the way, maybe we can agree to the terms in principle with the neurosurgery group contingent upon clearing the directive’s wickets.”
  - We confirmed, to the extent possible, that for the first 2 years of the contract period, payment was made at the contracted rate with few exceptions:
    - Multiple units were sometimes billed. One pricing sheet indicated that the multiple units were related to the number of spinal levels performed. As discussed on the next page, reporting of multiple units is not appropriate for four of five CPT codes for which multiple units were reported.

---

<sup>13</sup> VA Directive 1663, *Health Care Resources Contracting – Buying* (Title 38 U.S.C. 8153), August 10, 2006.

- Total estimated underpayment is \$591.73 for calendar years 2005 and 2006, combined. This is assuming that the unit multipliers applied were correctly stated and verified. See discussion below regarding the proper coding to account for multiple units.
- The statement of work specifies that bills from the vendor will be submitted on a health insurance claim form, the Office of Management and Budget (OMB) “Form 1500.” However, these claim forms did not conform to the pricing established under the contract (for example, the bills represented charges and not the amount agreed to, which was approximately the Medicare rate). While there was no actual effect on the price paid, there was a significant discrepancy between the amount shown on the bills and the price paid. In accordance with FAR 52.212-4, Contract Terms and Conditions – Commercial Items, item (g), invoices submitted from the neurosurgery group to the system are to include a description, quantity, unit of measure, unit price, and extended price of the items delivered. Since there was no pricing schedule to use, it appears that they simply used their normal charge amount for the procedures, and the COTR determined the amount to be paid using the VA pricer program, which is based on Medicare. The absence of a price list resulted in additional administrative costs for both parties and made it impossible to audit the records to ensure proper billing and payments.
- The OMB “Form 1500” submitted as the billing document does not properly conform to Medicare billing practices. The use of units is inappropriate in accordance with the National Correct Coding Initiative and had these forms been submitted to Medicare, they would have likely been denied. Four CPT codes were reported with inappropriate unit multipliers (63035, 63048, 63076, and 22585). The codes should have been listed separately, in addition to the code for the primary procedure. In the case of another code, 22851, the use of units may be appropriate, with reconciliation to the number of devices indicated in the patient’s medical record.

## Conclusions

We concluded that the system’s managers needed to complete actions already initiated in complications reporting, business rules, and emergency airway management.

We also concluded that contracting personnel did not adequately develop, award, or administer the three contracts reviewed. Proper controls were not in place to ensure that the system paid the agreed upon price for the services rendered nor that the system paid a fair and reasonable price for the services received. Documentation for one contract shows that actions were taken specifically to avoid compliance with VA Directive 1663.

The VISN and system contracting personnel need to correct the identified deficiencies and change their processes to prevent future occurrences.

## Recommendations

**Recommendation 1.** We recommended that the VISN Director require the System Director to ensure that invasive procedure complications are properly identified, reported, and thoroughly reviewed and that problems are addressed within reasonable timeframes.

**Recommendation 2.** We recommended that the VISN Director require the System Director to ensure that actions are taken to secure patient medical information, including routinely monitoring the CPRS business rules to ensure they are appropriate and current and revising the system policy to address the process for making changes in CPRS entries.

**Recommendation 3.** We recommended that the VISN Director require the System Director to ensure that provision of emergency airway management complies with regulations.

**Recommendation 4.** We recommended that the VISN Director require the System Director to ensure that training on proper contract formation and administration is provided (including training on VA Directive 1663) to all COs, contract administrators, COTRs, Team Leaders, Chief Logistics Officers, Directors, Chiefs of Staff, and others involved in the award and administration of contracts for services.

**Recommendation 5.** We recommended that the VISN Director require the System Director to ensure that appropriate action is taken to address the scheduling and other administrative issues that were the basis of the request by the neurosurgery group to increase pricing for the last option year.

**Recommendation 6.** We recommended that the VISN Director require the System Director to ensure that all contracts awarded under the provisions of 38 U.S.C. 8153 are reviewed to ensure compliance with VA Directive 1663.

## Comments

The VISN 21 and VA Sierra Nevada Health Care System Directors concurred with the findings and recommendations and had already implemented actions that addressed the issues in Recommendations 1, 2, 3, 5, and 6. In addition, they submitted acceptable action plans for Recommendation 4, which included providing training for contracting personnel and managers at the facility and VISN levels. We find these actions and plans acceptable and will follow up on the planned actions until they have been implemented.

*(original signed by:)*

JOHN D. DAIGH, JR., M.D.  
Assistant Inspector General for  
Healthcare Inspections

improve clinical and administrative services. We look forward to working with OIG to complete the implementation of our action plan and resolve all deficiencies.

*(original signed by:)*

Robert L. Wiebe, M.D., M.B.A.

Director, VA Sierra Pacific Network (VISN 21)

## VISN Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** August 2, 2007

**From:** Director, VA Sierra Pacific Network (10N21)

**Subject:** **Healthcare Inspection—Quality of Care, Administration,  
and Contracting Issues, VA Sierra Nevada Health Care  
System, Reno, Nevada**

**To:** Director, OIG Los Angeles Regional Office of Health Care Inspections  
(54LA)

**Thru:** Director, VHA Management Review Services (10B5)

1. I appreciate the opportunity to provide comments to the report of the Office of Inspector General (OIG) assessment of Quality of Care, Administration, and Contracting Issues at VA Sierra Nevada Health Care System (VASNHCS) in Reno, Nevada. I carefully reviewed the report and related documents. I also discussed the findings and recommendations with senior leadership at VASNHCS and the VISN 21 office, including the Quality Management Officer and Chief Logistics Officer. In brief, I concur with all of the recommendations proposed by OIG, and I have worked with VASNHCS to develop an appropriate action plan.

2. I am pleased that all of the actions regarding clinical practice (i.e., reports involving invasive procedure complications, airway management, and operating room throughput) and many of the actions regarding administrative practice (e.g., business rules regarding the electronic medical record, compliance with VA Directive 1663, and scheduling) have already been implemented. The remaining issues (i.e., those involving training) will take additional time.

3. In closing, I would like to thank the OIG Team Leader and her staff for a careful and thoughtful review. Many of the issues addressed by OIG staff were complex, highly technical, and subject to interpretation. I appreciate the knowledge, expertise, and considerable efforts of all team members. Their recommendations and additional insights will help us

## System Director Comments

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

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

**Recommendation 1.** We recommended that the VISN Director require the System Director to ensure that invasive procedure complications are properly identified, reported, and thoroughly reviewed and that problems are addressed within reasonable timeframes.

Concur. In January 2007, Quality Management began reviewing 100 percent of all invasive procedures within 72 hours of a procedure and at 30 days of completion of procedure. Data gathered from these reviews is documented and submitted to the Chiefs of the appropriate clinical department for follow-up actions. Compilations of these reviews are submitted to the interdisciplinary/multi-departmental Invasive Procedures Committee for discussion and action. Peer Review action is taken within 45 days, as outlined in VHA Directive 2004-054.

**Target Completion Date:** Completed/Closed

**Recommendation 2.** We recommended that the VISN Director require the System Director to ensure that actions are taken to secure patient medical information, including routinely monitoring the CPRS business rules to ensure they are appropriate and current and revising the system policy to address the process for making changes in CPRS entries.

Concur. VASNHCS is compliant with CPRS business rules. Updates to the CPRS business rules will be reviewed and implemented on an ongoing basis by the CPRS Clinical Application Coordinators in collaboration with the Chief, Health Information Management. The facility Compliance Officer will conduct an annual audit to ensure compliance with appropriate CPRS business rules.

Chief, Health Information Management, has revised the facility directive, which formalizes and clarifies the process for making changes to CPRS entries, including the Radiology and Lab packages.

**Target Completion Date:** Completed/Closed

**Recommendation 3.** We recommended that the VISN Director require the System Director to ensure that provision of emergency airway management complies with regulations.

Concur. VASNHCS has an intubation privileged physician in house 24/7 to manage emergency airways in compliance with regulation.

**Target Completion Date:** Completed/Closed

**Recommendation 4.** We recommended that the VISN Director require the System Director to ensure that training on proper contract formation and administration is provided (including VA Directive 1663) to all COs, contract administrators, COTRs, Team Leaders, Chief Logistic Officers, facility Directors, Chiefs of Staff, and others involved in the award and administration of contracts for services.

Concur. All VISN 21 Contracting Officers, Contracting Officer Technical Representatives (COTR's), Consolidated Contracting Activity (CCA) Team Leaders, Chief Logistics Officer, Facility Directors, Chiefs of Staff, and others involved in the award and administration of health care contracts will receive appropriate training in these areas relative to their level of involvement in the contracting process. Refresher training will be provided during the next 90 days.

In addition, VISN 21 Consolidated Contracting Activity will provide training in August 2007 to the VASNHCS leadership staff, service chiefs, administrative officers, COTRS, and all others directly involved with the administration of contracts.

**Target Completion Date:** November 1, 2007

**Recommendation 5.** We recommended that the VISN Director require the System Director to ensure that appropriate action is taken to address the scheduling and other administrative issues that were the basis of the request by the neurosurgery group to increase pricing for the last option year.

Concur. Appropriate actions were put in place to remediate the scheduling and other issues that were the basis of the request by SNG to increase pricing:



Appropriate quantity of surgical equipment had not been available to turn over rooms within a timely manner. Additional equipment was ordered to accommodate and expedite turn over of rooms and surgeries performed by SNG.

Additionally, to further expedite the operating room turn rates, an Anesthesia technician is being recruited. The technician will be responsible for set-up of the operating room, which frees the Anesthesiologist to prepare the next patient for surgery.

Operating room delayed starts are monitored and documented in the Surgical VistA package. Leadership will review this information on a bi-weekly basis to evaluate performance.

**Target Completion Date:** Completed/Closed.

**Recommendation 6.** We recommended that the VISN Director require the System Director to ensure that all contracts awarded under the provisions of 38 U.S.C. 8153 are reviewed to ensure compliance with VA Directive 1663.

Concur. CCA managers have modified the internal review form to insure the requirements of VHA Directive 1663 are included in all applicable contracts.

These reviews will be documented and maintained as part of the contract folder for future reference. The CCA will continue to perform internal reviews of all health care contracts, one level above the Contracting Officer. This internal review will be accomplished in addition to the higher level reviews, as required by FAR/VAAR and VA Directives.

**Target Completion Date:** Completed/Closed

## OIG Contact and Staff Acknowledgments

---

OIG Contact	Julie Watrous, RN Director, Los Angeles Office of Healthcare Inspections (213) 253-2677 ext. 4972
-------------	---

---

Marci Anderson  
Jerome Herbers, M.D.  
Maureen Regan, RN, JD  
Michelle Porter, RN

## Report Distribution

### **VA Distribution**

Office of the Secretary  
Veterans Health Administration  
Assistant Secretaries  
General Counsel  
Director, Veterans Integrated Service Network (10N21)  
Director, VA Sierra Nevada Health Care System (654/00)

### **Non-VA Distribution**

House Committee on Veterans' Affairs  
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and  
Related Agencies  
House Committee on Oversight and Government Reform  
Senate Committee on Veterans' Affairs  
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and  
Related Agencies  
Senate Committee on Homeland Security and Governmental Affairs  
National Veterans Service Organizations  
Government Accountability Office  
Office of Management and Budget  
U.S. House of Representatives: Harry E. Mitchell

This report is available at <http://www.va.gov/oig/publications/reports-list.asp>.