10-12397

DS
HI-242

Administrative Closure
Alleged Conflict of Interest
Marion VAMC, Marion, IL
(2010-01107-HI-0276)

3/23/11 Approved by admin staff 4/1.

I. Purpose and Objectives

The purpose of the inspection was to determine the validity of allegations related to alleged conflict of interest by a VA physician.

II. Background

A confidential complainant sent a letter to the Marion VA Medical Center (the facility) alleging that a facility physician was referring VA patients and their family members to [redacted] private medical practice for his own personal gain. The facility director instructed a facility employee to contact the OIG Hotline Division concerning the possible conflict of interest. Specifically the complainant alleged:

- The VA physician was performing [redacted] procedures on his VA clinic patients and their family members at [redacted]'s private medical practice. The VA physician's [redacted], also a physician, would provide minimal assistance during the procedure which allowed her to bill for those services.

III. Scope and Methodology

Scope and Methodology - We interviewed the complainant, administrative staff, clinical support staff, and reviewed relevant documents. Prior to our site visit, we discussed the allegations with OIG Investigations (51KC) who concluded there did not appear to be evidence of criminal activity that would be prosecuted at this time and agreed to be available for consultation during our inspection. We performed an onsite inspection on March 2–4, 2010. Our inspection was limited to allegations that pertained to the VA and did not include possible private sector violations.

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

IV. Inspection Objectives

Issue 1: Determine if the VA physician was referring VA patients to an un-approved non-VA clinic for personal gain (conflict of interest).

We were unable to substantiate or refute the allegation. While there is no VA affiliation with [redacted] or her private medical practice, VA policy allows eligible veterans to be seen by both VA and non-VA healthcare providers. We do not have access to private medical records to determine if patients were seen and a conflict of interest existed.

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Interviews with the complainant and staff members reported information which was not documented and could not be verified. The following are comments reported during our interviews.

Statements from the complainant:

- (b)(6);
- [redacted]
- Provided six names of patients she remembered as veterans treated at the private clinic.
- Stated one of the patients was (b)(3); 5 U.S.C. App 3 (IG Act); (b)(6); and that he would speak with us.
- VA physician deliberately recruited VA patients with Medicare and supplemental insurance so that his wife could bill for services.
- VA physician was not approved to bill insurance or Medicare in the private sector. For this reason, his wife would minimally assist during a procedure (insert sutures) and then bill for the services. The patients also incurred co-pays which were of concern.

Statements from the former dermatology clerk:

- VA physician told her he was building up patient workload because he intended to eventually leave the facility and go to work with (b)(6); in the private sector.
- VA physician told her he worked on weekends at (b)(6); 's private practice and treated VA patients.
- Heard the VA physician tell his VA patients to go to (b)(6); 's private medical practice.

Current VA dermatology clinic nurse and primary care clinic clerk:

- Reported they had never heard the physician refer patients (b)(6); 's practice and could see no reason for him to do so.
- The facility is capable of performing dermatology procedures and the VA physician routinely performs those in his clinic. Normal waiting times are 1–2 weeks but they can see patients sooner, if required. They could think of no reason that VA dermatology patients would need to be seen in a private clinic.

Patient Interview

- Patient was treated by the VA physician at the facility but had not been treated by (b)(6); or the VA physician at (b)(6); 's private medical practice.

We reviewed VA medical records to determine if the patients were veterans. The two patients mentioned in the letter forwarded to the OIG Hotline Division were not veterans. The remaining four patients we reviewed had been treated by the VA physician in either his VA dermatology or primary care clinics and all had Medicare with supplemental insurance. We found documentation that one patient was treated by both the VA physician and [b;6;]. She had faxed a request to the VA to fill a prescription for the patient. The Chief of Staff (COS) reviewed the clinical record and determined that the medication request was appropriate for the patient.

Issue 2: Consult/refer with 51KC for any potential criminal activity.

We offered 51KC the opportunity to review the complaint both prior to and at the conclusion of our onsite visit. The investigator determined no criminal activity could be substantiated or pursued at this time.

V. Conclusions

The facility has posted the VA Code of Ethics that clearly states seeking personal gain is an ethical violation. If the VA physician accessed patient insurance information for financial gain, it would constitute a privacy violation.

We reported our findings to the COS who questioned why the case was referred to the OIG rather than dealt with at the local level. The COS entered on duty at the facility after the case had been referred to the OIG. She stated she would have interviewed the physician and asked him about the allegations. While there may not be evidence to indicate criminal activity within the VA, she had concerns about his ethical behavior and requested the opportunity to pursue further review by the facility. Due to this request and on advice of 51KC, we did not conduct further interviews with staff and patients.

We also spoke with the Chief, Human Resources, who had concerns about the alleged conflict of interest and stated that she would support an administrative investigation so that the facility could take possible disciplinary action, if appropriate.

Results of our inspection were shared with the Acting Medical Center Director who agreed with our assessment. Therefore, we are closing this case with referral back to the facility for appropriate action.

(original signed by:)
Karen A. Moore
Director, Kansas City
Office of Healthcare Inspections