VA Office of Inspector General

Veterans Health Administration

Review of Alleged Improper Non-VA Community Care Consult Practices at Ralph H. Johnson VA Medical Center, Charleston, South Carolina

December 20, 2016
14-02890-352

ACRONYMS

CPRS	Computerized Patient Record System
EHR	Electronic Health Records
FY	Fiscal Year
MRI	Magnetic Resonance Imaging
NVCC	Non-VA Community Care
OIG	Office of Inspector General
OSC	Office of Special Counsel
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VHA	Veterans Health Administration

Highlights: Review of Alleged Improper Non-VA Community Care Consult Practices at VAMC, Charleston, SC

Why We Did This Review

On April 14, 2015, the Office of Special Counsel (OSC) forwarded to the Department of Veterans Affairs (VA) Secretary allegations of wrongdoing that occurred at the Ralph H. Johnson VA Medical Center (VAMC) in Charleston, SC, in early FY 2014. A multidisciplinary team of auditors and health care inspectors began to address the allegations. These allegations were:

- Management at the Ralph H. Johnson VAMC directed claims assistants to discontinue pending consult requests that were "aged out," a phrase previously unfamiliar to the complainants.
- Fee Basis clerks were directed to discontinue consults by marking them as being completed when they were incomplete.
- Management interfered in the consult request process, including directing care for ineligible patients and allowing the Fee Basis Unit chief to direct his own care.

What We Found

We partially substantiated the allegation that management directed claims assistants to discontinue consults, but we found that practice to be consistent with the VAMC's administrative policy.

We substantiated the allegation that the Fee Basis clerks did not properly discontinue consults, identifying three that had been marked completed prior to medical documentation being uploaded into the patient's electronic health record.

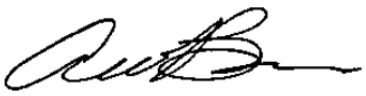
We did not substantiate the allegation that management directed care for ineligible patients and allowed the Fee Basis Unit chief to direct his own care.

What We Recommended

We recommended the Ralph H. Johnson VAMC director initiate an independent review regarding one patient who experienced a delay in receiving specialty care and that the director ensure consults that were not acted on within 7 days be tracked and managed in accordance with national policy. The VAMC director subsequently had the one patient's case reviewed by three outside experts who determined that the delay did not change the outcome for the patient. OIG agreed with the assessment and considers the recommendation closed.

Agency Comments

The Director, Ralph H. Johnson VAMC, concurred with our findings and recommendations and provided an appropriate action plan.



ANDREA C. BUCK
Chief of Staff for
Healthcare Oversight Integration

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INTRODUCTION

Allegations

On April 14, 2015, the Office of Special Counsel (OSC) forwarded to the Department of Veterans Affairs (VA) Secretary allegations of wrongdoing that occurred at the Ralph H. Johnson VA Medical Center (VAMC) in Charleston, SC. A multidisciplinary team of auditors and health care inspectors began to address the latest allegations, specifically:

- Management directed claims assistants to discontinue pending consult requests that were "aged out," a phrase previously unfamiliar to the complainants.
- Fee Basis clerks were directed to discontinue consults by marking them as being completed when they were incomplete.
- Management interfered in the consult request process, including directing care for ineligible patients and allowing the Fee Basis Unit chief to direct his own care.

Scope and Methodology

To evaluate these three allegations, OIG staff conducted a site visit, April 12–14, 2016, at the Ralph H. Johnson VAMC. The facility director was notified of this visit on April 8, 2016, to make sure relevant staff would be available for interviews. While onsite, VA OIG staff interviewed OSC's three complainants, the Chief of Staff, the Chief of Surgery, the Chief of the Fee Basis Unit during the period of the allegations, the Chief of Health Administrative Services at the time of the allegations, and two Fee Basis claims assistants, as well as the Compliance and Business Integrity officer.

We also reviewed national and local policies and procedures related to consult management and non-VA Community Care (NVCC). We reviewed specific consults identified by the complainants, as well as related patient notes.

Government Standards

We did not perform this review in accordance with CIGIE Inspection and Evaluation Standards. However we believe the scope of our review and the work completed was sufficient to support the findings and recommendations in this report.

RESULTS AND RECOMMENDATIONS

Finding 1 Management Directed Claims Assistants To Discontinue Pending Consult Requests That Were "Aged Out"

We partially substantiated the allegation that management directed claims assistants to inappropriately discontinue pending consult requests that were aged out. Management did direct claims assistants to discontinue consult requests, but we determined that VAMC staff complied with local policy when discontinuing consults that were not approved within seven days. However, in the course of our clinical review of consults, we initially identified a case that required further review. Subsequently, Ralph H. Johnson VAMC performed a clinical review using three outside experts who determined that the delay in treatment did not result in any difference in the patient's outcome.

The term aged out was used by a claims assistant in the Fee Basis Unit to describe pending consults that were discontinued because they were not approved within seven days. Veterans Health Administration (VHA) Directive 2008-056, VHA Consult Policy, dated September 16, 2008, required each VA facility director to "[establish procedures] to track and process clinical consultation requests that are without action within seven days of the request."

According to Ralph H. Johnson VAMC Policy Memorandum 136-13-03, dated September 18, 2013, "pending consults must be approved/disapproved by the designees on the Delegation of Authority within four days of submission; if the consult does not have the proper approval, a NVCC Care Coordination Note will be sent to the requesting provider and will be discontinued if not approved and still pending after seven days or more."

When we interviewed a Fee Basis claims assistant, she denied she was instructed to discontinue pending consults that had not been approved within four to seven days. When we interviewed a second Fee Basis claims assistant, she confirmed being instructed by the former Chief of the Fee Basis Unit to discontinue these types of pending consults. She explained that when these pending consults were discontinued, the consult system would alert the VA clinicians that the consult had been discontinued. Additionally, the local Ralph H. Johnson VAMC policy lacked a process for tracking consultation requests that were discontinued because they were without action within seven days after they had been requested, to determine if providers appropriately reassessed whether the patient had a continuing need for the service.

Review of Consults Provided by Complainants

On April 18, 2016, the three complainants provided documentation containing 15 veteran consults that had been aged out. We reviewed the 15 consults and other information available in the patients' VA electronic health records (EHRs). We did not access any other records, such as medical records from care provided outside of VHA or death certificates (if applicable). We did, however, review outside medical records that were scanned into the patients' VA EHR from care provided through NVCC.

We determined the following:

- All 15 consults that were discontinued conformed to the local Ralph H. Johnson VAMC policy—that is, they were discontinued after seven or more days because the facility did not take action on the consult.
- For 14 of the 15 discontinued consults, the patients subsequently received the care requested in the initial consult. One patient did not receive care (chemotherapy) because VA clinical staff determined that due to the patient's weakness and poor prognosis, it was inappropriate to proceed with chemotherapy.
- For three of the discontinued consults, the patients received delayed care. The delays ranged from 135 to 192 days. We found none of these delays to be clinically significant, based on the consult notes, as well as the patient's medical history and current health status.

Review of Consults Provided by Fee Basis Claims Assistant

A complainant provided a spreadsheet containing a list of consults, which appeared to have been created on November 1, 2013. The spreadsheet contained several columns including:

- Patient name
- SSN
- To Service (i.e., Optometry, Dental, etc.)
- CPRS status (Pending, Active, Scheduled)[1]
- File entry
- Age (days elapsed since the consult had been initiated)

Because the allegation concerned discontinuing pending consults, we looked at consults for which the "CPRS status" was identified as "Pending." Pursuant to local VHA policy, consults pending for greater than seven days without approval had been discontinued. However, we identified for review 225 consults on the spreadsheet in which the "Age" column was equal to, or less than, seven days.

[1] CPRS is VA's Computerized Patient Record System.

The 225 consults, representing 218 unique patients, were submitted by Charleston VA Health Care System providers between October 25, 2013, and November 1, 2013. We reviewed all records available within the patients' EHRs related to these consults. We did not review any other records, including death certificates or non-VA hospital records. We evaluated each medical record to determine (1) whether the consults resulted in clinical care, and (2) whether or not harm might have resulted for services that were delayed or not completed.

Discontinued Consults

Thirty-nine consults (18 percent) were designated as discontinued. Seven consults were discontinued within seven days and before being approved. Of these seven consults, four were duplicates, two were entered for incorrect services, and one consult was entered by non-authorized staff. Of the remaining 32 discontinued consults, four consults were duplicates, five were entered for incorrect services, 20 were declined or the veteran did not respond to the request to schedule an appointment, one was entered by non-authorized staff, and one consult did not have a procedure specified.

We determined that six of the 39 cases had documented delays in care; but none of the 39 discontinued consults resulted in harm. Most of the delays were the result of inaccurate or incomplete information submitted by the referring provider. In one of the six cases, VAMC staff made repeated unsuccessful attempts to contact the patient by telephone and by mail. The non-VA provider subsequently canceled the appointment after receiving no response from the patient.

Canceled Consults

Five of the 225 consults (two percent) were designated as "Canceled." Three consults were canceled after contact with the veteran while two were canceled following multiple failed attempts to contact the veteran. These consults should have been classified as discontinued consults per local VAMC policy. We determined that none of the consult cancellations resulted in harm.

Completed Consults

One hundred eighty-one consults (80 percent) were designated as complete. We reviewed these consults to determine whether patients received requested services and whether or not harm might have resulted for services that were delayed or not completed.

Thirty-six of the 181 consults listed as complete (20 percent) had no documentation in the EHR to show that patients received the requested services. Most of the referrals were for services such as audiology and physical therapy, for which we determined there was no clinically significant effect from the delays. In others, we noted that patients did obtain care, but had opted to pursue that care outside of the VA. In each of these cases, we determined that there was no evidence of harm.

One hundred forty-five of the completed consults (80 percent) had supporting documentation in the EHR. In one of these cases, the indication for care was for treatment of an advanced cancer. Our review of this patient's care is detailed below:

> The patient was a male over 50 who was diagnosed with inoperable liver cancer[2] in mid-2012. He repeatedly declined various chemotherapies typically offered to patients who are not candidates for liver transplants.[3] An ultrasound and MRI in late 2013 already showed local disease progression before a consult was initiated for radiation treatments.[4] An NVCC consult for radiation therapy was placed by his oncology provider. However, the initial appointment with radiation oncology did not take place until 77 days had elapsed and the radiation treatment was not scheduled to begin until day 90. Upon presentation to the non-VA facility for the requested radiation therapy, the patient was found to be in critical condition.[5] He was admitted briefly but died two days after being discharged.

At the time the consult for radiation treatment was placed, this patient had refused chemotherapy for over a year, developed a significant tumor burden and had a very poor prognosis. The patient died before receiving the requested radiation treatment as a result of delays in processing the NVCC consult request. However, it is unlikely that timely radiation treatment would have cured the patient's liver cancer. Whether his response to timely radiation treatment would have reduced the tumor burden enough to provide symptomatic relief or alleviate any secondary complications was unclear.

In following up on our recommendation to have an additional clinical review of this case, the Ralph H. Johnson VAMC retained three outside experts with specialized expertise in the treatment of liver cancer, who determined that the delay in radiation treatment did not result in any difference in outcome or symptom relief. OIG agreed with the assessment, and now considers the recommendation closed.

Conclusion

Administratively, the practice of discontinuing pending consults that were not approved within seven days was consistent with VAMC policy. However, it may not have been consistent with national policy, which

[2] The patient was diagnosed with hepatocellar carcinoma, which is the most common form of primary liver cancer.
[3] The patient was offered transcatheter arterial chemoembolization, which is the delivery of chemotherapy directly through the artery that gives blood to the tumor. He was also offered Sorafenib—an oral chemotherapy drug used to treat patients with inoperable liver tumors.
[4] The patient agreed to undergo SIR-Spheres Y-90 resin microsphere radioembolization, which is the delivery of radiation directly through the artery that gives blood to the tumor.
[5] The patient was hypoxic, which refers to low oxygen levels in the blood and is associated with poor perfusion to vital organs. The patient also suffered from hyperkalemia, which refers to high levels of potassium in the blood and is associated with heart failure.

required that the facility be able to track consults that had not been acted upon within seven days. Other than giving referring providers a "view alert" that their requested consult had not been acted on, there was no evidence that the facility tracked discontinued consults. We also noted that NVCC medical documentation was missing in many cases.

Recommendations

1. We recommended the Director, Ralph H. Johnson VAMC, initiate an additional clinical review regarding the patient identified in this report, and take action as appropriate.

2. We recommended the Director, Ralph H. Johnson VAMC, ensure that consults that were not acted on within 7 days can be tracked and managed in accordance with national policy.

Agency Comments

The Director, Ralph H. Johnson VAMC, concurred with our findings and recommendations.

OIG Response

The Director, Ralph H. Johnson VAMC, addressed both recommendations prior to this report being finalized. The responses to our recommendations were acceptable, and we consider both recommendations to be closed.

Finding 2 Fee Basis Clerks Were Directed To Discontinue Consults by Marking Them as Being Completed When They Were Incomplete

We substantiated the allegation that Fee Basis clerks did not properly discontinue consults. Specifically, staff did not comply with local policy when marking consults "Complete" before obtaining medical documentation from non-VA providers.

The Ralph H. Johnson VAMC Policy Memorandum 136-13-03, dated September 18, 2013, states "non-VA Care consults will remain in Scheduled status until reports are received, scanned into CPRS, and matched to consults." The September 18, 2013, policy superseded Policy Memorandum 136-10-03, dated June 18, 2010, which provided similar language: "Fee basis consults will remain in active status until reports are received and scanned into CPRS."

According to the complainants, the correct process for closing out consults was to attach the medical documentation associated with the non-VA care consult and then change the consult to Complete. However, the complainants alleged that the former Chief of the Fee Basis Unit directed consults to be marked Complete before medical documentation was received for the non-VA care.

When we spoke with the former Chief of the Fee Basis Unit, he confirmed that there was an initiative late in 2013, prompted by VAMC leadership, to "clean up" open non-VA care consults. He stated that his guidance to his staff was to review each consult by attempting to retrieve medical documentation from the non-VA provider. If staff were unable to get the medical documentation, they would then attempt to contact the patient to ensure they had received their appointment. When we asked if this guidance was in writing, he told us it was not.

Two Fee Basis claims adjusters confirmed that they were given lists of pending consults to track, with the goal of marking them Complete. They further confirmed that they attempted to retrieve the medical documentation for each consult. When unable to do so, they contacted the veterans to ensure that the non-VA care was provided before marking consults Complete. They were unable to determine how many consults they marked Complete prior to receiving medical documentation.

To support their allegation, the complainants gave us a list of eight veterans whose consults they believed had been inappropriately marked Complete. We reviewed each consult, and found that four of the consults were discontinued, and the other four were marked Complete. To determine whether the remaining four were inappropriately marked Complete, we

compared the date the consult was marked Complete to the date the medical documentation was loaded into the patient's EHR. Three of the four had been marked Complete before the medical documentation had been loaded into the patient's EHR. This table summarizes our findings for each of these consults.

Table. Summary of Inappropriately Completed Consults

Consult	Date Marked Complete	Date Medical Documentation Added	Elapsed Days
Consult 1	October 26, 2013	February 5, 2014	102
Consult 2	October 24, 2013	November 7, 2013	34
Consult 3	October 15, 2013	April 5, 2016	903

Source: VA OIG analysis

On October 28, 2014—about a year after the scope of our review—VHA's National Non-VA Medical Care Program Office issued guidelines for managing non-VA consult referrals. This document, *Non-VA Medical Care Consult/Referral Management*, now allows VAMC staff to complete consults without having medical documentation, provided VAMC staff have made three unsuccessful attempts to obtain clinical documentation from the non-VA provider.

Conclusion

Employees of the Ralph H. Johnson VAMC improperly completed consults by failing to obtain the required medical documentation—contrary to the VAMC's written policy. However, because of the National Non-VA Medical Care Program Office's updated guidance for completing non-VA consults, we make no recommendation regarding this allegation.

Finding 3 Management Interfered in the Consult Request Process, Including Directing Care for Ineligible Patients and Allowing the Fee Basis Unit Chief To Direct His Own Care

We did not substantiate the allegation that management interfered in the consult request process. Specifically, we determined that the former Chief of the Fee Basis Unit did not direct his own care nor receive special treatment beyond what is available to any veteran.

Fee Basis Chief Self-Referral

On January 22, 2014, the former Chief of the Fee Basis Unit was referred to a non-VA provider by a VA physician for an orthopedic procedure. The consult was approved by the Chief of Surgery the following day. According to the former Chief of the Fee Basis Unit, he requested that his surgery be performed at a private facility ("preferred facility"), because he had been seeing a provider at that facility and had an MRI done there at his own expense. However, according to a Fee Basis case manager, patients needing this type of care are normally referred to another non-VA facility, so she scheduled him at the other non-VA facility. According to notes in the non-VA consult, the appointment with the non-VA facility was canceled on March 4, 2014, and on March 27, 2014, the Chief of Staff approved his appointment at the preferred facility.

The Chief of Surgery affirmed that it was normal practice, for the sake of continuity of care, to refer a patient to the non-VA provider with which the patient had an existing relationship. Our review of VHA policies supported that decision. According to the NVCC *Process Guide, Appointment and Clinical Documentation Management*, dated December 2013, normal practice is for the Fee Basis team to "collaborate with the Veteran and the non-VA provider to identify non-VA provider preferences, schedule the appointment(s), and generate the appropriate patient and non-VA provider correspondence."

Two of the complainants further alleged that the former Chief of the Fee Basis Unit pursued his appointment with the preferred facility, while at the same time issuing guidance to the Utilization Review staff not to send other patients there. The former Chief of the Fee Basis Unit denied this allegation. During our interview with one of the complainants, the complainant stated that she would provide an email showing that the former Chief of the Fee Basis Unit advised them not to use the preferred provider. We received the email from the complainant, but were unable to conclude that the email clearly indicated that the former Chief of the Fee Basis Unit advised them not to use the preferred facility.

Referral for an Oral Prosthetic

The complainants also alleged that the former Chief of the Fee Basis Unit and the Chief of Staff interfered with the review of other patients' consults. They alleged that, on one occasion, a veteran submitted a claim for an oral prosthetic, and the Chief of Staff directed the former Chief of the Fee Basis Unit to pay a claim on the basis that the veteran could not afford the device on his own, despite a former determination by the Chief of Dental Service that the patient was not eligible for reimbursement of dental care with the VA.

When we reviewed the patient's consult, we confirmed the assertion that the Chief of Dental Services had stated that the veteran was not eligible for dental care. However, according to our review of the patient's medical records, the prosthodontic device was ordered to treat sleep apnea, not for dental care. As a result, both the Chief of Surgical Services and the Chief of Surgery approved the request for the prosthodontic device to treat the sleep apnea.

Referral Denied for Cataract Surgery

In another example, the complainants alleged that a patient's request to have cataract surgery close to his home was denied. The basis of this request was that he was undergoing chemotherapy and traveling to the Ralph H. Johnson VAMC would have been difficult.

When we reviewed the patient's medical notes, we noted that the acting Chief of Staff, in consultation with the Chief of Surgical Services, denied non-VA care on the basis that the VAMC was able to perform the surgery. This is consistent with VHA Directive 2010-027, which states that "purchased care may only be considered when the patient can be treated sooner than at a VA facility and the service is clinically appropriate and of high quality."

Conclusion

While the complainants identified several incidents that did not follow the pattern of typical non-VA referrals, we did not find evidence that these practices violated policy. We make no recommendations regarding this allegation.

Appendix A Management Comments

Department of Veterans Affairs

Memorandum

Date: Nov 18, 2016

From: Director, Ralph H. Johnson VA Medical Center (534/00)

Subj: Draft Report, Review of Alleged Improper Non-VA Community Care Consult Practices at Ralph H. Johnson VA Medical Center, Charleston SC

To: Assistant Inspector General for Audits and Evaluations (52)

CC: Director, VA Southeast Network, VISN 7 (10N7)

1. I have reviewed the Draft Report, Review of Alleged Improper Non-VA Community Care Consult Practices.

2. **Recommendation 1:** We recommended the Director, Ralph H. Johnson VAMC to initiate an additional review regarding the Veteran identified in this report, and take action as appropriate.

We concur. The Office of Inspector General (OIG) identified a possible negative impact to a patient regarding the processing of a routine consultation for palliative care therapy for an end stage cancer patient in October, 2013. At the request of the OIG, a full review of this case was conducted by Ralph H. Johnson VA Medical Center staff and by three nationally recognized outside experts. The three nationally recognized specialists were Board Certified Physicians with relevant expertise in liver cancer, thoracic and oncological surgery, gastroenterology, and transplant hepatology. Based upon this review, it was determined extensive care was provided to this patient subsequent to his initial diagnosis in June, 2012. Over fifteen months, this patient was seen by numerous providers in Oncology and Gastroenterology on a frequent basis with appropriate treatment rendered. Further, it was determined by the external subject matter experts that, had the full assessment for the appropriateness of the requested palliative care therapy been completed, it would likely have been determined the therapy would have caused serious injury due to the existence of cirrhosis in the patient's small amount of remaining liver tissue. It was also noted that this patient was likely not a candidate for the preliminary liver angiogram required prior to the requested therapy. Therefore, it was found by external subject matter experts that the procedures and timelines associated with the processing of this

consult did not change the outcome for the patient. As noted in the report, OIG agreed with this assessment and considers this recommendation closed.

3. **Recommendation 2:** We recommended the Director, Ralph H. Johnson VAMC ensure that consults that were not acted on within 7 days can be tracked and managed in accordance with national policy.

We concur. While we contend that the facility procedures at the time of this review related to processing of consults were not out of alignment with facility and national policy, we agree that the processes in place in 2013 could be improved upon and have been improved upon. Current National policy outlines more extensive procedures to track and process clinical consultation requests that are without action within 7 days of the request (VHA Directive 1232, "Consult Processes and Procedures", dated August 23, 2016). Non-VA Coordinated Care (NVCC) Service at the Ralph H. Johnson VA Medical Center currently tracks all consults including those without action within 7 days of request on a daily basis. This information is provided weekly to the Assistant Medical Center Director and monthly to the entire Leadership team for review and action as needed.

4. We feel we have fully addressed the recommendations and request closure.

5. Please contact Melissa Harrelson, RN, Quality Manager, at 843-789-7303 if you have any questions.

(original signed by:)

Scott R. Isaacks, FACHE

For accessibility, the format of the original documents in this appendix has been modified to fit in this document.

Appendix B OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Matthew Rutter, Director John Bertolino, MD Chris Enders Todd Groothuis Michael Kelly Julie Kroviak, MD Robin Moyer, MD Loi Pham Yohannes Debesai

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