VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Audit of Alleged Inappropriate Scheduling of Electromyography Consults at the Memphis VA Medical Center

July 20, 2017
16-02468-281

ACRONYMS

EMG	Electromyography
FY	Fiscal Year
OHI	Office of Healthcare Inspection
OIG	Office of Inspector General
OSC	Office of Special Counsel
VA	Department of Veterans Affairs
VAMC	VA Medical Center
VCL	Veterans Choice List
VHA	Veterans Health Administration

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Highlights: Audit of VHA's Alleged Inappropriate Scheduling of EMG Consults at the Memphis VA Medical Center

Why We Did This Audit

The former Chairman of the House of Representatives Committee on Veterans' Affairs requested the VA Office of Inspector General review an allegation of inappropriate scheduling for 143 VA Electromyography (EMG) consults at the Memphis VA Medical Center (VAMC).[1] Additionally, the Office of Special Counsel provided us similar allegations stating the intent was to disguise wait times.

What We Found

We substantiated that Memphis VAMC staff did not follow appropriate procedures when they discontinued a backlog of 143 EMG Clinic consults for 140 veterans. We did not substantiate that EMG staff discontinued consults to disguise wait times.

The Assistant Chief of the Business Office's decision to discontinue these consults in February 2016 and authorize a Veterans Choice Program (Choice) consult was inappropriate and circumvented established procedures.[2] Because the VAMC provides EMG services, the EMG staff should have first scheduled the veteran an EMG appointment within the VAMC. If the VAMC appointment was more than 30 days out, the EMG staff should have placed the veteran on the Veterans Choice List, and then Business Office staff would contact the veteran to determine if they wished to receive care through Choice. For veterans who opted to obtain their care through a Choice appointment, Business Office staff should have then created a Choice authorization and electronically provided it and other related medical documents to the Choice third-party administrator, TriWest Healthcare Alliance (TriWest).

This circumvention of procedures occurred because the Assistant Chief thought bypassing the required scheduling process would save time and effort, and veterans would receive more timely care through Choice than by waiting for the care at the VAMC. The Assistant Chief demonstrated that she was unaware her instructions conflicted with VHA policy and guidance.

The effect of not following procedures was that patients who did not opt in to obtain their care through a Choice appointment risked having a VA appointment to fall back on. From our June 2016 review of the 140 veterans, we identified 21 veterans who opted not to use Choice and as a result no longer had any appointment to receive the EMG care. EMG staff ultimately created new VA consults for these 21 veterans in or after June 2016.

In reviewing the allegations, we determined that Memphis VAMC staff did not provide timely care (within 30 days of the clinically indicated date) to these 140 veterans. As of June 20, 2016, veterans for 66 consults waited an average of 169 days for care, veterans for 70 consults were still waiting, and Business Office staff properly closed the remaining seven consults. In March 2017,

[1] An EMG measures muscle response or electrical activity to nerve stimulation. The test can help detect neuromuscular abnormalities, such as carpal tunnel syndrome, nerve injury, or muscular dystrophy.

[2] The Veterans Choice Program resulted from the Veterans Access, Choice, and Accountability Act of 2014.

we performed an additional review of the 70 consults where veterans were still waiting for their care. We found that veterans for 37 consults received care after an average of 250 days, Business Office staff appropriately closed 27 consults, and veterans with six consults were still waiting for care.

These conditions occurred because VAMC staff did not timely process VA EMG or Choice consults. The delays resulted from insufficient staffing resources in the EMG Clinic and the Business Office. As a result, veterans encountered delays in receiving their EMG appointments. On average, the veterans who received their EMG appointment waited an average of 198 days to receive care.

We consulted with OIG's Office of Healthcare Inspections (OHI) to review the care for the 140 veterans with 143 referred consults. OHI found no evidence that any of the veterans suffered any adverse clinical impact because of the delay in their EMG care.

What We Recommended

We recommended the Director of the Memphis VAMC ensure staff schedule appointments for veterans referred for EMG care and use the Veterans Choice List in accordance with policy. We recommended the Director ensure the EMG Clinic and the Business Office have sufficient staffing resources to enable timely processing of VA and Choice EMG consults, to include adequate monitoring of TriWest's timeliness. Finally, we recommended the Director ensure staff review the six Choice EMG consults that were still waiting for care.

Agency Comments

The Director of the Memphis VAMC concurred with the report recommendations and provided appropriate action plans. The Director expected actions addressing Recommendations 2 and 3 to be completed by August 31, 2017. Furthermore, he stated that actions addressing Recommendations 1 and 4 had been completed.

OIG Response

The Director's planned corrective actions are acceptable. We will monitor the facility's progress and follow up on the implementation of our recommendations until all proposed actions are completed. We consider Recommendations 1 and 4 closed based on the corrective actions and documentation provided.

LARRY REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Objective

Our objectives were to determine if:

- Memphis VA Medical Center (VAMC) staff inappropriately discontinued VA consults for electromyography (EMG) services
- Veterans affected by this process received timely care
- The intent of actions taken by the VAMC staff was to disguise patient wait times and give the appearance of improved clinic performance

Congressional Referral

On March 9, 2016, the then-Chairman of the House Committee on Veterans' Affairs requested the OIG review an allegation of inappropriate scheduling practices that were indicative of a manipulation to mask lengthy wait times. According to the allegation, in February 2016, EMG staff at Memphis VAMC discontinued a backlog of 143 VA EMG Clinic consults for 140 veterans and created new consults for the veterans to receive care through the Veterans Choice Program (Choice).

Office of Special Counsel Allegation

On May 9, 2016, the OIG received notification of similar allegations sent to the Office of Special Counsel (OSC) involving EMG services at the Memphis VAMC. OSC's letter stated the complainant alleged he observed approximately 150 pending EMG tests were canceled by one EMG employee with one instance of a veteran who had been waiting over 16 months. The letter also stated EMG Clinic staff improperly discontinued consults to disguise patient wait times while giving the appearance of improved clinic performance. We incorporated this allegation into the scope of our work.

Electromyography Services

An EMG measures muscle response or electrical activity to nerve stimulation. The test can help detect neuromuscular abnormalities, such as carpal tunnel syndrome, nerve injury, or muscular dystrophy.

RESULTS AND RECOMMENDATIONS

Finding 1 Memphis VAMC Staff Did Not Follow Appropriate Procedures To Offer Choice

We substantiated that Memphis VAMC staff did not follow appropriate procedures when they discontinued a backlog of 143 VA consults associated with 140 veterans for EMG Clinic consults.[3] The Assistant Chief of the Business Office's decision to discontinue these consults in February 2016 and to unilaterally authorize a Choice consult was inappropriate and circumvented established procedures. This occurred because the Assistant Chief of the Business Office thought this process would save time and effort and that veterans would receive more timely care through Choice. However, her instructions conflicted with Veterans Health Administration (VHA) policy and guidance.

Because the VAMC provides EMG services, the EMG staff should have first scheduled each veteran an EMG appointment within the VAMC. If the VAMC appointment was more than 30 days out, the EMG staff should have placed the veterans on the Veterans Choice List (VCL). Business Office staff would then contact the veterans to determine if they wished to receive care through Choice. For veterans who opted to obtain their care through a Choice appointment, Business Office staff should have then created a Choice authorization and electronically provided it and other related medical documents to the Choice third-party administrator, TriWest Healthcare Alliance (TriWest).

The effect of not following procedures was that patients who did not opt in to obtain their care through a Choice appointment risked not having a VA appointment to fall back on. From our review of the 140 veterans, we identified at least 21 veterans who opted not to use Choice, and as a result, no longer had any appointment to receive EMG care. EMG staff ultimately created new VA consults for these 21 veterans in or after June 2016.

In addition, the Memphis VAMC's VCL did not accurately reflect the number of veterans who could not receive timely access to EMG services provided by the facility. Without appropriate management of consults, VAMC managers, such as the VAMC's Director, Chief of Staff, Chief of Neurology,[4] and Chief of the EMG Clinic, are not using accurate EMG wait time data to determine whether veterans are receiving EMG services timely.

[3] Memphis EMG staff created the 143 VA EMG consult between August 2015 and February 2016, then discontinued the consults from February 25 through February 27, 2016.
[4] EMG is a clinic within the Neurology service.

Procedures Were Not Followed

EMG staff did not follow appropriate procedures when they discontinued a backlog of 143 EMG consults identified in the allegation for veterans who had not been scheduled for a VA appointment. We reviewed the 143 EMG consults and determined staff discontinued them, and then created Choice consults for 140 of them for the veterans to receive EMG services through the Veterans Choice Program. EMG staff failed to create Choice consults for three of the discontinued EMG consults. For one of the three, EMG staff ultimately created a new EMG consult in January 2017 that received care through the EMG Clinic in February 2017. For the other two consults, VAMC staff failed to follow up and these consults had not been addressed as of March 2017. The 143 EMG consults were about 96 days past their clinically indicated date when the facility discontinued them. EMG staff did not schedule these consults for a VA appointment since they planned to provide the care through Choice. VHA's *Choice First Standard Operating Procedure (SOP): Non-VA Medical Care Referral Process for Services Unavailable and 30-Day Wait Time*, November 2, 2015, states when the VAMC provides the service and cannot schedule a VA appointment within 30 days of the clinically indicated or preferred date, staff should offer access to Choice care through use of the VCL. Using the VCL, Business Office staff document whether each veteran chooses to receive care through Choice.

Since the VAMC provided EMG services, the EMG staff should have scheduled each veteran a VA EMG appointment, placed the veterans on the VCL, and contacted the veterans to determine if they wished to receive care through Choice. For veterans who wanted a Choice appointment, Business Office staff should have then created a Choice authorization and electronically provided it and other related medical documents to the Choice third-party administrator, TriWest Healthcare Alliance (TriWest).

Why This Occurred

These inappropriate procedures occurred because the Assistant Chief of the Business Office provided instructions inconsistent with VHA's Choice procedures. She thought her process would save time and effort based on her belief that veterans would receive more timely care through Choice. The Assistant Chief demonstrated that she was unaware her instructions conflicted with VHA policy and guidance.

In January 2016, the Chief of Neurology requested advice from the Business Office on what to do with a large backlog of unscheduled EMG consults. The Assistant Chief of the Business Office provided guidance to the VAMC's EMG Clinic to discontinue the VA consults and create new Choice consults when the clinic could not schedule the appointment within 30 days of the clinically indicated date. She provided the guidance believing the veterans would receive earlier appointments through Choice. She also believed staff would have wasted time scheduling veterans for appointments in the VAMC's EMG Clinic months in the future, adding the veterans to the VCL, contacting the veterans to ask if they wanted Choice care, and then

canceling the previously scheduled VA appointment if the veteran opted in and received a Choice appointment.

Effect

As a result of EMG staff discontinuing the VA consult and creating a Choice consult, veterans who declined Choice were put at risk of not receiving care and encountering longer delays for care. This is especially true for the three discontinued consults for which EMG staff failed to create a Choice consult, and, therefore, did not offer care through Choice. Since EMG staff did not schedule a VA appointment according to policy, veterans who declined Choice did not have a VA appointment to fall back on. From our review of the 140 veterans, we identified 21 who opted not to use Choice, and as a result no longer had any appointment to receive EMG care.

Following our inquiry in June 2016, EMG staff created new VA consults for these 21 veterans and started the process over at the beginning to schedule the veterans for care. Upon review, 15 of the 21 veterans received care with 10 of the veterans waiting more than 30 days past the creation of the new VA consult. For the remaining six veterans who did not receive care, they ultimately declined scheduling, did not respond to scheduling requests, or failed to show for a scheduled appointment. Additionally, the Memphis VAMC's VCL did not accurately reflect the 140 veterans who did not receive timely access to EMG services provided by the facility.[5]

The Memphis VAMC needs to ensure staff schedule veterans referred to the VAMC EMG Clinic and place veterans on the VCL in accordance with Choice guidance.

Conclusion

We substantiated that Memphis VAMC staff did not follow appropriate procedures when they improperly discontinued a backlog of EMG Clinic consults. The Assistant Chief of the Business Office's decision to discontinue this backlog of consults and offer veterans access to Choice was intended to save time and effort based on her belief veterans would receive more timely care through Choice. However, her instructions conflicted with VHA policy and guidance. As a result of staff circumventing Choice procedures, veterans were put at risk of not receiving care and encountered longer delays for care. Additionally, the Memphis VAMC's VCL did not accurately reflect the 140 veterans who did not receive timely access to EMG services provided by the facility.

[5] After our review in June 2016, VHA signed VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, dated July 15, 2016. This directed schedulers to only add veterans to the VCL who opt in to Choice. Of the 140 veterans, 108 opted in originally.

Recommendation

1. We recommended the Director of the Memphis VA Medical Center ensure Neurology Clinic staff schedule veterans referred to the Electromyography Clinic and place veterans on the Veterans' Choice List in accordance with Veterans Choice Program guidance when appointments are scheduled 30 days beyond the clinically indicated date.

Management Comments

The Director of the Memphis VA Medical Center concurred with Recommendation 1 and requested closure based on completing their planned corrective actions. The Director reported Neurology Service staff responsible for scheduling EMGs were given clear direction on scheduling procedures. As of April 27, 2017, EMG lab staff had signed a statement indicating they have reviewed and understand the Choice guidance on when and how to place veterans on the Veterans Choice List.

OIG Response

The Director of the Memphis VA Medical Center's planned corrective actions are responsive. We consider the recommendation closed based on the VAMC's corrective action.

Finding 2 Memphis VAMC Did Not Provide Timely EMG Care

Memphis VAMC staff did not provide timely EMG care to veterans within 30 days of the clinically indicated date annotated on the consult. There were 140 veterans with 143 VA EMG consults identified from the congressional referral that alleged VAMC EMG staff inappropriately discontinued the VA consults with intent to create Choice consults. As of June 20, 2016, veterans with 66 of the 143 VA EMG consults waited an average of 169 days to receive care. Veterans with 70 of the 143 VA consults had not been scheduled for appointments, and had been waiting for an average of 192 days from the clinically indicated date on the VA consult. Business Office staff appropriately closed the Choice consults for the remaining seven VA EMG consults for such reasons as: veterans declined care, did not respond to scheduling attempts, or failed to attend multiple scheduled appointments.

In March 2017, we performed an additional review for the veterans with 70 consults waiting to be scheduled for care as of June 20, 2016. Of these 70 consults, 37 resulted in care after veterans waited an average of 250 days past the clinically indicated date on the VA EMG consult, staff appropriately closed 27 consults, and veterans with the remaining six consults were still waiting for care.

The VAMC did not provide timely care because:

- EMG staff did not timely process VA EMG consults to schedule the veteran and determine eligibility for Choice.
- Business Office staff did not timely provide the authorizations to TriWest.

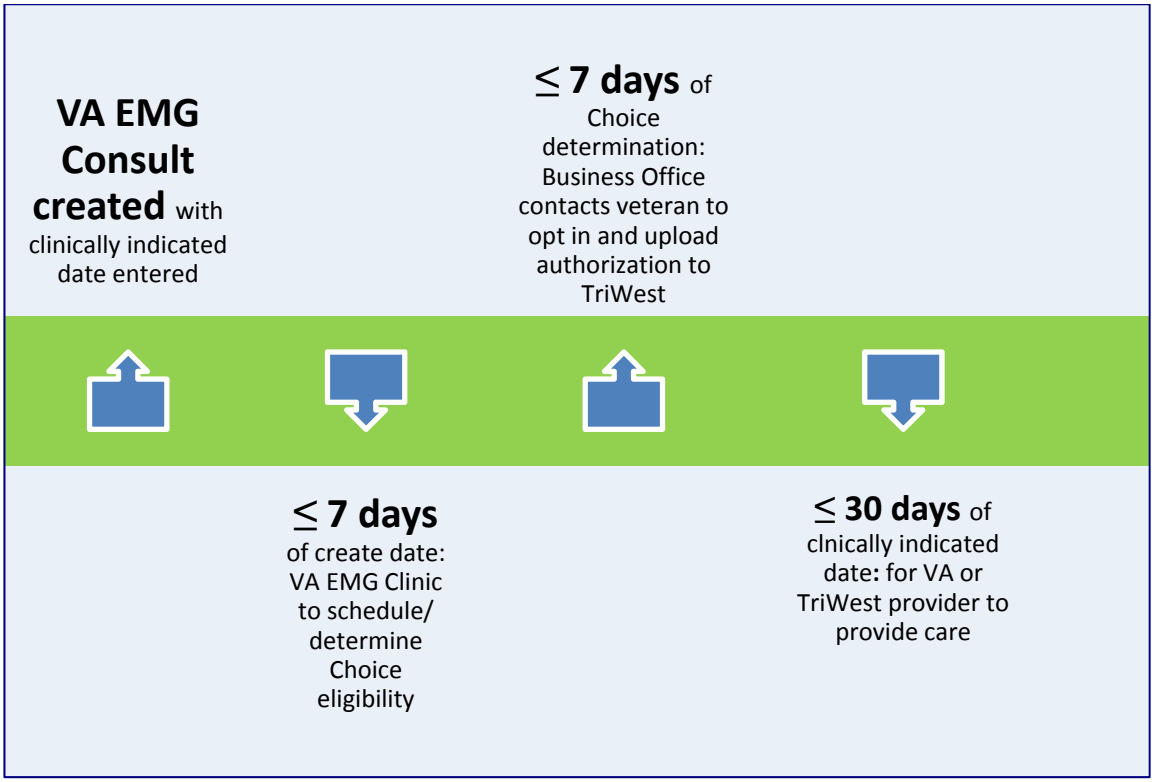
As a result, veterans encountered avoidable delays in EMG care. Veterans who received care waited an average of 198 days. Without timely processing of EMG consults, the Memphis VAMC runs the risk that veterans' necessary medical treatment would be delayed.

Consult Processing

VA providers create VA EMG consults and enter a clinically indicated date on them. *VHA Interim Consult SOP*, March 30, 2015, states staff must take action within seven days of the consult "create date." To act upon a consult means to review the consult request and/or schedule the veteran for an appointment. Once scheduled, VHA's *Choice First Standard Operating Procedure (SOP): Non-VA Medical Care Referral Process for Services Unavailable and 30-Day Wait Time* instructs staff to determine if the veteran is eligible for Choice because the scheduled appointment is greater than 30 days past the clinically indicated date on the VA consult.

For veterans with appointments greater than 30 days, the Business Office staff verifies the veteran's eligibility for Choice and contacts the veteran to offer Choice care. If the veteran agrees (opts in), the Business Office staff provides the authorization to TriWest. According to Business Office staff, the facility's goal was to provide the authorization to TriWest within seven days. The authorization provided by VA staff informs TriWest to contact and schedule the veteran for an appointment. The Choice contract, signed October 9, 2015, stated the Choice appointment should occur within 30 days of the authorization's clinically indicated date. Figure 1 below, details the timeliness goals for scheduling with a Choice eligibility determination within seven days, uploading authorizations to TriWest within seven days, and a total timeliness goal of an appointment within 30 days of the clinically indicated date.

Figure 1: Consult and Choice Consult Timeliness Goals



Source: VHA Policy and Guidance with Memphis VAMC upload goal

Untimely Care

Memphis VAMC did not provide timely care to the 140 veterans with 143 EMG consults identified in the congressional referral. For the 143 VA EMG consults, veterans with 66 consults received care after waiting an average of 169 days past the clinically indicated date on the VA EMG consult. For seven of the 143 consults, while not timely, Business Office staff appropriately closed the consults after an average of 143 days when the care request was a duplicate request, or veterans declined care, failed to

respond to scheduling attempts, or were deceased. For the remaining 70 consults, veterans were waiting for an appointment to be scheduled an average of 192 days as of the dates of our reviews conducted May 19 through June 20, 2016.

In March 2017, we conducted additional reviews of the electronic health records for the veterans with these 70 consults waiting for scheduling as of June 20, 2016. We determined veterans with 37 of the 70 consults received care after waiting an average of 250 days past the clinically indicated date on the VA EMG consult. For veterans with 27 of the 70 consults, Business Office staff closed the consult after an average of 288 days when the veteran declined care, failed to respond to scheduling attempts, or failed to attend multiple scheduled appointments. For the remaining six consults, veterans were still waiting for an appointment an average of 467 days after the clinically indicated date of the VA EMG consult.

EMG Clinic Did Not Process VA Consults Timely

VAMC EMG staff did not timely initiate processing for the 143 VA EMG consults. Processing EMG consults includes scheduling the veterans and making the eligibility determinations for Choice. The EMG Clinic has one physician and two technicians to perform and interpret EMGs. While the clinic maintained this staffing level since before FY 2014, the demand for EMG services at Memphis VAMC has increased. As shown in Table 1, the number of consults submitted to the VAMC's EMG Clinic increased by nearly 27 percent from FY 2014 to FY 2016.

Table 1. Increase in Demand for EMG Services at Memphis VAMC

Date Range	FY 2014	FY 2015	FY 2016
Consults Submitted for VA EMG services	892	1,052	1,129

Source: VHA Support Service Center's Consult Cube

The two technicians are responsible for scheduling in the clinic. The primary EMG scheduler stated his clinical duties overwhelmed him and he could not act on the consults within the required seven days. According to the scheduler, he would generate a report of open consults and attempt to contact and schedule patients when not performing EMG clinical duties. The scheduler was aware that delays existed, but stated he was not aware that guidance required them to act on consults within seven days. For the 143 consults sent to the VAMC's EMG Clinic, EMG staff took greater than seven days to initiate action on 97 consults (68 percent) averaging about 21 days, ranging from about eight to 38 days.

Our Recommendation 2 addresses the actions Memphis VAMC needs to take to ensure the clinic has sufficient EMG staff to comply with VHA's consult policy by acting on consults within seven days.

Business Office Did Not Provide Authorizations Timely

Memphis VAMC Business Office staff did not timely upload Choice authorizations to TriWest for the 143 consults identified in the congressional request. Of the 143 consults, Business Office staff provided 108 authorizations to TriWest. Business Office staff took longer than seven days on 107 of the 108 authorizations, and averaged 60 days from the create date of the Choice consult to the date the authorization was provided to TriWest.

For 32 consults, either Business Office staff sent the consult back to the EMG Clinic after the veteran refused care through the Choice Program or the consult was appropriately closed. This took an average of 78 days after the clinically indicated date on the Choice consult, ranging from 17 days before the clinically indicated date to 212 days after the clinically indicated date. For the remaining three consults, VAMC EMG Clinic staff failed to create a Choice consult after inappropriately discontinuing the VA consult. According to the Chief of the Business Office, processing Choice care was delayed because they were understaffed. In June 2016, he stated the Business Office was in the process of increasing its numbers from 13 to almost 26 staff.

While the Choice contract requires that care be provided within 30 days of the authorizations' clinically indicated date, the Business Office staff did not provide authorizations to TriWest within 30 days for 92 percent of the authorizations. Therefore, we evaluated TriWest's timeliness of providing care using 30 days from the date the Business Office staff issued the authorization to TriWest. Of the 108 authorizations provided to TriWest, 81 authorizations resulted in a completed appointment in an average of 30 days and ranged from six to 138 days. As of our review in March 2017, TriWest had not scheduled two of the 108, but returned the remaining 25 authorizations to the VAMC without the veteran receiving care through the Choice Program. TriWest returned the authorization when the veteran decided to opt out of the Veterans Choice Program, declined care, failed to respond to scheduling attempts, or failed to attend multiple scheduled appointments.

Our Recommendation 3 addresses actions Memphis VAMC needs to take to ensure the Business Office has sufficient resources to improve the timeliness of processing and adequate monitoring of Choice consults.

Effect

As a result of Memphis VAMC staff not following VHA policy regarding Choice consults processing, veterans encountered avoidable delays in the detection of neuromuscular abnormalities. Veterans with 103 of the

143 EMG consults waited an average of 198 days to receive care. Business Office staff appropriately closed 34 EMG consults for reasons such as: veterans declined care, did not respond to scheduling attempts, or failed to attend multiple scheduled appointments. Veterans with the remaining six consults were still waiting to be scheduled an average of 467 days after the request date when we concluded our second review in March 2017.

Our Recommendation 4 addresses actions Memphis VAMC needs to take to ensure the veterans sent to Choice were either provided care or the veterans declined care.

Office of Healthcare Inspections

We consulted with OIG's Office of Healthcare Inspections (OHI) to review the care for the 140 veterans with 143 congressionally referred consults. For these 140 veterans, OHI found no evidence that any of the veterans suffered any adverse clinical effect as a result of the delay in their EMG care.

Conclusion

Memphis VAMC staff did not provide timely care to 140 veterans with 143 EMG consults. The VAMC's EMG staff did not act timely on VA EMG consults and the Business Office staff did not ensure timely processing and monitoring of consults for care through Choice. Veterans with 103 of the 143 EMG consults waited an average of 198 days to receive care, Business Office staff appropriately closed 34 EMG consults, and veterans with the remaining six consults were still waiting to be scheduled. Memphis VAMC leadership needs to ensure management directions and staff actions comply with VHA consult and Choice policies to mitigate delays in EMG care.

Recommendations

2. We recommended the Director of the Memphis VA Medical Center ensure the VA Electromyography Clinic has sufficient staffing resources to comply with VHA's scheduling policy to act on consults within seven days.

3. We recommended the Director of the Memphis VA Medical Center ensure the Business Office has sufficient staffing resources to enable timely processing of Veterans Choice Program consults.

4. We recommended the Director of the Memphis VA Medical Center ensure staff review the six Veterans Choice Program consults for Electromyography services that were not scheduled for care.

Management Comments

The Director of the Memphis VA Medical Center concurred with Recommendations 2, 3, and 4. For Recommendation 2, the Business Office hired two medical support assistants for Neurology Service. The

two medical support assistants were scheduled to start work on June 25, 2017. The new staff will receive training and will be monitored by senior members of the EMG lab for quality control and to make sure scheduling policy is followed.

For Recommendation 3, the Business Office made 30 selections for new medical support assistants. After four weeks of training, the newly hired staff can begin processing Choice consults. For Recommendation 4, the Director of the VA Medical Center requested closure of the recommendation based on the completion of their planned corrective actions. The Director reported that, as of July 3, 2017, all six Choice consults for electromyography services were resolved.

OIG Response

The Director of the Memphis VA Medical Center's planned corrective actions are responsive. Regarding the medical center's corrective actions for recommendation 4, we reviewed the electronic health records for all six veterans on July 6, 2017. We found sufficient evidence that one veteran declined care and the other five veterans received EMG services. We consider the recommendation closed based on the VAMC's corrective actions.

Finding 3 Memphis VAMC Staff Did Not Discontinue Consults To Disguise Wait Times

We did not substantiate the allegation made to OSC that the intent of the decision to discontinue VA EMG consults and create a Choice consult was to disguise patient wait times resulting in the appearance of improved clinic performance.

What We Did

We interviewed the complainant and the complainant's stated source for this allegation; and the primary decision maker of the improper action, the Assistant Chief of the Business Office. We also obtained and reviewed the performance standards and goals for the Acting VAMC Director, Chief of Neurology Service, Chief of the EMG Clinic, and the Assistant Chief of the Business Office.

What We Found

While the actions taken ultimately improved performance metrics, we did not find any evidence or support that the intent of improperly discontinuing VA EMG consults was to manipulate clinic performance. We identified one or two references in each individuals' performance standards and goals[6] that related to wait time or access goals. However, these were just one of many standards or goals from which each of these individuals would be evaluated. The percentage attributed to these specific standards or goals would have minimal effect on the overall evaluations for each individual.

The complainant confirmed his belief in the allegation, but he did not provide any further support for his conclusion other than referring us to his source. The complainant's source did not confirm these actions were taken in order to falsify wait times or to give the appearance of improved performance metrics. The complainant's source stated this action was to provide more timely care through Choice rather than waiting for a VA EMG appointment months in the future. EMG and Business Office staff, such as the Chief and Assistant Chief of the Business Office, the Chief of Neurology, and the nurse manager who worked alongside the Business Office, believed their actions were appropriate. During interviews with VAMC staff, we determined they believed they were taking the correct action to provide timely service to veterans. The complainant alleged that he observed approximately 150 EMG consults canceled by one named EMG employee with one instance of a veteran waiting over 16 months. We found the named employee canceled about 73 percent of the 143 consults we reviewed. Two other EMG employees canceled the remaining consults. We were unable to

[6] We reviewed the FY 2016 Performance Standards or Goals for the Acting VAMC Director, Chief of Neurology Service, Chief of the EMG Clinic, and the Assistant Chief of the Business Office.

identify the veteran who waited over 16 months for care. The longest wait we identified for the initial discontinued VA EMG consults was about six months.

Appendix A Background

Congressional Inquiry

The former Chairman of the House Committee on Veteran's Affairs requested an investigation into Memphis VAMC EMG staff canceling 143 facility EMG consults and replacing them with Choice consults. He asked the OIG to investigate the following:

1. Why did EMG staff discontinue VA consults and create a new consult when offering veterans Choice care?
2. Did the 143 veterans affected by this process receive timely care upon the new date entered on the new consult for Choice?
3. Were reported wait times affected by this process?

Office of Special Counsel Letter

During our review, we received a letter from OSC detailing a whistleblower allegation of similar actions taken on backlogged consults in Memphis VAMC's EMG Clinic during the same time frame. The complainant's letter alleged staff took the action falsely to improve the performance measures of the VAMC's EMG Clinic.

VHA Consult Management

In 2015, VHA provided facilities with updated consult management guidance and distributed an Interim Consult SOP. *VHA Consult SOP* (March 2015) reiterated that staff are required to take action on consults within seven days of the consult create date.

VHA also developed guidance called *National Guidance for Discontinuing or Cancelling Consults* (June 2015), which stated staff can discontinue consults under certain circumstances and that facilities are required to document the reason for discontinuing a consult. The guidance specifies these circumstances include when the patient canceled multiple times, did not respond to the minimum scheduling efforts, or did not show up for a scheduled appointment multiple times. Additionally, guidance permits staff to discontinue consults if the patient is deceased, the consult was a duplicate request, the patient refused care, or the patient opted for non-VA care.

Veterans Access, Choice, and Accountability Act of 2014

To improve veterans' access to timely medical care, the President signed Public Law 113-146, Veterans Access, Choice, and Accountability Act, on August 7, 2014. In response, VA initiated the Veterans Choice Program in November 2014.

Care Not Available Within 30 Days

To fulfill the Veterans Choice Program's mission, VHA implemented procedures for medical facilities to establish and manage a Veterans Choice List (VCL). The facility is required to identify and include veterans on the VCL who have waited more than 30 days from the clinically indicated or preferred appointment date.

When VA medical facility staff schedule an appointment over 30 days after the clinically indicated date, they place the veteran's name on the VCL and facility staff contact the veteran to determine if they wish to opt in. If a veteran opts in, facility staff create a Choice authorization and electronically provide it and other related medical documents to the third-party administrator. TriWest is the third-party administrator for the Memphis VAMC.

Care Not Available at VA Facility

VA implemented the Choice First process that incorporates a Veterans Choice Program option in the community care referral hierarchy for cases when care is not available within VA facilities. VHA's *Choice First Standard Operating Procedure* (November 2015) states that when a facility does not provide a service, eligible veterans can choose to have the care provided by non-VA providers. In these cases, facility staff must contact the veteran to ask if they would like to opt in to Choice, and create a Choice authorization only if a veteran opts in. If a veteran opts in, staff electronically provides the authorization and other related medical documents to the third-party administrator. If the veteran opts out at any point, the contractor documents the decision in the portal, if applicable, and facility staff documents the decision on the consult.

Appendix B Scope and Methodology

Scope

We conducted our audit work from April 2016 through May 2017. To assess the merits of the allegations, we focused on the 143 consults provided through the congressional referral and conducted a site visit at the Memphis VAMC during June 2016.

Methodology

We conducted 23 interviews with 15 facility staff, including the complainant, complainant's source, schedulers, nurses, clinical Chiefs of Services, and other management responsible for providing consult management guidance and care through the facility EMG Clinic and the Veterans Choice Program. We obtained and reviewed all 143 consults provided through the congressional referral. We reviewed patients' electronic health records to determine if there were delays in consult management, omissions of eligible veterans from the VCL, and inappropriately discontinued consults. We also obtained and reviewed the performance standards and goals for the Acting VAMC Director, Chief of Neurology Service, Chief of the EMG Clinic, and the Assistant Chief of the Business Office.

Fraud Assessment

The audit team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this audit. The audit team exercised due diligence in staying alert to any fraud indicators by:

- Performing an assessment to identify fraud indicators and the likelihood of their occurrence
- Interviewing Memphis VAMC staff concerning potential fraudulent activities within the scope of our objective
- Considering risk factors such as outdated policies and procedures

We did not identify any instances of fraud during this audit.

Data Reliability

We used computer-processed data from VHA's Consult Cube, Completed Appointments Cube, and TriWest's internet portal. To assess the reliability of VHA's Consult Cube data, we compared details of the consult data reported in the Consult Cube with consult data of individual patient records in VHA's Compensation and Pension Record Interchange. To assess the reliability of VHA Support Service Center's Completed Appointments Cube data, we compared details of the completed appointment data reported in the Completed Appointments Cube with completed appointment data of individual patient records. To assess the reliability of TriWest's internet portal, we compared patient and appointment data in the TriWest's internet portal with individual patient records. We did not identify any material inconsistencies with the reviewed records, and concluded that the data used were sufficiently reliable to meet the audit objectives and support our findings and recommendations.

Government Standards

Our assessment of internal controls focused on those controls relating to our audit objectives. We conducted this performance audit in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

Appendix C Management Comments

Department of Veterans Affairs Memorandum

Date: July 5, 2017

From: Director, Memphis VA Medical Center (614/00)

Subj: OIG Audit of Alleged Inappropriate Scheduling of EMG Consults, Memphis, TN; Project No. 2016-02468-R5-0150

To: Director, Kansas City, Audit Operations Division (52KC)

1. Attached please find the VA Medical Center, Memphis, Tennessee's response to the OIG Draft Report, Audit of Alleged Inappropriate Scheduling of EMG Consults. A site visit to the VAMC Memphis, TN was conducted in June 2016.

2. If you have any questions regarding the information provided, please contact Jan Slate, Accreditation Manager, Quality Management and Performance Improvement. Mrs. Slate can be reached at (901) 577-7379, menu choice #5.

(original signed by:)

David K. Dunning, MPA
Medical Center Director

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

Attachment

Audit of Alleged Inappropriate Scheduling of EMG Consults, VA Medical Center, Memphis, TN. Project No. 2016-02468-R5-0150

Date: July 5, 2017

Attached please find the VA Medical Center, Memphis, Tennessee's response to the OIG Draft Report, Audit of Alleged Inappropriate Scheduling of EMG Consults. A site visit to the VAMC Memphis, TN was conducted in June 2016.

If you have any questions regarding the information provided, please contact Jan Slate, Accreditation Manager, Quality Management and Performance Improvement. Mrs. Slate can be reached at (901) 577-7379, menu choice #5.

OIG Recommendations

Recommendation 1. We recommended the Director of the Memphis VA Medical Center ensure Neurology Clinic staff schedule veterans referred to the electromyography clinic and place veterans on the Veterans' Choice List in accordance with Choice guidance when appointments are scheduled 30 days beyond the clinically indicated date.

Concur/Do Not Concur: Concur

Target date for completion: Closed

Facility response: Neurology Service staff who are part of the EMG Lab and/or are responsible for scheduling EMGs, have reviewed the Department of Veterans Affairs current Hierarchy of Care and the Veterans Choice Program guidelines. Under the current structure, clear direction was given. If a Veteran is scheduled in the EMG Lab outside the 30 days of the clinically indicated date (CID), the Veteran must be offered the option to opt in or opt out of the Choice Program. The Veteran must be scheduled in a Neurology EMG clinic first to be added to the Veteran's Choice List (VCL) and the wait time must be greater than 30 days. If the Veteran opts in, the Choice Program staff will make arrangements for the EMG. If the Veteran opts out, he/she must wait for the Veteran's VAMC appointment. If the Veteran is ineligible for the Choice program, he/she has the option to receive care at another VA facility. If the other VA facility and Choice Program options do not provide the needed care, then the Veteran will be referred for non-VA care in the community. Members of the EMG Lab signed a statement that they have reviewed and understand the above policy. This document was sent to the Chief of Staff's office on April 27, 2017.

Recommendation 2. We recommended the Director of the Memphis VA Medical Center ensure the VA electromyography clinic has sufficient staffing resources to comply with VHA's scheduling policy to act on consults within 7 days.

Concur/Do Not Concur: Concur

Target date for completion: August 31, 2017

Facility response: In a June 9, 2017 email, the Business Office confirmed that two newly hired MSAs will be assigned to Neurology Service. The effective date for the news hires is June 25, 2017, which will be followed by four weeks of training by the Business Office. In August, the two MSAs dedicated to Neurology will receive further training to assure understanding of the current hierarchy of care, as well as the special considerations and individual patient needs that go into scheduling EMG studies correctly. The new MSAs will be monitored by the senior members of the EMG Lab for quality control and to make sure scheduling follows VA policy.

Recommendation 3. We recommended the Director of the Memphis VA Medical Center ensure the business office has sufficient staffing resources to enable timely processing of Choice consults.

Concur/Do Not Concur: Concur

Target date for completion: August 1, 2017

Facility response: The Business Office made selections for new MSAs the last week of May 2017. Offers were made by Human Resources and positions accepted June 8, 2017. Thirty (30) applications were processed for vacant MSA positions. The effective date for the new hires is June 25, 2017. Training will take approximately four weeks before the MSAs can begin processing Choice consults. Business Office will assign two MSAs to Neurology Service who will then receive further training by Neurology Service.

Recommendation 4. We recommended the Director of the Memphis VA Medical Center ensure staff review the six Choice consults for Electromyography services that were not scheduled for care.

Concur/Do Not Concur: Concur

Target date for completion: Closed

Facility response: As of July 3, 2017, the six EMG consults that were still waiting for care have been resolved as follows. One declined services. The Interim Chief Neurology Service contacted the Veteran to find out why the Veteran declined service and documented the response in the electronic medical record, CPRS. The remaining five Veterans had EMGs completed and the consults have been closed.

Appendix D OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Ken Myers, Director Brad Lewis Russ Lewis Erin Routh Eric Sanford Jason Schuenemann

Appendix E Report Distribution

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