DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Improper Coding and Unnecessary Overtime at the Central Texas Veterans Health Care System

AUDIT | REPORT #18-03159-74 | MAY 2, 2019

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Executive Summary

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) received allegations on January 31, 2018, that a psychologist (Psychologist X) at the Temple campus of the Central Texas Veterans Health Care System (CTVHCS or the facility) "double-coded" group therapy sessions and received improper overtime pay.[1] The OIG conducted this audit to determine the merit of these allegations. The OIG also received an allegation that Psychologist X created false medical notes, but that allegation was determined to be unfounded. See the Fraud Assessment in Appendix A for more details.

Psychologist X and Others Improperly Coded Mental Health Services

The OIG substantiated that Psychologist X improperly coded mental health services for about 66 percent of patient encounters for the 20-week period from October 1, 2017, through February 17, 2018. Psychologist X double-coded services, used codes not supported by the medical documentation, and entered codes not permitted for psychologists' use.

As a result of the improper coding and other errors, the audit team estimated that Psychologist X overstated his or her clinical productivity by about 43 percent. When corrected for these overstatements, Psychologist X's actual performance was about 29 percent below the Veteran Health Administration's (VHA's) national productivity target. The psychologist admitted to using duplicate codes for patient encounters but said that practice reflected the training psychologists receive upon beginning employment with VA. Psychologist X, however, failed to maintain professional competencies in coding and was unaware his or her coding practices were improperly double-coding patient encounters. The team did not find training material that would corroborate Psychologist X's assertion, and interviews with colleagues did not corroborate Psychologist X's claim that double-coding was ever taught or considered appropriate. The team identified instances of the psychologist double-coding patient encounters as early as 2015.

During the review, the team developed concerns that other psychologists were improperly coding patient encounters as well. The OIG found similar errors, except for double coding, when reviewing other psychologists' patient encounters at the system. The team estimated that these other psychologists entered improper codes for about 29 percent of the encounters completed during the same period.

The Chief of Psychology did not ensure that staff met clinical practices and professional standards for coding their services by failing to make certain that staff attended training or

[1] Coding is the practice of health care providers entering standardized codes into patient records for the purpose of tracking the professional effort and time required for the services performed. These codes are the basis for measuring provider productivity and billing insurance companies. Double coding refers to the practice of inappropriately assigning duplicate codes to a patient encounter when only a single code would be appropriate.

otherwise received proper instruction. The Psychology Chief also failed to provide oversight by not reviewing the health care providers' coding for accuracy.

Furthermore, the Chief of Health Information Management (HIM) failed to perform mandatory coding reviews, which were required for each provider annually. The HIM Chief indicated she was unaware of the requirement and focused instead on reviewing coding that was billed to third parties. CTVHCS managers, including the Chief of Medical Administration Service (MAS), the Assistant Chief of MAS, and the corporate compliance officer all stated they were unaware of the coding review requirement.

Psychologist X Did Not Maximize Regular Clinic Hours to Provide Direct Patient Care

During the 20-week review period, Psychologist X averaged only 15 of the 30 hours allocated for direct patient care appointments each week. This is almost nine hours below VHA's suggested standard that about 78 percent of clinicians' clinic hours should be spent in generating direct patient care.[2] In total, 180 hour-long psychotherapy sessions went unscheduled, which translated into Psychologist X receiving about $7,700 in salary for clinic time not spent providing direct patient care.[3] This means that Psychologist X had sufficient unused clinic time during regular hours to provide the patient care he or she ultimately delivered during overtime hours. Therefore, the team also substantiated that the authorization for Psychologist X to receive more than 243 hours in overtime pay did not meet VHA policy.

The Chief of Psychology relied on Psychologist X's overstated productivity and did not perform sufficient clinic capacity reviews. Also, managers approved improper scheduling practices for Psychologist X's telehealth clinic. Finally, Psychologist X violated VHA policy by inappropriately using a paper planner to track future patient appointments scheduled in his or her telehealth clinic, instead of using VHA's electronic scheduling system. This computerized system gives schedulers and supervisors the ability to view scheduled appointments and has built-in safeguards to protect veterans' personally identifiable information.

The Chief of Psychology Authorized Unnecessary Overtime

The Chief of Psychology stated that he authorized overtime to provide direct patient care to the general Mental Health Clinic, which faced challenges meeting patient demand for care. Psychologist X received about $12,120 in unnecessary pay for overtime hours even though there was sufficient availability in his or her schedule during regular clinic hours to provide the direct

[2] The 15 hours in direct patient care includes patient cancellations the day of or after the scheduled appointment and when the veteran failed to present.

[3] Calculated from the average hours worked in the clinic and applying the 2014 Office of Mental Health Operations suggestion that about 78 percent of clinicians' clinical hours worked per year should be spent in generating direct patient care.

patient care needed. The Chief of Psychology acknowledged his failure to assess, before approving the overtime, whether the care provided during overtime could have been provided during regularly scheduled clinic hours, as required by policy. Instead, he only reviewed productivity data.

The Psychology Chief's authorization for overtime began in March 2016 and lacked a defined duration, with the approval lasting longer than two years.

What the OIG Recommended

The OIG made eight recommendations to the Director of the Central Texas Veterans Health Care System. Namely, that the Director ensure all psychologists receive medical coding training and stronger oversight, review of overtime is improved, facility hours are fully used to provide direct patient care, and all psychologists follow VHA's scheduling policies and use approved systems that safeguard patients' information and accurately track appointment and wait times.

Management Comments

The Director of the Central Texas Veterans Health Care System concurred with the report recommendations and provided appropriate actions plans. The Director anticipated actions addressing all recommendations to be completed by the end of March 2019. On April 5, 2019, the facility requested closure of all recommendations, but did not provide sufficient evidence that all actions were completed.

OIG Response

The Director's corrective action plans are acceptable. The OIG will monitor the facility's progress and follow up on the implementation of these recommendations until all proposed actions are completed.

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Abbreviations

CBI	Compliance and Business Integrity
CPT	Current Procedural Terminology
CTVHCS	Central Texas Veterans Health Care System
FTE	full-time equivalent
FY	fiscal year
HIM	Health Information Management
MAS	Medical Administration Service
OIG	Office of Inspector General
RVU	Related Value Units
VA	Department of Veterans Affairs
VHA	Veterans Health Administration

Introduction

The VA Office of Inspector General (OIG) conducted this audit to determine whether a psychologist at the Temple campus of the Central Texas Veterans Health Care System (CTVHCS or the facility) improperly coded mental health services and received unwarranted overtime pay.[4]

On January 31, 2018, the OIG received allegations that a CTVHCS psychologist (Psychologist X) "double-coded" group therapy sessions and manipulated scheduling to receive unearned overtime pay. These practices increased the potential for overbilling and gave the appearance that Psychologist X produced more than other health care providers. The complainant alleged that these practices were causing significant issues for veterans seeking access to mental health services at CTVHCS. The complainant further alleged that Psychologist X created false medical notes, but that allegation was determined to be unfounded. See the Fraud Assessment in Appendix A for more details.

CTVHCS has two medical centers located in Temple and Waco; a large stand-alone multi-specialty outpatient clinic in Austin; four outpatient clinics in Brownwood, Bryan/College Station, Cedar Park, and Palestine; and an outreach clinic in La Grange.

Coding Medical Procedures and Services

Current Procedural Terminology (CPT) codes, developed and maintained by the American Medical Association, are used by VA to measure, among other things, the complexity and time required to perform medical procedures. Typically, Veterans Health Administration (VHA) health care providers enter CPT codes into the records of their patients to track the professional effort and time required for the services performed. VHA then uses CPT codes to measure provider productivity and to bill insurance companies. Every year, the American Medical Association updates its CPT guidance for coding medical services and associated documentation. This guidance includes codes providers may use, codes that should not be paired together, and codes reflecting distinct levels of effort based on the time spent with a patient. The following are examples of American Medical Association coding guidelines followed by VHA:

- VHA psychologists do not prescribe medications; therefore, they should not use codes related to prescribing medications.

[4] Coding is the practice of health care providers entering standardized codes into patient records for the purpose of tracking the professional effort and time required for the services performed. These codes are the basis for measuring provider productivity and billing insurance companies.

- Psychologists should not, within the same encounter, enter separate CPT codes to indicate both a review of their patient's records and a psychotherapy session, because the CPT code for psychotherapy already includes efforts associated with reviewing the record.
- For individual psychotherapy, there are several codes from which to choose, with the appropriate selection depending on the amount of time spent face-to-face with a patient. In contrast, group psychotherapy codes are not based on the amount of time spent with patients.

Overtime Policy

VA Handbook 5007, *Pay Administration*, Part V Chapter 2, states that overtime can be used only when necessary operations cannot be performed through planned coverage by on-duty personnel during their regular non-overtime basic workweek.

Results and Recommendations

Finding 1: Psychologist X and Others Improperly Coded Mental Health Services

The OIG substantiated the allegation that Psychologist X improperly coded mental health services by double-coding services provided during a single patient encounter, used codes not supported by the medical documentation, and entered codes not permitted for psychologists' use. Psychologist X entered improper CPT codes in approximately 66 percent of the patient encounters completed during the OIG's 20-week review period from October 1, 2017, through February 17, 2018.

The OIG determined that Psychologist X failed to maintain professional competencies in coding.[5] Likewise, Psychologist X's supervisor (the Chief of Psychology) failed to provide sufficient oversight to ensure that staff coding was done correctly. In fact, this lack of oversight was not limited to the Chief of Psychology; the Chief of Health Information Management (HIM) did not perform the mandatory coding reviews for providers while managers and leaders in other areas of CTVHCS did not ensure that mandatory CPT coding reviews were performed.

Properly coding medical services allows health professionals and their managers to judiciously quantify and allocate a facility's finite resources. Proper coding also promotes billing accuracy.

What the OIG Did

The initial scope of the audit focused on Psychologist X's patient encounters completed from October 1, 2017, through February 17, 2018. After identifying similar coding errors throughout Mental Health Services, the OIG expanded the scope of its inquiry to include encounters from all facility psychologists during this 20-week period. The audit work included announced site visits to the facility, as well as a site visit to the Mid-South Consolidated Patient Accounts Center to interview billing staff and review documentation. The OIG team separately reviewed one sample from the 449 patient encounters completed by Psychologist X and another sample from the 30,247 patient encounters completed by other psychologists. These samples were stratified into two types of encounters: those with one CPT code and those with multiple CPT codes. In all, the team reviewed 195 of the 30,696 patient encounters to determine whether the CPT codes entered by psychologists were supported by documentation in the medical records.

[5] The psychologist's fiscal year (FY) 2018 performance standards included participating in continuing education activities.

Finding 1 addresses these issues:

- Improper coding of mental health services
- Failure to maintain professional competencies and lack of adequate coding oversight

Improper Coding of Mental Health Services

From October 1, 2017, through February 17, 2018, the OIG estimated that Psychologist X improperly coded mental health services in about 66 percent of the 449 patient encounters. Table 1 details the estimated percentage and types of errors found.

Table 1. Psychologist X's Percent of Coding Errors by Type from October 1, 2017, through February 17, 2018

Type of error	Percent estimate
Entering two group therapy codes (double-coding) for a patient's group session	29
Using codes not supported by the medical documentation	53
Coding a standard evaluation of mental status as psychological testing[6]	11
Using evaluation and management codes reserved for medical providers	8

Source: OIG documentation review of patient encounters from VHA's Physician Productivity Cube

Note: Differences due to rounding

During the audit, the OIG team developed concerns that other psychologists were improperly coding as well. The team found similar instances of improperly coded patient encounters, except for double coding, when reviewing other CTVHCS psychologists' practices. The team estimated that these other psychologists entered improper CPT codes for about 29 percent of the encounters completed during the same period.

Nonadherence to industry coding standards affects management's ability to accurately measure provider productivity, which hinders its efforts to accurately evaluate staff performance and ensure psychologists maximize their capacity for providing direct patient care. After correcting the overstated productivity resulting from improper coding, the audit team estimated that all CTVHCS psychologists' productivity averaged about 17 percent below VHA's national target. Furthermore, erroneous data from improper coding makes it difficult to accurately bill third parties and to appropriately gauge a facility's overall workload.

[6] Evaluations of mental status included in a clinical interview can be a list of questions concerning symptoms and should not be billed as psychological testing. For example, the Patient Health Questionnaire contains nine questions and, according to the VA Clinical Practice Guideline, *Management of Major Depressive Disorder*, providers can administer the questionnaire in less than two minutes, and it is simple to score.

Impact of Improper Coding on Performance Evaluations

Psychologist X's performance evaluations might have been flawed because the productivity results used as the bases for the evaluations were overstated. After replacing the improper codes with CPT codes supported by documentation, the audit team estimated that Psychologist X overstated his or her productivity by about 43 percent from October 1, 2017, through February 17, 2018. Rather than surpassing VHA's national productivity target by 14 percent, as claimed, Psychologist X's actual productivity was about 29 percent below the target for the first four-and-a-half months of FY 2018.

During the same period, the other CTVHCS psychologists overstated their productivity by about 20 percent. While the facility deemed the average productivity for all psychologists to be 101 percent of VHA's national productivity target, the OIG estimated the actual performance for all psychologists to be only about 83 percent of that target. Merely taking into account the first four-and-a-half months of FY 2018 and using FY 2018 performance standards to evaluate performance would inflate the average psychologist productivity and produce a rating of *Exceptional.*[7] However, if one were to use the actual average, productivity would have barely met the lower performance level of *Fully Successful*.

Impact of Coding Errors on Billing

The audit team did not find instances in which improper coding resulted in improper billing to third parties. This conclusion is based on information provided by facility revenue staff who reviewed all the improper CPT codes the team identified. This lack of finding may be because the care was provided to veterans for service-connected disabilities—VHA is not authorized to recover or collect charges for care and services provided to veterans for service-connected disabilities. While the team did not find improper billing, coding errors increase the risk that VHA could overcharge veterans and other third parties for services not provided.

Failure to Maintain Professional Competencies and Lack of Adequate Coding Oversight

Psychologist X did not maintain professional competencies in coding and was unaware he or she was improperly coding. When asked about the practice of double-coding, Psychologist X admitted to using multiple CPT codes on single encounters and stated this practice was consistent with training psychologists receive upon beginning employment with VA. The audit team did not find this statement credible. The team did not find training material that would

[7] The FY 2018 performance standard for CTVHCS psychologists lists productivity as the first of four rating standards under the critical element of Patient Care Services. According to those standards, psychologists are considered *Fully Successful* if their workload falls within 20 percent of VHA's productivity target; the rating is considered *Exceptional* if psychologists' workload is at or above the target.

corroborate Psychologist X's assertion on the use of multiple CPT codes for single encounters. Furthermore, interviews with colleagues did not corroborate Psychologist X's claim that double-coding was ever taught or considered appropriate. The audit team found instances in which Psychologist X double-coded encounters as early as 2015, shortly after receiving authorization to independently code and complete patient encounter documentation.

Coding practices and policies are updated annually, which make it necessary for staff to remain up-to-date on current practices. The audit team found that Psychologist X did not attend seven of eight optional coding trainings held by the facility from May 2015 through March 2018. In an April 19, 2018, interview, Psychologist X acknowledged neither attending the latest training held a month earlier nor reviewing the training course follow-up email. A review of the information provided in the follow-up email confirmed that clear guidance was provided about double-coding being improper.

According to the facility, the Mental Health Lead of the Veterans Service Integrated Network 17 completed a review of Psychologist X's coding and documentation on May 3, 2018. Based on that review, the facility concluded that administrative action was not warranted, and that Psychologist X would be provided additional coding training. Psychologist X was required to attend training on June 6, 2018, and August 15, 2018. Therefore, the OIG team did not recommend a review Psychologist X's conduct to determine if administrative action was warranted.

The Chief of Psychology Did Not Provide Adequate Coding Oversight

VHA policy states that the Chief of Psychology is responsible for ensuring clinical practices and professional standards are met.[8] The Chief of Psychology failed to make certain that Psychologist X and all other psychologists followed coding guidelines.

The Chief of Psychology performed limited productivity reviews of unique patients treated, total encounters, and overall productivity. The oversight methodology used did not include provider-specific coding reviews and had the unintended consequence of rewarding overstated productivity. The Chief confirmed he did not review provider coding but stated that he performed general productivity reviews and had access to results of the Point-of-Care Audit. Point-of-Care Audits are peer-to-peer chart audits by psychologists to meet accreditation standards for reviewing medical records. They are a valuable but limited tool, depending on what reviewers examine. Reviews include these indicators: presence of information in record, timeliness, legibility, accuracy, authentication, and completeness of data and information.

[8] VA Handbook 5005/103 Part II, Appendix G18. *Psychologist Qualification Standard GS-180*, February 7, 2018, stated that Chiefs of Psychology have overall responsibility for clinical practice and supervision for the service. This includes ensuring policies have been fully coordinated.

Point-of-Care Audits showed 100 percent accuracy for Psychologist X in the fourth quarter of FY 2017; however, the reviews looked only at treatment documentation and did not address coding accuracy.

Supervisory review of coding practices is necessary for monitoring psychologists' compliance with coding guidance; this type of monitoring serves to meet standards and provide pertinent data for management decisions. The CTVHCS Director should improve oversight by ensuring psychologists are properly trained for coding and by requiring that the Chief of Psychology routinely reviews provider coding.

The Chief of Health Information Management Did Not Perform Provider Coding Reviews

The Chief of HIM failed to perform mandatory coding reviews.[9] This affected coding oversight, which is the primary responsibility of the Chief of HIM.[10] The Chief of HIM stated that she was unaware of the need to perform provider-specific coding reviews. She also stated that the priority was to ensure reviews of billable work and that the reviews of provider coding were limited to ad hoc reviews when requested. HIM staff perform these coding reviews at the request of the various services but, according to the Chief of HIM, no staff from Mental Health Services ever made a request for provider coding reviews. Because mandatory coding reviews give managers the tools necessary for staff improvement and because those tools support the reporting of reliable and accurate data, the OIG recommended the CTVHCS Director ensure the Chief of HIM performs the mandatory provider-specific coding reviews.

Facility Managers Failed to Provide Adequate Oversight

The Chief of Medical Administration Service (MAS) and the Assistant Chief of MAS, who provide direct supervision of HIM at the facility, both relied on the Chief of HIM to know and perform her duties. They did not review the applicable HIM policies themselves. They reportedly were unaware of the requirement to review provider coding accuracy until the audit team brought this mandate to their attention. Likewise, the corporate compliance officer had not reviewed the applicable HIM policies and was unaware of the provider coding review requirement until the team brought it to the officer's attention.[11] For his part, the Medical Center Director was unaware that the coding reviews were not being conducted. He expected staff to inform him whenever

[9] VHA Health Information Management (HIM)/Office of Compliance and Business Integrity (CBI) Practice Brief: *Monitoring Clinical Coder Accuracy and Productivity, and Provider Accuracy* mandates the review of each provider at least once per fiscal year.

[10] VHA HIM *Clinical Coding Program Guide*, section 4(f) and 4(i), states that HIM Service provides continuous review and oversight of coding, as well as clinical coding education to ensure codes are accurate.

[11] VHA Health Information Management (HIM)/Office of Compliance and Business Integrity (CBI) Practice Brief states that the facility Compliance Office will ensure HIM Service is sending the monthly monitoring report in a timely manner and assisting HIM Service to ensure appropriate follow-up action is taken.

those requirements were not being performed. Without keeping oneself current with applicable policies and knowing one's responsibilities, managers cannot perform their necessary function of providing effective oversight of internal controls such as provider coding accuracy, which can lead to the types of overstated productivity observed. The CTVHCS Director needs to ensure that provider-specific coding reviews occur.

Conclusion

The OIG substantiated allegations that Psychologist X improperly coded mental health services and estimated that about 66 percent of Psychologist X's patient encounters were double coded, lacked medical documentation to support the CPT codes selected, or used CPT codes not permitted for psychologists' use. The OIG also found that other psychologists improperly coded about 29 percent of their encounters. Improper coding can hinder management's ability to evaluate staff and ensure resources are used effectively. The audit team estimated that productivity was overstated by about 43 percent for Psychologist X, while the other psychologists' productivity was overstated by about 20 percent. The OIG estimated that actual productivity for all psychologists was about 17 percent below VHA's national standards. This occurred because Psychologist X failed to keep up on coding guidelines, and the Chief of Psychology did not ensure staff followed coding guidelines. In addition, the Chiefs of HIM and MAS, Assistant Chief of MAS, and the facility Compliance Office staff did not perform or oversee the completion of mandatory provider coding.

Recommendations 1–4

The OIG recommended that the Central Texas Veterans Health Care System Director

1. Ensure that all psychologists are properly trained on coding;
2. Instruct the Chief of Psychology to review provider coding accuracy in routine evaluations;
3. Make certain the Chief of Health Information Management performs annual reviews of provider coding as specified in Veterans Health Administration policy; and
4. Confirm that the Chief and Assistant Chief of Medical Administration Service, along with the compliance officer, provide adequate oversight of the Health Information Management provider coding reviews.

Management Comments

The Director of the CTVHCS concurred with Recommendations 1–4. For Recommendation 1, the facility provided training to 94 percent of psychologists with planned training for the remaining psychologists to be performed on March 1, 2019. Furthermore, the facility will provide monthly training as needed when providers score below 95 percent accuracy, and to all onboarding providers. For Recommendation 2, the Chief of Psychology will evaluate coding

accuracy monthly using reports developed by the Corporate Compliance Section. This monitoring was to begin March 1, 2019. For Recommendation 3, the Corporate Compliance Section will complete annual reviews and report to the Quality Safety Value Executive Board through the Corporate Compliance Committee with a target completion of March 15, 2019. For Recommendation 4, the Director assigned the role of the completing annual provider coding audits to the compliance officer and added three nurse informatic positions to supplement the coding auditing program. Furthermore, the Director confirmed the oversight roles of the Chiefs of HIM and MAS, Assistant Chief of MAS, and the facility compliance officer. The target completion is March 29, 2019.

On April 5, 2019, the facility requested closure of all recommendations, but did not provide sufficient evidence that all actions were completed.

OIG Response

The Director's corrective action plans are acceptable. The OIG will monitor the CTVHCS's progress and follow up on the implementation of our recommendations until these proposed actions are completed.

Finding 2: Psychologist X Did Not Maximize Regular Clinic Hours to Provide Direct Patient Care

The audit team determined that Psychologist X provided direct patient care for only 48 percent of regular clinic hours from October 1, 2017, through February 17, 2018. This occurred because the Chief of Psychology relied on Psychologist X's self-reported, inflated productivity and did not perform sufficient clinic capacity reviews. Meanwhile, at Psychologist X's telehealth clinic, managers approved improper scheduling practices that violated VHA policy and further reduced their ability to make certain Psychologist X's clinic hours were fully scheduled.

What the OIG Did

The audit team reviewed Psychologist X's scheduling practices from October 1, 2017, through February 7, 2018. The audit work included two site visits at the facility, a collection of documentary and testimonial evidence, a review of national policy governing scheduling, and an analysis of scheduled clinic time.

Finding 2 addresses these issues:

- Clinic capacity
- Scheduling practices

Unscheduled Capacity

For the 20-week period of review, Psychologist X worked 70 days of eight- or 12-hour shifts, not including overtime. Of the 70 days worked, Psychologist X had 35 days (50 percent) during which six or more hours were left unscheduled. As shown in Table 2, Psychologist X averaged slightly less than 15 hours of scheduled patient care per a 40-hour week.

Table 2. Psychologist X's Average Clinic Use per 40-Hour Week from October 1, 2017, through February 17, 2018

Clinic activity	Hours
Non-clinic time	9.9
Clinic duties scheduled[12]	14.6
Available clinic time not scheduled with an appointment	15.5

Source: Facility-provided timecards, no-shows, cancellations and VHA's Physician Productivity Cube

[12] This includes completed appointments and one-hour appointment slots for each scheduled appointment for which the patient failed to report or canceled on or after the appointment date.

In 2014, VHA's Office of Mental Health Operations presented an analysis to VHA leaders suggesting that about 78 percent of clinicians' clinic hours should be spent in generating direct patient care. Using this suggested standard, Psychologist X should have spent an average of almost 24 of about 30 clinic hours available each week providing direct patient care. Instead, Psychologist X averaged just under 15 scheduled clinic hours, leaving an additional nine hours available for direct patient care unused in a standard workweek.

Over the 20-week review period, Psychologist X had 180 hours of unscheduled regular clinic hours below VHA's suggested direct patient care standard. The unscheduled time equaled about $7,700 in salary paid that did not result in expected direct patient care.

Insufficient Reviews of Clinic Capacity

The Chief of Psychology relied on his staff's self-reported productivity and did not adequately review Psychologist X's clinic capacity to confirm full scheduling. The Chief said he reviewed unique patient counts, total encounters, and overall productivity reported. These reviews were flawed because they could not effectively detect that capacity went unused. Psychologist X performed several group therapies each week, thereby inflating the number of unique veterans and total encounters when compared to psychologists who did not perform the same amount of group therapy. As Finding 1 shows, Psychologist X's improper coding overstated his or her productivity by about 43 percent, resulting in a false representation of overachievement. The Chief's reviews of Psychologist X's self-reported productivity failed to detect this problem and thus did not trigger additional levels of review that would have otherwise resulted. Without those additional reviews to inform his decision-making, the Chief was unaware that full capacity was not being realized. The OIG concluded that the CTVHCS Director needs to ensure that clinic hours are sufficiently scheduled to maximize direct patient care and achieve targeted productivity.

Improper Scheduling Practices

While reviewing overtime records, the audit team discovered that the scheduling practices for Psychologist X's telehealth clinic did not comply with VHA's scheduling policy.[13] Psychologist X was the only scheduler for the clinic and did not enter scheduled appointments into the VHA official health information system—opting instead to manually track them in a paper planner. It was only after the encounter had been completed that Psychologist X would enter appointments into VHA's electronic scheduling system.

[13] VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, Appendix B, states that staff must create and capture outpatient appointments using VHA's electronic scheduling system. Appendix J states that employees must not use any other documents such as paper lists, logbooks, or calendars whenever patient information is recorded for tracking patient requests for outpatient appointments.

Improper clinic scheduling limited the Chief of Psychology's ability to provide oversight and to appropriately evaluate staffing needs, which include the need for overtime. Moreover, the use of a paper planner placed veterans' personally identifiable information at risk while it remained outside the controls of VHA's official electronic scheduling system.

Scheduling Guidance Was Not Always Consistent with Policy

In 2014, the Chief of Psychology authorized telehealth scheduling procedures; his approval was based on guidance issued by the Telehealth Rural Access Program Coordinator, which did not conform to VHA's electronic scheduling process and thus violated VHA scheduling policy.[14] The Coordinator stated that the inappropriate scheduling practices were introduced because telehealth services' demand was unpredictable; if the facility were to follow the standard scheduling practices that require the creation of appointment times, inefficiencies would ensue and appointments would go unused. However, the Coordinator said that around October 2017, she had given the Chief of Psychology new guidance, so the telehealth scheduling procedures would follow VHA scheduling policies. According to the same Coordinator, new guidance was issued because Psychologist X's telehealth clinic had acquired sufficient demand to justify the creation of appointments in VHA's official electronic scheduling system. The Chief of Psychology said he did not recall discussing this new guidance with the Coordinator, who herself could not produce any corroborating documentation about providing such guidance to the Chief of Psychology. The CTVHC Director needs to ensure that all telehealth clinics follow policy by using VHA's electronic scheduling system to allow schedulers and supervisors to view scheduled appointments. This action will also promote the accuracy of veteran wait time data.

Psychologist X Did Not Follow Policy

As mentioned earlier, Psychologist X violated VHA's scheduling policy by tracking patients' appointments in a paper planner. Psychologist X stated that, to keep track of the appointments, psychologists noted in a daily planner the date and time of future appointments along with the veterans' last four digits of their social security number and initials. Several days before the appointment date, Psychologist X would enter the appointments in the telehealth software that sent out digital links to veterans, so they could access the appointments. Not only is this kind of appointment tracking and scheduling improper, but it can undermine the ability of managers to give assurances that appointments are timely.

On November 2, 2018, the facility took administrative action against Psychologist X for keeping his or her appointments in a paper planner. Therefore, the OIG team did not issue a recommendation to review Psychologist X's conduct. However, the team advised the CTVHCS

[14] VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, Appendix B, states that staff must create and capture outpatient appointments using VHA's electronic scheduling system.

Director to ensure that the paper planner is properly disposed of, and veterans' information is secure.

Conclusion

The audit revealed that Psychologist X did not perform sufficient direct patient care during regular clinic hours to reach full capacity over the 20-week review period. This inefficiency was the result of inaction or inappropriate practices by the Chief of Psychology, the Telehealth Rural Access Program Coordinator, and Psychologist X. The Chief of Psychology did not effectively review capacity. The Coordinator provided improper guidance on scheduling procedures that violated VHA policy. And Psychologist X violated VHA policy by using a paper planner for scheduling appointments instead of the electronic scheduling system.

Recommendations 5–7

The OIG recommended that the Central Texas Veterans Health Care System Director

5. Ensure that clinic hours are sufficiently scheduled to maximize direct patient care and achieve targeted productivity;
6. Make certain that all telehealth clinics follow the Veterans Health Administration's scheduling policies by using the approved electronic scheduling system and assign properly trained telehealth schedulers; and
7. Oversee the proper disposal of the paper planner and secure patients' information.

Management Comments

The Director of CTVHCS concurred with Recommendations 5, 6, and 7. For Recommendation 5, the facility will use its Group Practice manager to identify inefficiencies, and the Chief of Psychology will perform monthly reviews of productivity with a target completion of March 29, 2019. For Recommendation 6, the facility will ensure only properly trained telehealth schedulers will schedule telehealth appointments. The Corporate Compliance Section will conduct audits to ensure compliance with this requirement. Target completion date was March 1, 2019. For Recommendation 7, Psychologist X certified the paper planner was shredded, and the facility initiated further corrective action to provide additional details with a target completion of March 1, 2019.

On April 5, 2019, the facility requested closure of all recommendations, but did not provide sufficient evidence that all actions were completed.

OIG Response

The Director's corrective action plans are acceptable. The OIG will monitor the facility's progress and follow up on the implementation of these recommendations until the proposed actions are completed.

Finding 3: The Chief of Psychology Authorized Unnecessary Overtime

Psychologist X received $12,120 in pay for overtime that was unnecessary. The audit team substantiated the allegation that Psychologist X received authorization for overtime from the Chief of Psychology for more than 243 hours for the 16-month period spanning October 17, 2016, through February 17, 2018, that did not comply with VA's overtime policy.[15] The team found that Psychologist X had sufficient unused clinic time during regular hours to provide the care that he or she instead delivered during the scheduled overtime. The Chief failed to adequately assess, prior to authorizing overtime, whether the necessary operations could be scheduled within the capacity of existing clinics.

What the OIG Did

The audit team examined Psychologist X's timecards, as well as the Chief of Psychology's approval and justification of overtime for more than 243 overtime hours from October 17, 2016, through February 17, 2018. The audit work included two site visits to the facility, a collection of documentary and testimonial evidence, a review of national policy governing the use of overtime, and an analysis of scheduled clinic time.

Finding 3 addresses the issue of overtime.

Unnecessary Overtime

The audit team substantiated the allegation that Psychologist X received unnecessary overtime pay. The team concluded that the misspent payment occurred because the Chief of Psychology authorized overtime for work that could have been performed during regular hours. This violates VA policy that overtime can be used only when necessary operations cannot be performed despite planned coverage by on-duty personnel during their regular workweek. The Chief of Psychology identified the necessary operations as direct patient care to the general Mental Health Clinic, which faced challenges meeting patient demand for care. From October 17, 2016, through February 17, 2018, Psychologist X worked just over 2,185 clinic hours. Of the total clinic hours, almost 1,092 hours (50 percent) were scheduled or resulted in completed appointments. However, VA paid Psychologist X for an almost equal number of hours (1,093 hours) for work that did not result in direct patient care. Even though Psychologist X devoted a considerable number of hours to clinical work other than direct patient care, the Chief still authorized Psychologist X to work more than 243 overtime hours from during this same period of time. For example, Psychologist X worked 13.5 hours of overtime the week of November 28, 2016, despite having availability for 23.5 of the 40 hours in his or her regular workweek schedule to conduct direct patient care.

[15] VA Handbook 5007, *Pay Administration*, Part V, Chapter 2, states that overtime can be used only when necessary operations cannot be performed despite planned coverage by on-duty personnel during their regular basic workweek.

Overall, the team found that the roughly $12,120 paid in overtime to Psychologist X was unnecessary because Psychologist X had the capacity, through his or her regular work schedule, to provide all the direct patient care that occurred during overtime hours.

The Chief of Psychology admitted to (1) not assessing whether regularly scheduled hours offered the necessary coverage and (2) not ensuring overtime hours resulted in direct patient care. The Chief's authorization for overtime occurred in March 2016 and lacked a defined duration, with the authorization lasting more than two years. The Chief stated that he would rely on productivity data instead of assessing if all appointment times during regular work hours were scheduled. The Chief also acknowledged not reviewing the work completed during overtime to ensure direct patient care occurred; he said he trusted staff to comply with his instructions to use overtime for that purpose.

The OIG concluded the CTVHCS Director should ensure, before authorizing overtime, that the Chief of Psychology assesses whether necessary operations cannot be performed during regular work hours.

Conclusion

The OIG substantiated the allegation that Psychologist X received approval for unnecessary overtime hours given he or she could have provided the same direct patient care during regular work hours. This breach of policy led to about $12,120 in unnecessary overtime pay and occurred because of the Chief of Psychology's failure to assess Psychologist X's available clinic capacity during regular work hours.

Recommendation 8

8. The Central Texas Veterans Health Care System Director make certain that the Chief of Psychology determines, before authorizing overtime, whether the requested services could be performed during normal working hours.

Management Comments

The Director of the CTVHCS concurred with Recommendation 8. For this recommendation, with a target completion date of March 1, 2019, the Chief of Psychology implemented a stringent pre-approval process for overtime that includes reviews of the scheduled appointments and workload.

On April 5, 2019, the facility requested closure of all recommendations, but did not provide sufficient evidence that all actions were completed.

OIG Response

The Director's corrective action plans are acceptable. The OIG will monitor the facility's progress and follow up on the implementation of this recommendation until the proposed action is completed.

Appendix A: Scope and Methodology

Scope

The OIG conducted its audit from April 2018 through January 2019. The OIG focused on alleged improper CPT code usage from October 1, 2017, through February 17, 2018, and questionable overtime practices occurring at the facility from October 17, 2016, through February 17, 2018.

Methodology

The OIG reviewed applicable national and local policies, procedures, and guidance documents related to VHA's coding, overtime usage, and telehealth processes. The OIG conducted site visits at the facility to learn about the facility's coding and overtime practices and to obtain more documentation regarding the allegations. The OIG interviewed the facility's current and former staff, the Chief of Psychology, the Telehealth Rural Access Program Coordinator, the Corporate Compliance Officer, the Administrative Officer for Mental Health, the Assistant Chief of Staff for Mental Health, the Chief of HIM, the Chief of Domiciliary, the Deputy Director of the Office of Mental Health and Suicide Prevention, the Chief of MAS, the Assistant Chief of MAS, and the CTVHCS Director. The OIG obtained testimonial and documentary evidence from CTVHCS staff related to coding practices and overtime usage at the Mental Health Clinic. The OIG reviewed the CTVHCS telehealth processes to ascertain if the facility complied with VHA's standards.

To evaluate the coding practices, the OIG reviewed a statistical sample of mental health appointments created from October 2, 2017, through February 16, 2018. The OIG examined the electronic health records and compared those entries with VHA's mental health coding guidance and/or other nationally recognized coding standards used by the facility to determine whether psychologists appropriately coded those entries into VA's electronic health records. In addition, the OIG provided those sample reviews to the facility managers for concurrence.

To evaluate the overtime practices, the OIG reviewed time and attendance records, overtime approval records, testimonial evidence, analysis, and national policy on the use of overtime to evaluate the merits of the overtime used from October 17, 2016, through February 17, 2018. The OIG shared with the facility, for concurrence, the more than 243 hours of overtime submitted by Psychologist X that the OIG identified as unnecessary as a result of its analysis. While the CTVHCS Director agreed that the amount and approval of overtime were questionable, the facility did not agree to a defined number of overtime hours that were improper.

Fraud Assessment

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

1. Reviewing Psychologist X's double coding and overtime
2. Examining the facility's oversight process of alleged false medical notes made by Psychologist X

The OIG did not identify instances of fraud or potential fraud related to improper coding and overtime during this audit; however, the audit team worked with the OIG's Office of Investigations on potential implications that Psychologist X falsified medical notes. In coordination with the Office of Investigations, the team determined that the claim of falsified notes was unfounded.

The audit team determined that although Psychologist X received an FY 2017 performance rating of *Outstanding,* there were no other financial incentives identified as a result of overstated productivity. Given that Psychologist X openly admitted to double-coding patient encounters and doing so throughout his or her entire career, coupled with the lack of training attendance and the low financial incentive, the team determined that Psychologist X's double coding was attributed to misunderstanding, thereby making fraud unlikely.

The audit team also determined that Psychologist X did not falsely represent his or her overtime activities; Psychologist X's statements about his or her activities during overtime and the justifications entered by approving officials following the completion of overtime were consistent.

With respect to the alleged falsified notes, the audit team evaluated a facility-led review of records and veteran interviews that implied the facility had identified several veterans who denied having an appointment with Psychologist X. After being notified of the results of the facility-led review, the team coordinated with a special agent in the Office of Investigations to evaluate that review. The team determined that the allegations surfacing in the facility-led review lacked merit; those allegations failed to identify a single instance in which a veteran had implied that an appointment was falsely entered. After interviewing the complainant, Psychologist X, and several other staff at the facility, the team concluded it did not have sufficient information to warrant expanding the review and considered the implications of falsified notes unfounded.

Data Reliability

The audit team used computer-processed data from the VHA Support Service Center's Physician Productivity Cube. To test the reliability of the computer-processed data, the team validated patient encounter data to information available in VHA's electronic health records. The team assessed the transactions to determine if dates fell within the period of review, whether the encounter date matched the date on medical notes, and if CPT codes were the same between the computer-processed data and the electronic health record. The team determined that the data were sufficiently reliable for this audit's objectives.

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for its findings and conclusions based on its audit objectives. The OIG believes that the evidence obtained provides a reasonable basis for its findings and conclusions based on its audit objectives.

Appendix B: Statistical Sampling Methodology

To determine whether the allegation that Psychologist X used CPT codes improperly at the facility was true, the OIG evaluated statistical samples that assess the following:

1. Percentage of patient encounters with improper coding
2. Projection of overstated productivity

The audit team compared the documentation available in VHA's electronic health records to the CPT codes entered by psychologists to determine if there was sufficient support. Encounters for CPT codes that were unsupported were considered errors.

To assess the effect of improper coding on reported provider productivity, the team assessed the Related Value Units (RVUs) associated with each improper CPT code. RVUs are an industry standard to apply a work value based on the complexity and time required to perform professional services. VHA uses RVUs to calculate provider productivity. To calculate whether actual productivity was over- or understated, the team evaluated RVUs for CPT codes properly entered, CPT codes unsupported by documentation (or improper), and CPT codes supported by documentation but not entered at all.

Population

The population consisted of 30,696 patient encounters with RVU values completed by CTVHCS psychologists from October 1, 2017, through February 17, 2018. The audit team stratified the population-based encounters completed by Psychologist X and by all other psychologists. This allowed the team to assess the performance of both groups. To address double-billing concerns, the team further stratified by encounters with a single CPT code and encounters with multiple CPT codes, as shown in Table B.1.

Table B.1. Population Strata

Strata description
Psychologist X with a single CPT code
Psychologist X with multiple CPT codes
Other psychologists with a single CPT code
Other psychologists with multiple CPT codes

Source: OIG sampling

Sampling Design

The OIG selected a stratified random sample for its review. The OIG reviewed approximately 50 encounters per stratum for a total of 195 encounters from the population of 30,696 encounters created from October 1, 2017, through February 17, 2018. The OIG used this stratification method to provide more insight into recent procedural activities. All records had a known chance of selection. This allowed the OIG to make estimates over the entire population and by stratum.

Weights

The OIG calculated estimates in this report using weighted sample data. Sampling weights are computed by taking the product of the inverse of the probabilities of selection at each stage of sampling.

Projections and Margins of Error

Combing the respective strata, the OIG estimated that Psychologist X entered improper CPT codes for roughly 66 percent of encounters while other psychologists entering improper CPT codes on about 29 percent for the same period, as shown in Table B.2.

Table B.2. Statistical Projections—Encounters with Improper Codes

Description	Estimate	Margin of error	Confidence interval lower limit for 90 percent	Confidence interval upper limit at 90 percent
Psychologist X	65.9%	9.1%	56.8%	75.0%
Other psychologists	28.8%	8.4%	20.4%	37.2%

Source: OIG sampling

As shown in Table B.3., for Psychologist X, the OIG estimated the percentage of encounters with each of the four types of improper coding.

Table B.3. Statistical Projections—Encounters with Improper Codes for Psychologist X

Description	Estimate	Margin of error	Confidence interval lower limit at 90 percent	Confidence interval upper limit at 90 percent
Double coding	28.9%	9.7%	19.3%	38.6%
Not supported by documentation	52.9%	9.1%	43.8%	62.0%
Improper testing	10.5%	2.1%	8.5%	12.6%
Evaluation and management	7.6%	4.6%	3.0%	12.2%

Source: OIG sampling - Differences due to rounding

During the review, the audit team determined that Psychologist X's double-coded encounters could be identified by using data analytics rather than requiring sampling. Since the use of data analytics provided a more precise number, the team incorporated the analytics into the projection of overstated productivity. This required the team to remove the productivity effect of double coding from the sample, create an estimate of overstated RVUs from the sample, and add back the overstated RVUs found in the data analytics that identified all double coding performed by Psychologist X.

As shown in Table B.4., the OIG estimated that Psychologist X's clinical productivity was overstated by about 43 percent while the other psychologists overstated their clinical productivity by about 20 percent.

Table B.4. Statistical Projections—RVUs Overstated and Not Overstated

Description	Estimate	Margin of error	Confidence interval lower limit at 90 percent	Confidence interval upper limit at 90 percent
Psychologist X overstated	43.4%	8.6%	34.8%	52.0%
Psychologist X not overstated	524 (56.6%)	80 (8.6%)	444 (48.0%)	604 (65.2%)
Other psychologists overstated	19.6%	3.7%	15.9%	23.4%
All CTVHCS psychologists not overstated RVUs	39,169	1,816	37,353	40,984

Source: OIG sampling—differences due to rounding

To compare the actual productivity with VHA's productivity target, the audit team followed VHA's method for calculating productivity by examining the average productivity per full-time-

equivalent (FTE) staff devoted to clinical time. According to VHA data, Psychologist X's clinic time was 0.8 FTE and the facility had a total of about 53 FTE psychologists.

As shown in Table B.5., the OIG estimated that Psychologist X was about 29 percent below the VHA productivity target, with all psychologists achieving about 17 percent below that target.

Table B.5. Productivity Calculation for Psychologist X and All Other CTVHCS Psychologists as Compared with VHA Target

Description	Psychologist X	All psychologists
Estimated RVU productivity per FTE*	633	745
VHA's RVU target per FTE at CTVHCS	897	897
Percentage of VHA's target	70.6%	83.0%
Percentage below target	29.4%	17.0%

Source: OIG sampling

**Calculated average RVU per FTE from the estimated non-overstated RVUs from Table B.4. respectively using 0.8 FTE for Psychologist X and about 53 FTE for all psychologists.*

The margins of error and confidence intervals are indicators of the precision of the estimates. If the OIG repeated this audit with multiple samples, the confidence intervals would differ for each sample, but would include the true population value 90 percent of the time.

Appendix C: Monetary Benefits in Accordance with Inspector General Act Amendments

Recommendation	Explanation of benefits	Better use of funds	Questioned costs
8	The facility used the $12,121.59 salary paid to Psychologist X over 16 months without first assessing if the needed services could have been provided during regular hours. Over a five-year period, unnecessary overtime spending would total $45,331.77 if no changes are made to practices.	$0	$45,331.77
	Total	**$0**	**$45,331.77**

Appendix D: VISN 17 Director Comments

Department of Veterans Affairs Memorandum

Date: February 13, 2019

From: Director, VA Heart of Texas Health Care Network (10N17)

Subj: Draft Report, Audit of Improper Coding and Unnecessary Overtime at the Central Texas Veterans Health Care System (Project Number 2018-03159-R5-0110)

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

Thank you for the opportunity to review the draft report: Audit of Improper Coding and Unnecessary Overtime at the Central Texas Veterans Health Care System (Project Number 2018-03159-R5-0110).

I have reviewed and concur with the recommendations and responses.

(*Original signed by*)

Jeff Milligan

Network Director, VISN 17

Appendix E: CTVHCS Director Comments

Department of Veterans Affairs Memorandum

Date: February 13, 2019

From: Director, Central Texas Veterans Health Care System (674/00)

Subj: Office of Inspector General – Audit of Improper Coding and Unnecessary Overtime at the Central Texas Veterans Health Care System

To: Director, VA heart of Texas Health Care Network (VISN17)

1. I would like to express my appreciation to the Office of Inspector General audit team for their professional and comprehensive review.

2. I have reviewed the draft report for the Central Texas Veterans Health Care System audit and concur with the findings and recommendations.

3. Please express my gratitude to the audit team for their professional assistance to us in our continuing efforts to provide the best care possible to our Veterans.

(*Original signed by*)

Christopher R. Sandles, MBA, FACHE

Attachment

Comments in response to
OIGs Recommendations in *Audit of CTVHCS Improper Coding and Overtime*

RECOMMENDATION 1

The Central Texas Veterans Health Care System Director ensures all psychologists are properly trained on coding.

Concur.

Target date for completion: March 1, 2019

Director Comments

HIMS has provided additional coding training to 94% of the psychologists. The remaining psychologists will be trained by March 1, 2019. The CTVHCS now provides coding training to all onboarding providers. As part of further development of coding education, HIMS will provide monthly Coding training which will be available to all Providers; and HIMS will provide additional need-based training at least monthly. Providers that score below 95% accuracy on Provider Coding Accuracy audits will be required to attend coding training.

RECOMMENDATION 2

The Central Texas Veterans Health Care System Director instructs the Chief of Psychology to review care provider coding accuracy in routine evaluations.

Concur.

Target date for completion: March 1, 2019

Director Comments

The Chief of Psychology has been instructed to evaluate provider coding accuracy on a monthly basis. Corporate Compliance has developed reports which identify coding outliers and provided the process and instructions to the Analyst that supports Psychology. These reports will be used by the Chief of Psychology to review provider coding outliers. Provider Coding Accuracy audits are conducted by Corporate Compliance, using certified and experienced Coding Auditors. Psychologists are included in these audits. The results of the audits are provided to the applicable Service Chief. Providers that score below 95% accuracy are required to attend coding training.

RECOMMENDATION 3

The Central Texas Veterans Health Care System Director makes certain the Chief of Health Information Management performs annual reviews of provider coding as specified in VHA policy.

Concur.

Target date for completion: March 15, 2019

Director Comments

The Corporate Compliance Section is responsible for completing the annual reviews of provider coding accuracy. The results of these audits are reported to leadership through the Corporate Compliance Committee, which reports directly to the Quality Safety Value Executive Board, the senior-most executive committee. The audits are also sent to the Service Chief of the audited providers.

RECOMMENDATION 4

The Central Texas Veterans Health Care System Director confirms that the Chief and Assistant Chief of Medical Administration Service, along with the Compliance Officer, provide adequate oversight of the Health Information Management provider coding reviews.

Concur.

Target date for completion: March 29, 2019

Director Comments

The Director has confirmed that adequate oversight of provider coding reviews is accomplished by the Chief and Assistant Chief of Medical Administration Service, and the Corporate Compliance Officer. The role of the Corporate Compliance Officer is to ensure the annual provider coding audits are completed and the results are reported to stakeholders. The roles of the Chief and Assistant Chief of HIMS are to ensure that training is developed and provided, based upon the coding accuracy results. Additionally, CTVHCS added three Nurse Informatics positions to supplement the coding auditing program. These staff provide additional education to clinical staff using the coding audits to guide the areas of focus with individual providers.

RECOMMENDATION 5

The Central Texas Veterans Health Care System Director ensures clinic hours are sufficiently scheduled to maximize direct patient care and to achieve targeted productivity.

Concur.

Target date for completion: March 29, 2019

Director Comments

The CTVHCS Director agrees with this recommendation and corrective action has been initiated. The Chief of Psychology will review productivity reports provided by the Mental Health Program Analyst on a monthly basis. These reports will account for instances of double coding and duplicate visits. Additionally, CTVHCS will continue to use its Group Practice Manager to identify inefficient providers and clinics, partnering with their leadership to maximize their productivity and improve access to care.

RECOMMENDATION 6

The Central Texas Veterans Health Care System Director makes certain that all telehealth clinics follow VHA's scheduling policies by using the approved electronic scheduling system and assigns properly trained telehealth schedulers.

Concur.

Target date for completion: March 1, 2019

Director Comments

Only properly trained telehealth schedulers are allowed to schedule telehealth appointments. CTVHCS found that the primary issue was overuse of the Video-On-Demand function of the telehealth scheduling package by one psychologist. Corrective action has been initiated. Corporate Compliance will conduct audits to ensure compliance with this requirement.

RECOMMENDATION 7

The Central Texas Veterans Health Care System Director oversees proper disposal of the paper planner and secures patient information.

Concur.

Target date for completion: March 1, 2019

Director Comments

Psychologist X was instructed by the Chief of Psychology to shred the paper planner, and certified to the Chief of Psychology that it was done. Further corrective action has been initiated which will provide additional details and documentation of the proper disposal of the paper planner and to ensure the proper scheduling of all patients listed in the paper planner.

RECOMMENDATION 8

The Central Texas Veterans Health Care System Director makes certain the Chief of Psychology determines, before authorizing overtime, whether the requested services could be performed during normal working hours.

Concur.

Target date for completion: March 1, 2019

Director Comments

The Chief of Psychology has implemented a stringent pre-approval process for overtime. Before authorizing overtime, the Chief of Psychology reviews the requester's scheduled appointments and workload. There has been very little overtime approved since July 2018, most of it occurring because a Veteran showed up at the end of the day and required assessment and/or treatment.

For accessibility, the original format of these appendixes has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended

OIG Contact and Staff Acknowledgments

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