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**VA WHISTLEBLOWER'S PLIGHT DISCLOSES
MISMANAGEMENT OF \$40 MILLION
VA HEALTHCARE CENTER
HARLINGEN, TEXAS**

RESPONSE TO VA REPORT

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I have been asked to review the investigation, resulting from my complaint of Fraud Waste and Abuse at The Ambulatory Care Facility in Harlingen, Texas and the VA South Texas Coastal Bend Health Care System (VASTCBHCS). Once again I have been given the opportunity to review the responses made by the Veteran's Administration and make my final comments regarding my concerns. I do not believe that the Department of Veterans Affairs gave this issue a fair and honest review. They certainly spent a great deal of time inquiring into my complaints, however, the conclusions to which they have come as a result of the investigation all appear to be self-serving despite the clear facts that there were numerous problems which I had discovered and had relayed to the administration.

When I received the original report prepared by the VA, forwarded to me by the OSC, I made two specific observations beyond my disagreeing with the conclusions of the report. The first of these observations was that the people who participated in this investigation were not identified. We do not know who was testifying regarding each of the deficiencies that were examined. I requested that this omission in the report be corrected and it appears to have been reflected in this final report as a generic list with no specific attribution as to who made the comments. The other issue that I thought was relevant to my complaint, and to your review, was the dates that each of these "alleged" corrective actions occurred. That was not revealed nor resolved in the final report.

My remarks at the time I was directly involved with the ASC were honestly and fairly reported to the administration as early as October 2010. I had extensive experience in ambulatory care centers as is demonstrated in the package that accompanies this cover letter, and my concerns that everyone affiliated with this project except one nurse had ever been in a functioning Ambulatory Surgical Center or even an Operating Room Floor. I immediately noted there was a lack of sterilization areas, appropriate humidification systems, electrical systems with backup (especially in this area of the country where temperatures could go over 100 degrees with rolling black outs) and most importantly, there was absolutely no one from administration with the medical knowledge or medical understanding of what type of patient or surgery could be performed in an isolated, single structure ASC. As I explained to the administration involved, most Ambulatory Surgical Centers or Same Day Surgical wings, that have or had been built, are either attached to an existing hospital or built on the grounds of an existing hospital for emergency transfer. This group once again had no medical knowledge or insight of the dangers of a stand alone facility, especially with no specific emergency transfer policies in effect. This in itself could cause a serious morbidity or mortality to a patient to occur.

The VA report merely indicates that as of some date several months later, all these concerns were now "acceptable". The issue is when did they become acceptable? That question is not answered. The report needs to indicate whether refitting was required and if so at what expense. This facility had a ribbon cutting on February 02, 2011 and by the evidence the

report itself states, surgeries were not performed until July 2012. Clearly something was amiss. Clearly the VA patients were not properly served by this delay of over 17 months. It should also be noted, that as of the end of calendar year 2012, not one open surgical procedure has been performed in the operating room. This means that the procedures that are being performed on a limited basis, cataract extraction with lens placement and colonoscopies could have been done in a physician's office rather than the expenditure of a 40 million dollar structure.

Clearly the surgeons, whom the VA had unnecessarily and in some cases improperly hired, months before their skills were actually anticipated to be needed, continued in many instances to be unproductive and wasted precious financial resources during this extensive delay. However the Veterans Administration failed to acknowledge that there was anything at all wrong with the way that this facility was brought online. This report should have analyzed what benefits the VA actually received from these approximately 10 surgeons who were not performing or were doing "make work" projects for their \$200,000 dollar plus salaries.

My review of this report from the VA shows that they have attempted to defend their actions without explaining why there were these delays in bringing this facility on line. If the facility was properly designed, laid out and equipped as they suggest, then why was it not ready to perform surgery on patients until July 17, 2012. Something was wrong. Yet the VA has not acknowledged that they did anything wrong in this operation despite the facts saying otherwise. It seems that the delay itself established as a minimum waste if not an abuse.

During their minimal acknowledgement, the facts establish that they hired numerous surgeons much too early for this facility. It appears that in the vicinity of \$2 million dollars may have been wasted by the VA hiring surgeons 15 months in anticipation the facility's scheduled opening, and the keeping them on payroll for an additional six or seven months until they were actually needed. The argument that they had to hire people early to make sure they were available when needed is not really valid here when these sums of money were involved and more importantly, these were all local physicians.

Furthermore, it does not appear that they had difficulty hiring these surgeons a year early, what is it to say that they could not have hired them a month or two prior to the scheduled opening? Since the scheduled opening didn't result in immediate surgical procedures they probably could have waited the opening date or later to hire several of them. How can the VA not acknowledge that this was waste and abuse of the system?

A second illustration of the deficiency of this report is the manner in which my hiring and removal were conducted. There seems to be a consensus of opinion with the VA and OSC that I was hired for the purpose of primary care. That simply is untrue and is unsupported by the facts in the file and in my submission. During the period of my employment by the VA, three 5-Part-50-316 assignments were produced, as follows:

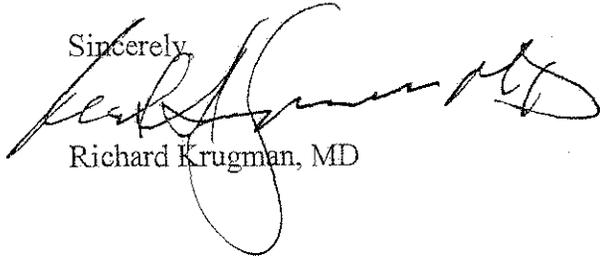
5-Part-50-316	dated 09/12/2010	Assignment Assoc COS Ambulatory Care
5-Part-50-316	dated 10/22/2010	Assignment Assoc COS Ambulatory Care
5-Part-50-316	dated 04/14/2012	Assignment Assoc COS Ambulatory Care

I invite you to look at these documents or exhibits (B7 to B9) in the Three Ring Binder I submitted to the OSC on January 17, 2013. It was both my intent and the intent of those that

hired me for me to command and make sure that this facility was functioning properly. Instead I was paid a significant sum of money for 10 months then placed on administrative leave for another 11 months while in the employment of the VA, and was not allowed to perform the duties for which I was hired. If they did not want me to run the ACS why did they keep me around for this period of time in a position that was not authorized? Again I submit that this is a further example of waste fraud and abuse in this system.

I sincerely hope that the reviewers of this package will carefully consider the submissions that I have made which are attached to this cover letter. I believe that in reviewing the VA report and my documentation you will see that this report is self-serving and fails to answer the questions. How much money was spent on this project, the facility, the surgeons who were not able to perform their duties, the expert who was hired to run the building who was allowed into it, and all the other acts of misfeasance or malfeasance that occurred? I believe that a congressional investigation of these events and acts identified in my allegations would be the only way that a truly independent review of what happened in Harlingen, Texas can occur. Relying on the VA to investigate themselves in this manner has only resulted in an opportunity for them to document their self-defense rather than to really examine errors that were made. I strongly urge that a separate and independent congressional review be made of this entire matter.

Sincerely

A handwritten signature in black ink, appearing to read 'Richard Krugman, MD', written in a cursive style. The signature is positioned above the printed name.

Richard Krugman, MD

SUMMARY OF FACTUAL FINDINGS IN VA REPORT THAT PROVES FRAUD WASTE AND ABUSE.

Although the report denies that fraud, waste and abuse occurred in the building and development of the ASC at Harlingen Texas, this report does confirm, as a minimum, that the following facts are correct and resulted in either fraud, waste of VA funds or abuse of management positions and/or the veteran's expecting health care from the facility. There is clear evidence of misfeasance here and critical questions remain.

1. Fact - Surgeons were hired up to 15 months prior to their intended start date and then kept on the pay role several more months before they could actually begin the work for which they were hired. They were used in non-productive capacities or were loaned out to other facilities that were already funded for their own employees. This reflects a waste of approximately \$2,000,000. The VA defends their actions by saying this was necessary without offering proof that these physicians could not have been hired in a more normal efficient manner. Hiring employees over a year early is simply not common practice. Their position is untenable and this is evidence of extreme waste. Why was this allowed to continue and not sanctioned by higher headquarters? Why should this be excused as the report attempts to do.
2. Fact - The ASC was opened in February 2011 and no surgeries other than minor procedures, which could have been accomplished in offices, were conducted until August 2012. Dr. Krugman has alleged that the facility and equipment were not suitable or functional as of October 2010. If all the equipment was obtained in a timely manner as the report suggests, why were surgeries not begun in February 2012? If everything was correct as the report suggests, the failure to utilize the facility immediately was itself a waste and abuse. The VA report does not indicate when the facility was brought up to standards or why there was a significant delay in it functioning as intended. This delay caused patients to be treated at other VA facilities at their inconvenience, or to be treated by civilian facilities at unnecessary expense. This unnecessary delay has neither been addressed nor explained.
3. Fact – Dr. Krugman was hired as the Associate Chief of Staff for the Ambulatory Care Center as reflected on his various SF Forms 50. He was not utilized in that position yet he was paid for a total of 21 months before and after his removal on the basis of his being given other duties for which he was not qualified. This was clearly a waste and an abuse of the personnel hiring system. Why was he not utilized as intended and as his official personnel documents indicate?
4. Fact – The VA at Harlingen had an expert in operating a facility of this kind. They ordered him not to go into the facility and assigned other duties. No one has ever provided a rationale for this treatment. Someone must ask whether proper utilization of Dr. Krugman could have saved some of these wasted funds and gotten service to patients in this \$40,000,000 more quickly than 19 months after it was opened.

5. Fact - Surgeons were not performing duties, patients were sent to private facilities rather than the new VA facility, patients were transported by ambulance to San Antonio, some refitting or rehabbing activity must have been occurring in the facility between February 2011 and July 2012 to make it functional, yet the VA has not acknowledged any waste or fault in any of these area. How much did all of this delay cost the US taxpayers? We all need to have this answer, and the VA is not providing it.

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I would like to remind the OSC that the Veterans Administration's rebuttal of OSC File No. D1-11-3558, dated March 2012 and re-delivered to the OSC January 2013, is now more than 1 ½ years since my dismissal date as the Associate Chief of Staff, Ambulatory Care on June 14, 2011.

The Veterans Administration continuously fails to accurately disclose that I, Richard Krugman, M.D. had reported multiple facts which would be considered Fraud Waste and Abuse at that time. If subsequently there was a cover up, a fabrication of files, a retro build of the ambulatory surgical center, hiding the true amounts owed to the private sector (who subsequently refused to see Veteran Patients) this is not the point of this investigation.

The paper trail which was created / left by the arrogance of the VA, paints a completely different picture. I will try to briefly summarize the inaccuracies of their rebuttal and use the 3 ring binder (3 ring binder presented to OSC January 17, 2013) as the verification of my points.

In the Executive Summary, it states that, "The Deputy Undersecretary for Health for Operations and Management requested that a Fact Finding Team Investigate a complaint lodged with the Office of Special Counsel by Richard Krugman, M.D. a whistleblower at the Department of Veteran Affairs, VA Texas Valley Coastal Bend Health Care System (VATVCBHCS) in Harlingen, Texas. The whistleblower provided the following broad categories of allegations: inadequate facilities at Harlingen Health Care Center; surgical staff hired but unable to practice; patient care concerns; discontinuation of patient records in advance of the Joint Commission visit; and outstanding VA debt to private providers compromising patient care. The Team conducted a site visit at the Health Care Center on February 8-9, 2012.

As the Deputy Undersecretary states, Richard Krugman, M.D. a whistleblower at VATVCBHCS in Harlingen, Texas provided broad categories of allegations. The very first sentence in the Veteran Affairs response is saying Richard Krugman, M.D. is a whistleblower. Why was I not given the protection of a whistleblower by the appropriate authorities? Especially after the Senate passed The Whistleblower Protection Enhancement Act by a unanimous consent on November 13, 2012.

During my Tenure with the Veterans Administration, I was physically and emotionally attacked, racially discriminated against, and a pristine 25-year medical career destroyed by the administration of VATVCBHCS. All because I believed that the veterans of South Texas deserved the best medical care possible. We sit here comfortably and free because a group of individuals have given their lives, their soul and parts of their bodies to allow us these freedoms. Does it not stand to reason that our veterans therefore deserve the best quality of care The United States of America can give"?

By presenting this paper trail (3 ring view binder which was presented to the Office of Special Counsel on January 17, 2013) my allegations are irrefutable. Nevertheless, the Team (VACO fact finding Team consisting of two Network Chief Medical Officers, a Chief of Staff, Director VHA Healthcare Engineering and 2 Staff Engineers) gives no written documents to support their findings.

How can you expect employees of the VA to give a true and fair unbiased evaluation, when there may exist fear of retribution if negative findings are given?

How does a biased investigative body or Team actually give a factual response? What is important to reference is not what the Team found, but the paper work I presented. The Team came to investigate over a year after my complaints. The Team interviewed "company" personnel who had a vested interest in continuing their career with the Veterans Administration.

On page 7 of their response, it is stated the Team interviewed 31 individuals in person (except as otherwise noted). The following names I present are either responsible or knowledgeable of the Fraud that occurred during that period of time. The 26 names I present are actually followed by an e-mail paper trail (**exhibits**) that is included in the 3 ring binder. Individuals with no listed exhibit numbers wish not to have their exhibits made public at this time.

- 1/ Les Cook CPCS, Program Specialist, credentialing and Privileging STVHCS (**exhibit B-12 Through B-17**) (**exhibit B-5**)
- 2/ Dr. Alan Dinesman, Service Chief of Compensation and Pension STVHCS (**exhibit B-16 To B-17**)
- 3/ Dr. Daniel Martinez, cardiothoracic surgeon (**exhibit B-18**)
- 4/ Dr. Daniel Brown, CMO McAllen OPC, Letter of recommendation (**exhibit B-31**)
- 5/ Dr. Pamela Fieldus, Chief Health Informatics Officer, letter of Recommendation (**exhibit B-30**)
- 6/ Mr. David Fell, R.Ph, Chief, Pharmacy Service, letter of recommendation (**exhibit B-29**)
- 7/ Dr. Robert Lozano, CMO Harlingen OPC, letter of recommendation (**exhibit B-32**)
- 8/ Salomon Torres, District Director, US Rep. Ruben Hinojosa (TX-15) (**exhibit VA Whistleblower's Plight Discloses**)
- 9/ Kevin Buccola, National Healthcare Recruitment Consultant (**exhibit B-30**)
- 10/ Stephen Castillo, Account Executive, Draeger (**exhibit B-25 through B-28**) (**exhibit A-35 through A-38**)
- 11/ Abel Gonzales, RN, Chief of SPD (**exhibit C-7 through C-9**) (**A-28 through A-30**)
- 12/ Dr. Ruben Salinas, Ophthalmologist (**exhibit C-11 through C-14**)
- 13/ Douglass Matney, Group Vice President of UHS South Texas Region (**exhibit A-43 Through A-46**) (**exhibit A-34**) (**C-19 through C-20**)
(Attachment of most recent e-mail dated Sunday January 27, 2013)
- 14/ Mali Shabazz
- 15/ Guy Unger (regarding original sterilization rooms with problems with Temp and Humidity)
- 16/ Sarah Bass, Operations Administrator (relating to temp and humidity and Power outage) (**exhibit C10**)
- 17/ Darlene Rider, Mainline Medical (**exhibit C-14**)
- 18/ Patient Roy Stamper / U.S. Rep. Blake Farenthold, R-Corpus Christi (**exhibit A-**

14 through A-16)

- 19/ Arturo "Treto" Garza (**exhibit A-17 through A-18**)
- 20/ Roxanna Godinez, Business Development, South Texas Health Care System
- 21/ Allegra Garcia-Cantu, MD
- 22/ Dr. Julianne Flynn, COS, STHCS
- 23/ Dr. Candace Downing, CMO Harlingen OPC
- 24/ Mr. Charles Dubois, Administrative officer, Surgical and Specialty Services
- 25/ Dr. Hilda Thompson, Pathology/Laboratory
- 26/ Dr. Ann McCracken, Acting Chief of Surgery
- 27/ Congressman Ruben Hinojosa (D-15th) (**exhibit A-5 through A-11**)
- 28/ Mr. Jeffery Milligan, (SES) (**exhibit B-23**)

The VACO investigating team (2 network CMOs, a COS, Director of VHA engineering, 2 engineers and an HR consultant) had a site visit on February 08, 2012, 8 months after my dismissal and over 1 year to my restriction of not visiting the facility.

VACO has clouded the issue of my true position and duties at VASTCBHCS with fraud and falsifying documents. They have basically stated that I was hired as a primary care physician (internal medicine) and anything that I may have reported on, was out of my scope of knowledge or expertise. The following documents listed below are in their original forms in the 3 Ring Binder. (**Exhibit B-5 through B-9**)

1/ VA Form 10-2543

Internship/Residency:	Pediatrics, Mount Sinai School Of Medicine, N.Y., N.Y.
Residency:	Anesthesiology, Hahnemann University Hospital, Phil., Pa.
Fellowships:	Cardiothoracic Anesthesia, Hahnemann University Hospital, Phil., Pa.
	Anesthesiology/Pain Management, Duke University School of Medicine, Durham, N.C.
Board Certification:	Anesthesiology, Indefinite

2/ VA Form 10-0432A

Compensation Panel Action; Recruit ACOS for Ambulatory Care

- 3/ 5-Part-50-316, Dated 09/12/2010, Assignment Assoc COS Ambulatory Care
- 5-Part-50-316, Dated 10/22/2010, Assignment Assoc COS Ambulatory Care
- 5-Part-50-316, Dated 04/14/2012, Assignment Assoc COS Ambulatory Care

SF-50 ACOS Ambulatory Care (never mention of Primary Care, Internal Medicine, Family Practice)

As you can see from VA forms 10-2534, 10-0432A, and 5-Part-50-316 produced 3 different time periods, states that at no time was I ever granted medical privileges. I must repeat this once again. At no time was I ever granted medical privileges from VASTCBHCS. Hence, it would be against the law to practice medicine. If I was to be granted any privileges it would be under my specialty, Anesthesia. I was an Administrator and developer of Ambulatory Surgical Centers. They still claim I was hired for primary care. All documents disprove this fact.

According to Dr. Aguilar, I reported to Dr. Brown, CMO of McAllen Outpatient Clinic for two afternoons to learn everything on consults and the CPRS system. Time wise it was two abridged afternoons. Secondly, what should have been said is, I was sent to McAllen OPC for instruction with Dr. Brown regarding CPRS. I was taught technically how to use this specific computer program. No one can teach Internal Medicine in 5 hours. A residency in Internal Medicine with a specialty takes 5 years. Obviously I was not sent to Dr. Brown to learn how to do consults or referrals. This was definitely at of my scope of residency and fellowship training. More importantly, I was never credentialed by VASTCBHCS to practice medicine. This was fraud and Dr Aguilar was told this many times. If you extrapolate this fact, Dr. Aguilar jeopardized hundreds of patients with his actions.

VASTCBHCS consistently states that I never gave suggestions or pathways to improve the facility. That in itself states that they were well aware something was wrong and the fact that the administration had no medical or administrative knowledge on bringing a facility like this through Joint Commission or the running of a successful Ambulatory Surgical Center. Once again a paper trail shows that I worked hand in hand with Abel Gonzales, RN chief of SPD, Guy Unger, Charles Dubois, Stephen Castillo, just to name a few. Even spoke with and retained the multiple paper trails to Raul Aguilar, Jeffrey Milligan, Dr Martinez and even the Chief Medical Officer of VISN 17, Dr Wendell Jones. The suggestions contained everything from my fear of the quality of patient care to the construction and development of the ASC being inadequate.

In the following pages will be a response to three important issues that VACO has declared that are allegations which were not substantiated. Remember the actual paper trail which is in the 3 ring binder proves that whatever VACO states is contrary to the actual e-mails that are provided,

In the VACO report "Outstanding VA debt to private provider's compromises patient care."

VACO states that the allegation that this debt has resulted in patient care being compromised is not substantiated.

Please review document (A-14 to A-18) titled VA works to resolve problems after doctors, veterans complain about sluggish reimbursements.

Once again please review (exhibit A-13), STHS is owed greater than \$14,000,000 and Valley Baptist is owed \$8,000,000 plus. Reported from the office of U.S. Rep Ruben Hinojosa (TX-15), Douglas Matney at STHS, and U.S. Rep. Blake Farenthold, R-Corpus Christie. Further documentation and complaints are presented in the 3 ring binder. These numbers just represent what is owed to the different Health Systems. It is never mentioned, the countless millions of dollars owed to the individual physicians or physician groups that partake in the care of the Veteran Patients.

Presently the Veterans Administration is stating that these financial matters have been resolved or never existed. An e-mail from Douglas Matney, Vice President – Acute Division Group for South Texas Health System was received on **Sunday, January 27, 2013**. This e-mail is presented in its entirety at the end of this response. Once again VASTCBHCS falls short in telling the truth. As I discussed previously, all statements that I make or made in my presentation are substantiated by an original paper trail, found in the 3 Ring Binder.

Discontinuation of Patient records in advance of Joint Commission evaluation.

Prior to inspection from the Joint Commission which was requested by San Antonio for a complete separation of systems, roughly 1,800 patient records were removed/deleted intentionally from the system. This demonstrates the discontinuation of patient care with removal from the system. It is said that the patients fell through the cracks of the separation or transfer of data to the new CPRS system. No matter what, 1,800 patient records were **purposely deleted** as a clean-up before the inspection. It was answered by VACO that Dr Aguilar reviewed the charts medically and then deleted. Once again, this falls somewhere short of the truth. Firstly, Dr Aguilar never reviewed the patient records (how do you review 1,800 records in a 24 hr period), but his Administrative Officer, (AO) Marissa Alamilla an employee with absolutely no medical training, authorized each and every deletion. This was all done to show a continuance of care. Once the inspection was completed, patient records were manually re-entered when a patient did return. (Documented by the 1hr appointments and the date of re-entry). If we review (**exhibit A-47 to A-48**) one of just many e-mail transcripts, it shows Administrative note, signed by Marisa Alamilla. I do not see a physician's signature, notation or review and total deletion of 1,800 patients in a 24hr period. I would title this Fraud and Abuse, but I think the expression Medical Malpractice is what the Public would call it after seeing it in print.

Inadequate Facilities at Harlingen Health Care Center and Ambulatory Surgical Center.

VACO returned from their inspection with statement, "Allegations not substantiated, recommendations – none.

Once again the ideology of this report is not what the condition of the building was or is 1 ½ years after my whistle blowing, but what it was the day I left. I should hope there were improvements made. But, when were the improvements made, at what cost as a retro-fit and why as of recent, there still has not been done an open surgical case performed. They do concede that they started with colonoscopies and cataract removals. All procedures which could have been done in a physician's office, but a \$40,000,000 dollar building?

To remind everyone, I was separated from the Veteran's Administration on June 14, 2011, and my separation was due to what I discovered / uncovered during my time of employment September 12, 2010 till June 14, 2011, not what is occurring presently or on the last VACO inspection dated February 8-9, 2012. Also that I was hired as a primary care physician. (As we see from the 3 ring binder with actual e-mails and VA documentation that this is truly false, fraudulent and deceptive.

Let me start with this statement, Twelve months after the ribbon cutting, five months after the VACO inspection or in total, seventeen months after the ribbon cutting, **NOT ONE OPEN SURGICAL CASE HAS BEEN PERFORMED.**

In fact the original Chief of Surgery, Dr Daniel Martinez, his AO officer Mr. Charles Dubois both resigned in April/May 2011. The Acting Chief of Surgery Dr Ann McCracken and DR Hilda Thompson, Chief of Pathology also left the system in disgust.

It has also been said that I never discussed the problems with administration during my tenure. However, E-mails dated as far back as February 2011 disprove this (**exhibit A-28 to A-30**). It also shows that I contacted VISN headquarters with my concerns regarding what was happening in South Texas as far back as December 2010. Exhibit (A-35 to A-37) show the administration with a lack of knowledge of setting up ASC's didn't even begin ordering equipment until 6 months after the ribbon cutting and wasn't placed in the facility until November 2011. (**Exhibit A-39 to A-41**) show that one of the surgeons hired to perform surgery became frustrated with these actions. Document (**exhibit A-43 to A-44**) demonstrated the failure of this project to the general population, veteran patients and congressional officials.

I would like to conclude with the two most recent developments that further validate the veracity of my allegations and the continual falsification of information by the Veterans Administration to the Congress, their representatives and their constituents, all who have been complaining of poor health care from the Administration and their facilities.

The first, is the most recent report by the Office of the Inspector General, OIG Report # 11-02548-291, dated January 10, 2013, with the title, **"Report Highlights: Review of VHA's South Texas Veterans Health Care System's Management of Fee Care Funds."**

Why We Did This Audit

Through the fee care program, eligible veterans may receive medical care from non-VA providers when they cannot easily obtain care at VA medical Facilities. We evaluated the merit of allegations that VASTVCBHCS authorized several million dollars in fee care, although it did not have sufficient funds obligated and available to pay for the services the veterans received.

What We Found

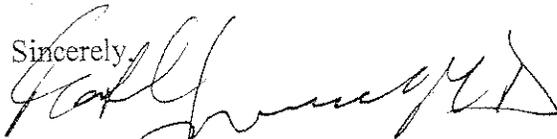
We substantiated the allegation.

What makes this important is that they did not have the sufficient funds to pay the roughly \$30,000,000 dollars owed to the private sector, but with the separation from San Antonio needing a separate CPRS system and the incorrect building of an Ambulatory Surgical Center the debt became greater and the only way to either ameliorate or hide this amount from the appropriate elected officials was to provide either inadequate care or no care to the veteran patient.

Presently the Veterans Administration is stating that these matters have been resolved or never existed. This has been confirmed to not be the case, as evidenced by the newest e-mail and rejoinder, dated **January 27, 2013**, by the senior member of South Texas Health Care System, as follows:

Thank You

Sincerely,



Richard Krugman, M. D.

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



Veterans Health Administration

*Review of
South Texas Veterans
Health Care System's
Management of Fee Care
Funds*

January 10, 2013
11-04359-80

ACRONYMS AND ABBREVIATIONS

CFO	Chief Financial Officer
OIG	Office of Inspector General
STVHCS	South Texas Veterans Health Care System
VA	Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

To Report Suspected Wrongdoing in VA Programs and Operations:

Telephone: 1-800-488-8244

E-Mail: vaoighotline@va.gov

(Hotline Information: <http://www.va.gov/oig/hotline/default.asp>)



Report Highlights: Review of VHA's South Texas Veterans Health Care System's Management of Fee Care Funds

Why We Did This Audit

Through the fee care program, eligible veterans may receive medical care from non-VA providers when they cannot easily obtain the care at VA medical facilities. We evaluated the merits of an allegation that the South Texas Veterans Health Care System (STVHCS) authorized several million dollars in fee care during FYs 2009 and 2010 although it did not have sufficient funds obligated and available to pay for the services the veterans received.

What We Found

We substantiated the allegation, determining that STVHCS authorized \$29 million in fee care during FYs 2009 and 2010 without sufficient funds to pay for the services received by veterans. STVHCS did not ensure clinical and fee staff complied with required steps for authorizing fee care and fee staff also did not timely process fee care payments. This occurred because STVHCS clinical and fee staff lacked defined roles and responsibilities, sufficient training, and adequate supervision.

In addition, management in neither STVHCS nor Veterans Integrated Service Network (VISN) 17 had effective oversight mechanisms in place to ensure sufficient funds were available to pay for the fee care received by veterans. STVHCS lacked visibility over these unpaid claims when vendors' invoices were received until fee staff researched, summarized, and processed this information dating back to FY 2009.

These processing deficiencies resulted in a shortfall of approximately \$29 million needed to cover a significant backlog of unpaid vendor claims. In addition, STVHCS incurred avoidable interest penalties when it did not make timely payments for contracted fee services subject to the Prompt Payment Act.

What We Recommended

We recommended the Director of VISN 17 establish procedures, including clear roles and responsibilities, to ensure clinical and fee staff process fee care authorizations properly and pay vendor invoices timely. The STVHCS Director should ensure staff receive periodic training on fee care procedures. Finally, we recommended the VISN 17 and STVHCS Directors establish oversight mechanisms to ensure effective control of fee care funds.

Agency Comments

The VISN 17 and STVHCS Directors concurred with our finding and recommendations and provided appropriate action plans. We consider these planned actions acceptable and we will follow up on the implementation of the corrective actions.

A handwritten signature in black ink, appearing to read "Linda A. Halliday".

LINDA A. HALLIDAY
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Objective	<p>On September 6, 2011, the Office of Inspector General (OIG) received an anonymous allegation that South Texas Veterans Health Care System (STVHCS) authorized several million dollars in fee care in FYs 2009 and 2010 although it did not have sufficient funds obligated and available to pay for the medical services received by veterans. We conducted this review to assess the merits of the allegation.</p>
Health Care System	<p>STVHCS is part of Veterans Integrated Service Network (VISN) 17. STVHCS includes the Audie L. Murphy VA Hospital in San Antonio, TX, and the Kerrville VA Hospital in Kerrville, TX. It also has Community Based Outpatient Clinics located in Beeville, Del Rio, Kingsville, New Braunfels, San Antonio, Seguin, Uvalde, and Victoria, TX. According to VISN and STVHCS officials, STVHCS had a total budget of approximately \$623 million, with over \$65 million budgeted for its fee care program in FY 2009. The STVHCS FY 2010 budget totaled approximately \$646 million, with over \$83 million budgeted for its fee care program.</p>
Program Overview	<p>The fee care program helps eligible veterans receive medical care from non-VA providers when they cannot easily obtain the care at VA medical facilities. The program pays non-VA costs when VA is unable to provide specific treatments or when a veteran's residence is so remote that it would be too costly to transport the veteran to a VA facility for medical care. Fee care may include dental services, outpatient care, inpatient care, emergency care, and medical transportation. VA requires pre-authorization for non-emergency inpatient and outpatient fee care.</p>
Prior OIG Audit	<p>In November 2011, we substantiated an allegation that the Phoenix VA Health Care System experienced a budget shortfall of \$11.4 million because it mismanaged its fee care funds (<i>Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System</i>, Report No. 11-02280-23). Authorization procedures were so weak that the Health Care System processed about \$56 million of fee claims during FY 2010 without appropriate review. Further, the Health Care System did not have adequate procedures to obligate sufficient funds to ensure it could pay its commitments for non-VA fee care services.</p>
Other Miscellaneous Information	<p>Appendix A includes details on the scope and methodology for this review. Appendix B provides comments from the VISN 17 Director. Appendix C provides comments from the STVHCS Director on a draft of this report.</p>

RESULTS AND RECOMMENDATIONS

Allegation **South Texas Veterans Health Care System Incurred Budget Shortfalls of \$29 Million in FYs 2009 and 2010**

We substantiated the allegation that STVHCS inappropriately authorized several million dollars in medical care purchased from non-VA providers in FYs 2009 and 2010. STVHCS did not have sufficient funds obligated and available to pay for the medical services the veterans received. Program management was ineffective because STVHCS officials did not have adequate controls in place. Specifically, STVHCS did not ensure that clinical and fee staff followed the required steps needed to process authorizations for fee care. Fee staff also did not timely process payments, which created a significant backlog of unpaid vendor claims. This occurred because clinical and fee staff lacked defined roles and responsibilities, sufficient training, and adequate supervision. We also found that neither STVHCS nor VISN 17 had effective oversight mechanisms in place to ensure funds were available and obligated to pay for fee care medical expenses.

STVHCS lacked visibility over these unrecorded liabilities until fee staff researched, summarized, and processed the unpaid vendor claims dating back to FY 2009. Ultimately, STVHCS officials had to request additional funding from VHA's Chief Financial Officer (CFO) to cover a combined budget shortfall of approximately \$29 million for FYs 2009 and 2010 so that fee staff could process the authorizations and payments needed to eliminate the backlog. In addition, STVHCS incurred avoidable interest penalties when it did not make timely payments for contracted fee services subject to the Prompt Payment Act.

Management of Fee Care Funds

According to VHA's National Fee Program Office, each service line, such as audiology, dental services, or radiology, at a VA medical facility is responsible for obligating, tracking, and expending the funds in its fund control point. Fund control points are accounts used to manage the funds allocated for fee care expenditures.

At STVHCS, clinical service chiefs and Medical Administration Service personnel serve as fund control point officials. Upon receipt of funds via budget allocations, these officials obligate initial amounts for fee care for each fund control point. Then, clinical staff initiate referrals for veterans to obtain non-VA health care as appropriate. Fee staff create the related authorizations for the use of fee care funds. As they process fee care payments, fee staff adjust the authorizations to reflect the actual costs for the fee care. On an ongoing basis, fund control point officials monitor their fund balances to ensure that enough money has been obligated and remains

available to pay for fee care services rendered. As necessary, service line officials take steps to increase their obligations when authorized fee care costs exceed available balances.

***Backlog of
Unpaid Vendor
Claims for Fee
Care***

An April 2010 internal report prepared by the STVHCS's Compliance Officer indicated that STVHCS had not paid vendor claims for fee care timely since at least late 2006. The report stated that while investigating patient and vendor complaints from late 2006 to early 2007, STVHCS discovered a sizeable backlog of vendor claims awaiting payment. Over the next three years, STVHCS received an increasing number of similar complaints. In FY 2010, the VISN 17 CFO made multiple unsuccessful attempts to determine the extent of the backlog by consulting with the STVHCS's Fee Section Chief.

Ultimately, the CFO requested that VHA's National Fee Program Office perform an assessment of the Fee Section's roles, responsibilities, and processes in April 2010. The assessment team determined that in addition to not paying vendor claims timely, fee staff were not scanning vendor claims into the Fee Basis Claims System on a daily basis so that the STVHCS could monitor whether it was paying vendors timely.

After receiving the assessment performed by the National Fee Program Office, STVHCS focused its efforts on eliminating the backlog of vendor claims. According to the STVHCS Fiscal Service Chief, as fee staff researched, summarized, and processed the backlog of vendor claims for payment, they discovered that in many instances, clinical and fee staff had not always taken the required steps to create authorizations for fee care. In some cases, fee staff were unaware of the authorizations because clinical staff failed to document fee consults in the Computerized Patient Record System. In other instances, fee staff simply did not establish the authorizations in the fee system.

In addition, STVHCS officials found that they did not have sufficient funds available to pay all of the vendor claims. Each vendor claim had to be reviewed to determine whether it had been authorized and was valid for payment. Duplicate claims also had to be identified to prevent processing improper payments.

***Factors
Contributing
to the Shortfall***

According to the assessments performed by the STVHCS Compliance Officer and the National Fee Program Office, fee staff lacked defined roles and responsibilities, sufficient training, and adequate supervision. The STVHCS clinical staff were lacking in these areas as well, as evidenced by the inappropriately processed authorizations.

In addition, STVHCS did not have effective oversight mechanisms in place to ensure that its fee care program was operating effectively. During the time period of the allegation, the STVHCS Compliance Officer lacked access

to the records needed to review the fee care program. STVHCS officials corrected this issue prior to our review by granting the Compliance Officer electronic access to the STVHCS fee care records so that this official might provide the oversight that the program needed.

Further, VISN leadership told us that they relied on inaccurate information self-reported by the STVHCS in Fee Stoplight Reports without performing additional verification or validation of the data reported. The self-reported information included timeliness data on fee care claims processing. For example, although fee staff had a significant backlog of delinquent vendor claims, the Fee Stoplight Reports generally indicated that staff were processing payments within 30 days of receipt of the claims as required. In spite of vendor complaints, VISN officials did not question this information.

***Impact of
Missing
Authorizations
and
Delinquent
Payments***

Because of the lack of oversight over the status of fee care funds, STVHCS incurred a budget shortfall. According to VHA guidelines, STVHCS fund control point officials are required to monitor whether adequate fee care funding is available by comparing obligated amounts to authorized amounts and completed transactions to ensure sufficient funds have been obligated to cover estimated expenses. However, unprocessed authorizations and delinquent payments of vendor claims resulted in unrecorded liabilities over which STVHCS lacked visibility.

Ultimately, STVHCS officials had to request additional funding of approximately \$29 million from the VHA CFO to pay the backlog of vendor claims. In addition, STVHCS incurred avoidable interest penalties when it did not make timely payments for contracted fee services subject to the Prompt Payment Act. VHA policy requires that 90 percent of all non-VA claims for fee care be processed within 30 days of the date the claim is received by the facility. Additionally, payments for contracted fee services must comply with the Prompt Payment Act. Accordingly, facilities are required to pay interest penalties when they do not make timely payments to vendors. With proper management, these expenses can be avoided.

These officials also took steps to address their fee care program weaknesses. In January 2012, according to the VISN CFO and the STVHCS Fiscal Service Chief, both the VISN and the STVHCS were in the process of revising their fee care procedures with the objective of preventing future budget shortfalls. VISN officials had begun developing standard operating procedures to define the fee care roles and responsibilities of clinical and administrative staff.

Further, to prevent a future backlog of claims, VISN officials told us that they established a new procedure whereby all vendors are instructed to mail their claims to the VISN's consolidated mail unit in Bonham, TX, where VISN staff date-stamp and scan the claims into the Fee Basis Claims System daily. According to STVHCS officials, STVHCS began assigning

workloads to fee staff by type of care, such as inpatient or outpatient, and alphabetically by patient name. Such measures facilitated the ability to track each staff member's performance in paying claims promptly.

VISN officials and the STVHCS Fiscal Service Chief also stated that they created several reports to help them monitor the fee care program. For example, the Fee Checkbook allows the STVHCS to track how much funding is available in each fund control point. The Fiscal Service Chief developed the report to overcome a system limitation—the inability of the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement system to capture outpatient authorizations. Accordingly, the report now facilitates the Fiscal Service Chief in comparing obligated amounts with authorized amounts and determining whether adequate funding has been obligated to cover estimated expenses. STVHCS management uses a Workload Report to monitor the productivity of each member of the Fee Section. Further, management uses an Aging Report to minimize the number of vendor invoices that are more than 30 days old.

Conclusion

We substantiated the allegation, determining that STVHCS authorized \$29 million in fee care during FYs 2009 and 2010 without sufficient funds to pay for the services received by veterans. Fee care program management was ineffective because STVHCS officials did not have controls in place to ensure that sufficient funds were available and obligated to pay for fee care medical expenses. Specifically, STVHCS did not ensure that clinical and fee staff followed the required steps needed to process authorizations for fee care. Fee staff did not timely process payments, which created a significant backlog of unpaid vendor claims. In addition, neither STVHCS nor VISN 17 had effective oversight mechanisms in place.

As a result, STVHCS lacked visibility over these unrecorded liabilities until fee staff researched, summarized, and processed the unpaid vendor claims starting in FY 2010. Ultimately, STVHCS officials had to request additional funding from VHA's Chief Financial Officer (CFO) to cover a combined budget shortfall of approximately \$29 million for FYs 2009 and 2010 so that fee staff could process the authorizations and payments needed to eliminate the backlog. In addition, STVHCS incurred avoidable interest penalties when it did not make timely payments for contracted fee services subject to the Prompt Payment Act.

VISN and STVHCS officials were in the process of implementing corrective actions to strengthen the control environment for the STVHCS fee care program. Due to the timing of the implementation of these actions, we did not validate their effectiveness. However, these corrective actions, in conjunction with sustained management attention, should improve STVHCS's ability to manage its fee program, and more specifically, its fee care funding effectively.

Recommendations

1. We recommended the Director of the Veterans Integrated Service Network ensure standard operating procedures clearly define roles and responsibilities and the procedures required for clinical and fee staff to properly process authorizations for fee care.
2. We recommended the Director of the Veterans Integrated Service Network ensure standard operating procedures clearly define roles and responsibilities and the procedures required for fee staff to process payments of vendor invoices timely.
3. We recommended the Director of the South Texas Veterans Health Care System ensure clinical and fee staff receive periodic training on fee care procedures.
4. We recommended the Director of the South Texas Veterans Health Care System establish independent oversight mechanisms, such as periodic audits or reviews by the Compliance Officer, to ensure that newly established procedures at the South Texas Veterans Health Care System are followed to properly control and manage funds for its fee care program.
5. We recommended the Director of the Veterans Integrated Service Network establish independent oversight mechanisms, such as periodic audits or reviews, to ensure that procedures for properly controlling and managing fee care program funds are followed at the South Texas Veterans Health Care System.

**Management
Comments
and OIG
Response**

VISN 17 is establishing a Non-VA Care Coordination Unit at each of its health care systems to ensure that clinical and fee staff process authorizations properly. These units will be fully operational by July 31, 2013. VISN 17 has developed standard operating procedures for the fee care program and will ensure that all staff receive annual training on the new procedures. These completed actions effectively close recommendation 2. STVHCS fee staff must complete 18 fee program-related courses annually and clinical staff performing fee program duties have also been assigned fee program training.

Further, STVHCS is establishing a fee program review process for its Compliance Office to perform. VISN 17 is hiring fee auditors to perform audits of the fee program. Finally, VISN 17 will perform monthly audits of 15 randomly selected fee bills to ensure staff are complying with newly established processes. We consider these completed and planned actions acceptable and we will follow up on their implementation. Appendixes B and C contain the full text of the VISN 17 and STVHCS Directors' comments.

Appendix A Scope and Methodology

We performed our review from October 2011 through August 2012. We conducted site visits to the South Texas Veterans Health Care System (STVHCS) and Veterans Integrated Service Network 17 (VISN 17). We focused our review on assessing the merits of an allegation that STVHCS authorized several million dollars in non-VA fee care in FYs 2009 and 2010 although it did not have sufficient funds available to pay for the medical services received by veterans.

To accomplish our review, we interviewed STVHCS officials responsible for administering and overseeing the non-VA fee care program. We also interviewed officials from VISN 17, who were responsible for providing oversight of STVHCS' fee care program. We researched Federal appropriations laws and VA guidance on how to manage non-VA fee care funds. Finally, we obtained and evaluated documentation relevant to the allegation.

Data Reliability We did not rely on computer-processed data to address our review objective. Accordingly, we did not assess the reliability of computer-processed data.

Government Standards We conducted our review in accordance with the Council of Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

**Appendix B Veterans Integrated Service Network 17 Director's
Comments**

**Department of
Veterans Affairs**

Memorandum

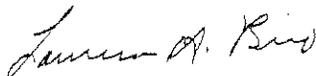
Date: December 18, 2012

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

Subj: Draft Report for the Review of South Texas Veterans Health Care
System's Management of Fee Care Funds 2011-04359-R6-0243

To: Director (53B), Audits and Evaluations Division, Office of Inspector
General (OIG), Dallas, TX
ATTN: Mario Carbone, Jehri Lawson

1. Thank you for allowing me to respond to this Draft Report for the Review of South Texas Veterans Health Care System's Management of Fee Care Funds 2011-04359-R6-0243.
2. We concur with the recommendations and have begun to implement corrective actions.
3. If you have further questions regarding this investigation, please contact Denise B. Elliot, Health System specialist at 817-385-3734.



LAWRENCE A. BIRO
Network Director

cc: Felicia Stephens

Appendix C South Texas Veterans Health Care System Director's Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 17, 2012

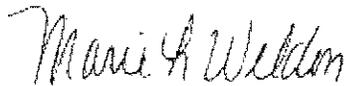
From: Director (10N17), STVHCS, 7400 Merton Minter Blvd., San Antonio, TX
78229-4404

Subj: Draft Report for the Review of South Texas Veterans Health Care
System's Management of Fee Care Funds 2011-04359-R6-0243

To: Director (53B), Audits and Evaluations Division, Office of Inspector General
(OIG), Dallas, TX
ATTN: Mario Carbone, Jehri Lawson

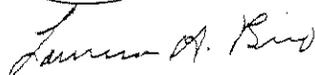
Thru: Network Director, VA Heart of Texas Health Care Network, Arlington, TX
(10N17)

1. Thank you for allowing me to respond to this Draft Report for the Review of South Texas Veterans Health Care System's Management of Fee Care Funds 2011-04359-R6-0243.
2. We concur with the recommendations and have begun to implement corrective actions. Included are the action plans with supporting documentation.
3. If you have further questions regarding this investigation, please contact Mr. Andrew T. Garcia, Chief, Fiscal Service at 210-617-5300, extension 68300 or via e-mail at Andrew.Garcia@va.gov.



MARIE L. WELDON, FACHE
Director

Approved Disapproved



Lawrence A. Biro
Network Director

VISN 17 and South Texas Veterans Health Care System (STVHCS)

Action Plan

OIG Draft Report, Review of South Texas Veterans Health Care System's Management of Fee Care Funds

Project No. 2011-04359-R6-0243

1. We recommend the Director of the Veterans Integrated Service Network ensure standard operating procedures clearly define roles and responsibilities and the procedures required for clinical and fee staff to properly process authorizations for fee care.

Director, VISN 17 Response: Concur.

We are establishing a Non-VA Care Coordination Unit at each of our Health Care Systems which follows the guidelines set by CBO for authorization processing. We have already started the process at each of our Health Care Systems and will be fully operational in FY 13. We have also set up a reporting system for authorizations which monitors when authorizations are entered.

Target Date: The Non-VA Care Coordination Unit will be complete VISN wide by 7/31/13. However, we already started the process at each HCS.

Actions taken to date: Authorization Reporting and review, is done monthly at Executive Leadership Committee and weekly at the Network-wide Fee meeting lead by the VISN CFO (report for a single HCS Attached, although each HCS has them).

2. We recommend the Director of the Veterans Integrated Service Network ensure standard operating procedures clearly define roles and responsibilities and the procedures required for fee staff to process payments of vendor invoices timely.

Director, VISN 17 Response: Concur.

Standard Operating Procedures have already been developed and disseminated to all staff to include training on all procedures.

Completion Date: A complete VISN wide training was completed in March of FY 12, although year training continues. We just completed quarterly Fee boot camp in November 2012.

3. We recommend the Director of the South Texas Veterans Health Care System ensure clinical and fee staff receive periodic training on fee care procedures.

Director, South Texas Veterans Health Care Response: Concur.

Fee staff are required to participate in monthly Purchased Care calls hosted by the Chief Business Office (CBO). Additionally, fee staff were required to complete 18 courses ranging from payment methodology to fraud, waste and abuse in the Talent Management System (TMS).

These courses have been assigned to the TMS Profiles of each Fee employee, which requires annual completion. The clinical staff participating in duties related to Non-VA Care have also been assigned training as recommended by CBO (Non-VA Training Guide FY13) with a target date of completion 1/18/13.

Target Date: 1/18/13

4. We recommend the Director of the South Texas Veterans Health Care System establish independent oversight mechanisms, such as periodic audits or reviews by the Compliance Officer, to ensure that newly established procedures at the South Texas Veterans Health Care System are followed to properly control and manage funds for its fee care program.

Director, South Texas Veterans Health Care Response: Concur.

Local processes have been established by the Fiscal Officer to manage and ensure adequate funding is obligated to meet all liabilities. As a result of this recommendation a process will be established in the next 30 days to ensure the Compliance Officer is provided with the needed access and data to perform the requested reviews.

Target Date: 1/18/13

Each month an FBCS report is run that identifies all Fee Authorizations (Inpatient and Outpatient) that have been created along with the estimated cost and corresponding Obligation Number. This information is then used to populate the South Texas Fee Checkbook which compares the funding obligated, by Obligation Number, to the estimated cost of care authorized for each month. The South Texas Fee Checkbook is shared with the responsible services along with South Texas Clinical Leadership so as to allow the parties to determine if additional funding is required and to also allow leadership the opportunity to analyze our Non-VA Care usage by requesting service.

5. We recommend the Director of the Veterans Integrated Service Network establish independent oversight mechanisms, such as periodic audits or reviews, to ensure that procedures for properly controlling and managing fee care program funds are followed at the South Texas Veterans Health Care System.

Director, VISN 17 Response: Concur.

We are hiring Fee Auditors, who will audit certain information daily, weekly and monthly. We will also use the FQAM and his audit team to perform monthly audits of 15 randomly selected bills to make sure processes are followed. The VISN CFO also runs reports weekly and discusses his findings on a weekly call with the Fee staff at each location.

Target Date: For the first review the VISN CFO had the CBO audit team come in and do a complete fee review of FY 12, this was completed the first week of September. The Fee Auditor's should be on board the second quarter of FY 13 where we will start the review of the first quarter transactions. The VISN CFO weekly review was started in Jan 2012 and continues to date.

Appendix D Office of Inspector General Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Mario M. Carbone, Director Jehri Lawson

Appendix E Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Office of General Counsel
Director, VA Heart of Texas Health Care Network (10N17)
Director, South Texas Veterans Health Care System (671/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans
Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans
Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget

This report will be available in the near future on the OIG's Web site at <http://www.va.gov/oig/publications/default.asp>. This report will remain on the OIG Web site for at least 2 fiscal years.



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

Healthcare Inspection

**Access and Coordination of Care at
Harlingen Community Based Outpatient
Clinic**

**VA Texas Valley Coastal Bend Health
Care System
Harlingen, Texas**

To Report Suspected Wrongdoing in VA Programs and Operations:

Telephone: 1-800-488-8244

E-Mail: vaoidhotline@va.gov

(Hotline Information: <http://www.va.gov/oig/hotline/default.asp>)

Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations made by a complainant related to access and coordination of care issues at the VA Texas Valley Coastal Bend Health Care System (HCS) in Harlingen, Texas (facility) and the Community Based Outpatient Clinic (CBOC) in Harlingen, Texas. The complainant alleged that:

- Patients are presenting to the CBOC for urgent and emergent medical care that is not available, losing possibly life-saving minutes while waiting to be triaged and transferred to the appropriate level of care.
- Patients cannot be seen in the timeframe requested by the patient or provider resulting in delays in follow-up care and in getting medications as well as long wait times in the CBOC.
- Providers were pressured into prescribing pain medications to drug-seeking patients.

We substantiated that patients go to the CBOC for urgent and emergent medical care; cannot be seen in the timeframe requested by the patient or their provider; have difficulty getting medications filled, refilled, or renewed; and that patients experience long wait times at the CBOC.

We did not substantiate that providers were pressured into prescribing pain medications to drug-seeking patients.

We recommended that the Facility Director:

- Ensure that patients receive increased education on the process for seeking emergent care in the community.
- Ensure that local transfer policies and community hospital contracts are reviewed for congruency.
- Ensure that primary care panel sizes are reviewed and maintained according to VHA directives.
- Ensure that all current CBOC staffing levels and patient flow plans are reviewed and adjusted to ensure consistency with local policy.

The Veterans Integrated Service Network and Facility Directors agreed with our findings and recommendations and provided acceptable improvement plans.



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

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

SUBJECT: Healthcare Inspection – Access and Coordination of Care at Harlingen Community Based Outpatient Clinic, VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to determine the validity of allegations made by a complainant related to access and coordination of care at the Harlingen Community Based Outpatient Clinic (CBOC) in Harlingen, TX.

Background

The CBOC is part of the VA Texas Valley Coastal Bend Health Care System (HCS) in Harlingen, TX. The CBOC provides outpatient health care including primary care, mental health, nutrition, social work, laboratory, and pharmacy services. The CBOC is located less than 1 mile from the parent facility, the VA Health Care Center at Harlingen (facility). Veterans Health Administration (VHA) established the HCS October 1, 2010, to serve veterans in 20 counties in South Texas. The facility provides inpatient care and emergent care through contracts with local community hospitals and uses fee-basis¹ referrals for specialty care not available through the facility.

A complainant used OIG's Combined Assessment Program's Employee Assessment Review Survey to provide the OIG with allegations involving access and coordination of care at the CBOC. Specifically, the complainant alleged that:

- Patients are presenting to the CBOC for urgent and emergent medical care that is not available, losing possibly life-saving minutes while waiting to be triaged and transferred to the appropriate level of care.

¹ Purchased or fee-basis care is used when VA services are unavailable or cannot be provided due to geographic inaccessibility.

- Patients cannot be seen in the timeframe requested by the patient or provider resulting in delays in follow-up care and in getting medications as well as long wait times in the CBOC.
- Providers were pressured into prescribing pain medications to drug-seeking patients.

As the allegations encompassed concerns related to several CBOC services and policies including access to emergency care, primary care Patient Aligned Care Team (PACT) panel size, seasonal veterans, Pharmacy Service, and Pain management, a brief overview of these services follows.

The CBOC does not provide emergency medical care onsite. These services are provided through a contract agreement with a local hospital Emergency Room (ER). Patients are advised to call 911 or go directly to the closest contracted ER for emergent care.² Local policies define procedures for transferring patients for urgent and emergent medical issues from the CBOC.^{3,4}

The CBOC delivers its primary care services through VA's PACT model.⁵ Local policy describes the PACT model including core team membership.⁶ The PACT core members are the patient, a primary care provider, a registered nurse (RN) care coordinator, a clinical staff assistant, and an administrative staff member. Coordination of care services is the responsibility of the RN care coordinator and a case manager (CM). The RN care coordinator, clinical staff assistant, and administrative staff member serve the provider's entire panel of patients.

During the enrollment process, each CBOC patient is assigned to a specific provider, and becomes a member of that provider's panel of patients. The local facility determines the maximum panel size for their primary care providers. The VHA-modeled panel size is 1,200 patients for a full time physician.⁷

Due to its geographic location, the CBOC serves a number of veterans traveling away from their primary residence that need non-routine medical care ("seasonal veterans"). VHA recommends that seasonal veterans needing acute care present to the local facility and see the referral CM. The CM will coordinate patients' acute care needs, but the

² Harlingen VA Outpatient Clinic Intranet website, <http://vaww3.va.gov/directory/guide/facility.asp>, accessed on May 15, 2012.

³ VA Texas Valley Coastal Bend Health Care System Policy Memorandum 11C-11-08, *Triage of Walk-In Patients*, February 23, 2011.

⁴ VA Texas Valley Coastal Bend Health Care System Policy Memorandum 11-10-06, *Walk-In and Late Patient Policy*, December 2, 2010.

⁵ Primary Care Program Office: Patient Aligned Care Team website, <http://www.va.gov/primarycare/pcmb/>, accessed on May 15, 2012.

⁶ VA Texas Valley Coastal Bend Health Care System Policy Memorandum 11-11-83, *PACT Policy*, March 25, 2011.

⁷ VHA Handbook 1101.02, *Primary Care Management Module (PCMM)*, April 21, 2009.

patient is typically not assigned a provider at the visiting facility. Patients are advised to delay routine, non-acute care until they return to the facility near their primary residence. VHA recommends that seasonal veterans be assigned to providers in two locations only if the patient has specialized or complicated medical needs and splits time between two primary residences in different areas of the country; however, this practice should be minimized.⁸

The CBOC pharmacy is able to fill all routine and available VA-approved medications the same day they receive the prescription. VA pharmacists are required to follow VA policy on filling prescriptions and dispensing medications whether a VA, fee-basis, or community provider writes the prescription. Patients may also bring prescriptions written upon discharge from a local hospital to the CBOC pharmacy to be filled. Non-formulary prescriptions are dispensed according to facility policy.^{9,10}

VHA defines a process that allows pharmacists to provide a temporary, or “bridge,” supply of medications to patients to ensure availability of needed medications until the patient can receive a refill prescription from the patient’s usual source.¹¹ The facility also has a local policy defining the process for providing bridge supplies of medications.¹²

The facility’s pain management policy states that all patients have a right to timely and effective pain management.¹³ The screening and assessment of pain is the responsibility of the medical staff, but accurate reporting and description of pain is the responsibility of the patient. Local policy recommends patients who display drug-seeking behavior be referred to the Drug Seeking Behavior Committee.

Scope and Methodology

We interviewed the complainant by telephone prior to our site visit. We conducted an onsite visit April 16–18, 2012, and interviewed CBOC patient care staff, scheduling staff, clinic-based outpatient pharmacists, and CBOC leadership. We reviewed documents, data, and policies and performed an electronic health record review of a random sample of patients transferred from the CBOC to a contracted, community hospital ER between March 1, 2011, and February 29, 2012.

⁸ VHA Directive 2007-016, *Coordinated Care Policy for Traveling Veterans*, May 9, 2007.

⁹ The VA formulary is an approved list of medications used to guide the management of drug therapies.

¹⁰ VA Texas Valley Coastal Bend Health Care System Policy Memorandum 119-10-02, *Outpatient Pharmacy Policy and Procedures*, April 15, 2010.

¹¹ VHA Directive 2007-016.

¹² VA Texas Valley Coastal Bend Health Care System Policy Memorandum 119-10-16, *Ambulatory Care Medication Policy*, April 9, 2010.

¹³ VA Texas Valley Coastal Bend Health Care System Policy Memorandum 11-10-22, *Pain Management*, November 26, 2010.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1: Urgent and Emergent Care for Patients

We substantiated that patients are presenting to the CBOC for urgent and emergent medical care that is not available at the CBOC and wait to be triaged and transferred to the appropriate level of care.

The CBOC transferred 316 patients to the local contracted hospital ER for care during the review period for an average of 1.26 patients per CBOC day. Our review of a random sample of 32 of these patients found that all 32 had medical issues that justified transfer to the ER. Furthermore, we found that only six (19 percent) of the reviewed patients had a scheduled appointment on the day of transfer; the remaining were patients who walked in for care that day.

We found conflicting facility guidance regarding transferring patients for urgent and emergent care. The contract with the local hospital ER states VA-eligible patients can present to the ER with a medical emergency and receive care. However, if a CBOC provider transfers a patient to the ER, the process for emergency services is as follows:

- The CBOC provider informs the ER provider and VA Utilization Management Clinician of the need for emergent care.
- The VA Utilization Management Clinician authorizes patient treatment, and the CBOC provider informs the ER.
- Copies of medical records and a completed patient transfer form are sent with the patient to the ER.
- VA is responsible for coordinating transportation of the patient to the ER.

Furthermore, two local policies and the local community hospital ER contract all provide conflicting guidance on the process to transfer patients needing emergency care. One local policy instructs staff to call 911 to transfer patients with emergent issues to the ER and patients with urgent issues be seen in the CBOC within 2 hours. The second local policy instructs staff to refer patients with urgent issues to the nearest ER within 2 hours. Staff reported that although the CBOC can transfer most patients to the ER within 60 minutes after check-in and triage, the check-in process and triage time might vary greatly depending upon how many patients are in the CBOC.

Staff relayed several reasons patients gave for continuing to present to the CBOC for urgent and emergent care despite receiving written and verbal instructions to go to the local ER for this type of care. Staff described that some patients preferred to be seen by a CBOC provider before being transferred to the ER. Other patients believed that without a referral to the ER by their VA provider they would be responsible for incurred charges at the non-VA facility. CBOC staff felt these concerns stemmed from previous complaints by community providers who had not received payment for fee-basis services. The facility leadership reported difficulty with coordinating payments for non-VA care while transitioning to an independent VA HCS in 2010. Facility leadership continues to address and resolve payment issues.

Issue 2: Access to Care

Delay in Follow-Up Care

We substantiated that patients cannot be seen in the timeframe requested by the patient or provider.

The CBOC has established five PACTs consisting of a physician, RN, licensed vocational nurse, and a clerk. In addition, a contract physician was hired to treat walk-in patients, but this physician is often temporarily reassigned to work at other CBOCs due to staffing shortages. The contract physician has a small panel of patients assigned as well, but those patients have no other PACT members assigned. Therefore, these PACT patients do not have the same resources as the other PACT patients.

The CBOC has one PACT RN position currently vacant. The remaining four RNs share triage duties for patients who do not have an assigned RN, including the contracted physicians' patients. The RNs triage all walk-in patients assigned to their PACT and patients who do not have a PACT RN. A telephone triage RN at the CBOC answers patient phone calls throughout the day, and this RN helps triage walk-in patients when there is a high patient volume in the CBOC. The PACT RNs are also responsible for any case management duties for their respective team because there are no PACT CMs for the CBOC. Facility leadership acknowledged that one RN CM was needed for every two PACTs; however, there are no immediate plans to establish these positions.

The clerks for the five PACTs rotate on a monthly basis between telephone duties in a telephone room and sitting at the front desk in the CBOC; however, they were not assigned exclusively to one PACT. The clerks had multiple competing duties including clerical support for audiology, dental, diabetic retinopathy, Coumadin®, radiology, and social work clinics in addition to checking in patients for the benefits counselor, covering for the release of information clerk, and serving as the travel clerk. When assigned to telephone duties, the clerk takes calls for all teams and can schedule appointments for various teams and clinics as well as forwarding calls to the appropriate services and PACT for further assistance. Clerks at the front desk check in patients for scheduled

appointments with all CBOC PACT teams, clinics, and services; make future appointments for patients who present requesting appointments; check in walk-in patients; and provide eligible patients with travel vouchers.

All CBOC staff interviewed told us that large provider panel sizes contribute to delays in care. The table below shows that panel sizes for all providers were higher than the facility-determined maximum size.

Active Panel Sizes and limits reported by the facility as of April 02, 2012.

Primary Care Team	Active Panel Size	Maximum Panel Size
Blue	1112	821
Green	1486	1271
Purple	1422	1229
Red	1527	1193
Yellow*	1368	1109
*Yellow (including resident physician panels)	1516	1313

During our interviews, staff reported only one PACT had immediate access for clinic appointments, and this availability had only recently occurred. Another PACT had appointments available in 30 days. The remaining 3 PACTs were booked several months into the future. The PACTs share the burden of seeing the contracted physicians' patients on days when this physician is assigned to another CBOC as well as seeing any walk-in patients during the day. Although the PACT schedule has limited appointments for walk-in patients daily, the need far exceeds the availability.

Staff also reported that seasonal veterans represent a large portion of the walk-in patients each year from October to April, but the CBOC did not have an accurate system for tracking the number of seasonal veterans seen. Staff were unable to identify the referral CM who should be coordinating care for these seasonal veterans even though facility leadership told us the CBOC had a referral CM.

Facility leadership reported that the CBOC requested another PACT based on panel sizes and patient volume, but this is still in the approval process. The facility leadership reported the need to evaluate panel sizes before considering approval for an additional PACT.

Medication Delays

We substantiated that patients have difficulty getting their medications filled, refilled, or renewed.

The CBOC pharmacy has a policy that allows pharmacists, at their discretion, to fill a bridge supply of medication if the patient has a future primary care appointment scheduled. Patients without an appointment are referred to the PACT clerk to make a future appointment or be seen as a walk-in patient for a prescription renewal, depending on patient preference.

The non-formulary medications prescription process causes delays in patients receiving needed medications. Community fee-basis providers are encouraged to prescribe only VA formulary drugs, but if the CBOC receives a non-formulary medication prescription, the pharmacist must contact the community provider to offer formulary alternatives, which can be filled immediately. If the provider feels the non-formulary medication is necessary, the pharmacist sends the request through the PACT RN for provider concurrence prior to submitting a non-formulary medication request. Typical response time through pharmacy service for a non-formulary medication request is 3–5 days with no guarantee of approval. Alternatively, the patient can take the prescription to a community pharmacy for immediate filling at the patient's expense. When asked, the facility could not determine how many fee-basis referrals originated from the CBOC during the review period.

Long Wait Times

We substantiated that patients experience long wait times at the CBOC.

We observed lines of 5–10 patients at various times during the day with only two clerks at the front desk checking in patients. Staff stated the lines were due to the number of walk-in patients rather than patients checking in for scheduled appointments. Staff reported that the CBOC sees approximately 40 walk-in patients on a typical day, but this increases to 65 per day and as many as 100 per day from October through April when seasonal veterans are in the area.

We reviewed CBOC patient complaints during the review period and found complaints concerning wait times and reaching PACTs by telephone. Staff informed us that many patients who cannot reach staff by telephone would come in to be seen as a walk-in patient when the issue could have been addressed over the telephone. Staff identified prescription issues as one of the main reasons for high numbers of walk-in patients. The pharmacy bridge policy is helping to improve this process, but the policy does not cover all of the walk-in patients' pharmacy needs.

Staff also described requests from seasonal veterans for non-acute medical care. Staff informed these patients that according to VA policy, routine care should be provided at the patients' primary VA facility. However, if patients persist in their request to have the service provided while they are in the Harlingen area, staff told us they were directed to enroll patients at the CBOC, assign a provider, and schedule patients' walk-in or future appointments, which causes increased demands on already large panel sizes.

Staff also described how wait times are affected by patient transfers to the local ER. The process is time consuming and can take 30–120 minutes depending upon the patient's medical needs. PACT members must stop routine duties to provide urgent and emergent patient care, thereby increasing wait times for patients with scheduled appointments.

Issue 3: Prescription Pain Medications

We did not substantiate that providers were pressured into prescribing pain medications to drug-seeking patients.

The CBOC providers did not feel pressured to prescribe pain medications inappropriately. Providers told us that they use pain treatment agreements for their patients on chronic pain medications and send consults to the Drug Seeking Behavior Committee when appropriate.

Conclusions

We substantiated that patients present to the CBOC for urgent and emergent medical issues. The reasons patients do not go directly to the ER are numerous. Additional process evaluation is needed to identify ways to encourage patients to seek appropriate care at local contracted hospital ERs rather than presenting to the CBOC where emergency treatment is not available. Furthermore, there is a need for congruency between local policies and the facility contract related to patient transfers for emergency care.

We substantiated that patients have difficulty accessing care with their assigned providers. Most providers did not have available appointments for several months, thus making it impossible for patients to be seen for an acute need without presenting as a walk-in patient. Although PACT schedules have allotted time for walk-in patients each day, the number of walk-in and urgent patients far exceeds the allotted daily walk-in appointment slots.

All core member positions within the PACT need to be filled in order to provide medical care based on the principles of the PACT model of patient care. Clerical staff need to be dedicated to their assigned PACT in order to efficiently and effectively perform the required duties within that PACT. Additionally, a referral CM should be the contact person for seasonal veterans who walk in for care; however, we were unable to determine who the referral CBOC CM was during our site visit.

Panel sizes reported by staff and provided by the facility are larger than facility-determined maximums. The facility has the responsibility to adjust panel sizes based on patient demographics, clinic and staff resources available, as well as any non-primary care duties performed by the provider in order to assign a capacity appropriate to the individual provider. Panel sizes that are larger than expected

maximums may reduce productivity, produce delays in access to care, and can negatively affect the quality of care provided.

The pharmacy medication bridging policy will help decrease the numbers of patients presenting to the CBOC. However, it does not address the reason for the high number of patients requiring temporary refills. The facility needs to address the underlying reasons patients are unable to get appointments in the timeframe requested by their providers before their prescriptions run out or expire and make provisions for seasonal veterans to refill or renew their prescriptions.

During our review, we identified issues such as the high number of walk-in patients, seasonal veterans, telephone communication, and daily emergent medical issues resulting in an average of 1.26 patients per day transferred to the local contracted hospital ER and affecting patient wait times in the CBOC. An in-depth review of patient wait times should be performed to determine ways to decrease wait time and increase patient and staff satisfaction.

We did not substantiate that providers were pressured into prescribing pain medications to drug-seeking patients. The local pain policy addresses appropriate VA-approved practices for treating patients with chronic pain or suspected drug seeking behavior. Providers at the CBOC were aware of the policy and used it properly.

Recommendations

Recommendation 1. We recommended that the Facility Director ensure that patients receive increased education on the process for seeking emergent care in the community.

Recommendation 2. We recommended that the Facility Director ensure that local transfer policies and community hospital contracts are reviewed for congruency.

Recommendation 3. We recommended that the Facility Director ensure that primary care panel sizes are reviewed and maintained according to VHA directives.

Recommendation 4. We recommended that the Facility Director ensure that all current CBOC staffing levels and patient flow plans are reviewed and adjusted to ensure consistency with local policy.

Comments

The Veterans Integrated Service Network (VISN) and Facility Directors concurred with our findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 11–14, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.



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

VISN Director Comments

Department of
Veterans Affairs

Memorandum

Date: August 2, 2012

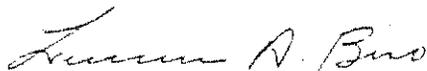
From: Director, VA Heart of Texas Health Care Network (10N17)

Subject: **Healthcare Inspection – Access and Coordination of Care at Harlingen Community Based Outpatient Clinic, VA Texas Valley Coastal Bend HCS, Harlingen, Texas**

To: Director, Dallas Office of Healthcare Inspections (54DA)

Thru: Director, VHA Management Review Service (VHA 10AR MRS)

1. Thank you for allowing me to respond to this Healthcare Inspection regarding Access and Coordination of Care at Harlingen Community Based Outpatient Clinic, VA Texas Valley Coastal Bend HCS, Harlingen, TX.
2. I concur with the recommendations and have ensured that an action plan has been developed.
3. If you have further questions regarding this inspection, please contact Judy Finley, Quality Management Officer at 817-385-3761, or Denise B. Elliott, VISN 17 HSS at 817-385-3734.



Lawrence A. Biro
Director, VA Heart of Texas Health Care Network (10N17)

Facility Director Comments

Department of
Veterans Affairs

Memorandum

Date: August 1, 2012

From: Director, VA Texas Valley Coastal Bend HCS (740/00)

Subject: **Healthcare Inspection – Access and Coordination of Care at Harlingen Community Based Outpatient Clinic, VA Texas Valley Coastal Bend HCS, Harlingen, Texas**

To: Lawrence Biro, Director, VA Heart of Texas Health Care Network (10N17)

1. I concur with the findings noted in this report. Action plans have been developed and monitoring will be conducted on a regular basis.
2. Should you require additional information, please contact Cathy Mezmar, Chief, Quality Management, 956.430.9343.

 8/2/12
(original signed by.)
Robert M. Walton
Director, VA Texas Valley Coastal Bend HCS (740/00)

**Director's Comments
to Office of Inspector General's Report**

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

OIG Recommendations

Recommendation 1. We recommended that the Facility Director ensure that patients receive increased education on the process for seeking emergent care in the community.

Concur **Target Completion Date:** August 31, 2012

Facility's Response:

A handout, describing when and how to seek emergent care in the community, was developed and disseminated to all clinical staff. Nursing staff will give the handout to the patients during their PACT visit. The handout will also be available in the waiting rooms and will be presented at New Patient Orientation. Supervisors will certify that all their staff have been educated on the handout and its presentation to patients.

Status: Open

Recommendation 2. We recommended that the Facility Director ensure that local transfer policies and community hospital contracts are reviewed for congruency.

Concur **Target Completion Date:** August 31, 2012

Facility's Response:

The policies related to community contract hospital transfer have been reviewed and rewritten to clarify emergent care. A clinic in-service will be given on the health system transfer process.

Status: Open

Recommendation 3. We recommended that the Facility Director ensure that primary care panel sizes are reviewed and maintained according to VHA directives.

Concur **Target Completion Date:** September 30, 2012

Facility's Response:

A Primary Care Panel Review has been implemented to evaluate the accuracy of current panel sizes. Based on the findings of the Panel Review, panel sizes and staffing needs will be determined per VHA directives. The Associate Chief of Staff for Primary Care will continue to review and maintain primary care panel sizes.

Status: Open

Recommendation 4. We recommended that the Facility Director ensure that all current CBOC staffing levels and patient flow plans are reviewed and adjusted to ensure consistency with local policy.

Concur **Target Completion Date:** September 30, 2012

Facility's Response:

To ensure consistency with local policy and facilitate access, one administrative and one clinical staff member will be designated to assist traveling/seasonal Veterans at each clinic site. Secure messaging, "fix the phones," telephone visits, groups visits, case management for specific patient populations by PharmDs, and Care Coordination Home Telehealth staff will continue to be emphasized for the PACT model of effective resource utilization. Mandatory training will be done with clinic staff to ensure they are aware of these resources.

Status: Open

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Cathleen King, MHA, CRRN, Project Leader Trina Rollins, MS, PA-C, Team Leader Monika Gottlieb, MD, Medical Consultant Misti Kincaid, BS, Management and Program Analyst Lin Clegg, PhD, Biostatistician

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

Healthcare Inspection

**Quality of Care Provided at Corpus
Christi Community Based Outpatient
Clinic**

**VA Texas Valley Coastal Bend Health
Care System
Harlingen, Texas**

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted a review to determine the validity of allegations made by a complainant regarding quality of care at the Corpus Christi Community Based Outpatient Clinic (CBOC) in Corpus Christi, TX. The CBOC is part of VA Texas Valley Coastal Bend Health Care System in Harlingen, TX (the facility). The complainant specifically alleged that:

- A provider did not diagnose a patient's fractured ankle when the patient presented with right foot pain after a fall.
- A provider diagnosed a patient with pressure ulcers rather than abscesses caused by medication injections, and treated the patient with antibiotics without obtaining wound cultures.

We substantiated that a CBOC primary care provider did not diagnose a patient's fractured ankle when the patient presented for evaluation. The facility had taken appropriate action prior to our review.

We substantiated that a CBOC primary care provider prescribed antibiotics without first obtaining wound cultures. The primary care provider acknowledged that it was the usual practice to obtain a specimen for culture when drainage was present in a wound prior to starting antibiotics.

We identified two additional factors that affected this patient's care:

- Failure to implement the facility's Skin Integrity Management Program Policy for managing the skin integrity of outpatients.
- Fee-basis records are not always available in the medical record. The facility identified opportunities for improvement prior to our review. We found their plan acceptable.

We recommended that the Medical Center Director ensure that the CBOC follow the Skin Integrity Management Program Policy.

The Veterans Integrated Service Network and Medical Center Directors concurred with our findings. We will follow up until the planned actions are completed.



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

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

SUBJECT: Healthcare Inspection – Quality of Care Provided at Corpus Christi CBOC, VA Texas Valley Coastal Bend HCS, Harlingen, Texas

Purpose

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations made by a complainant regarding quality of care at the Corpus Christi Community Based Outpatient Clinic (CBOC) in Corpus Christi, TX.

Background

The CBOC is part of VA Texas Valley Coastal Bend Health Care System (HCS) in Harlingen, TX (facility) and Veterans Integrated Service Network 17 located in Arlington, TX. The CBOC provides outpatient healthcare including primary care, mental health, orthopedic, nutrition, podiatry, social work, and physical therapy services. The clinic serves a population of approximately 15,000 veterans. The CBOC is approximately 135 miles from the facility.

The Veterans Health Administration (VHA) established the facility in December 2008 to provide a variety of outpatient specialty care. The facility provides inpatient care via contracts. The facility uses fee-basis referrals for specialty care that are not available at the CBOCs or facility. VHA policy¹ requires facilities to scan the reports and other results of fee-basis referrals into the patient's medical record.

In May 2011, a complainant contacted OIG's Hotline Division with allegations that CBOC physicians were not following standards of care when treating their patients. The complainant specifically alleged that:

¹ VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

- A provider did not diagnose a patient's fractured ankle when the patient presented with right foot pain after a fall.
- A provider diagnosed a patient with pressure ulcers rather than abscesses caused by medication injections and treated the patient with antibiotics without collecting wound cultures.

Scope and Methodology

We made a site visit to the CBOC on June 14–15, 2011. We interviewed facility and CBOC managers, clinicians, and other staff with knowledge of the complaints. We reviewed patient medical records and facility documents. We interviewed one patient for clarification after our medical records review.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Case Summaries

Patient 1

In February 2011, a man in his fifties with a history of diabetes with peripheral neuropathy,² hypertension, high cholesterol, and leg swelling presented to the CBOC for a routine primary care appointment. A licensed vocational nurse (LVN) assessed the patient prior to the appointment and documented that the patient described loss of consciousness, falling, and injuring his right foot. The patient complained that walking was painful and rated the pain as an 8 on a scale from 0 to 10. The LVN's note documented primary care provider (PCP) notification of the new, acute pain in the patient's foot radiating to the ankle.

The PCP's note documented that the patient presented for management of chronic medical problems. The PCP's note contained a vital signs section with the pain scale of eight, but did not address the pain in the body of the note. The PCP documented that examination of the extremities showed no swelling and normal pulses. The note states that the PCP reviewed images; however, there were no x-rays on record since August 2009. The PCP documented that a diuretic was controlling the patient's leg swelling.

Nine days later, the patient returned to the CBOC requesting a walk-in appointment with complaint of right ankle pain. A registered nurse (RN) documented that the patient had fallen 12 days prior and was walking slowly with a very swollen right ankle and discolored foot. Per triage clinic protocol, the RN sent the patient for an x-ray prior to a physician's examination. A different CBOC physician examined the patient during this

² Peripheral neuropathy refers to damage of nerves of the peripheral nervous system. Symptoms include numbness, pain, and problems with muscle control.

visit and the note documented the patient's fall, subsequent swelling and tenderness of the patient's ankle, and x-ray evidence of an ankle fracture. The physician consulted an orthopedic surgeon who recommended a follow-up appointment in 3 days. The surgeon discharged the patient with an ankle wrap, crutches, and recommended using ice and elevating the ankle. The patient already had an active prescription for pain medication.

Patient 2

In September 2010, a female in her fifties with a history of chronic back pain, hypertension, tobacco use, and bipolar disorder³ that required intramuscular risperidone⁴ injections (given in the hip) every 2 weeks presented to the CBOC complaining of chronic pain and skin ulcers at the hip injection sites. The patient's PCP did not document the ulcers in the examination, assessment, or plan during this visit.

Four days later, the patient returned to the CBOC requesting antibiotics for infections of the left and right hip injection sites. The patient's PCP's documentation noted small, infected lesions. The PCP prescribed an antibiotic for 10 days and instructed the patient to return if the symptoms did not improve.

Over the next two weeks, the patient twice reported to the pharmacist that the wounds had not improved, and remained painful and irritated. After a second notice from the pharmacist, the PCP scheduled the patient for a return appointment 4 days later.

At the appointment, the PCP noted the patient's non-healing hip ulcers. A blood test revealed the patient had a normal white blood cell count. The PCP's plan included daily iodoform gauze⁵ dressing changes until the ulcers healed with follow up in 3 months. The patient's home care RN was to continue weekly visits and perform the dressing changes. The patient's roommate changed the dressings when the RN was not scheduled to visit.

In November 2010, the home health RN documented that both hip ulcers were not improving, were tunneling,⁶ and had purulent drainage⁷ that required dressing changes up to 3 times per day. The RN requested a PCP appointment for re-evaluation.

In Mid-November at the next primary care appointment, the PCP noted a deep, non-healing, non-draining ulcer with slight redness. The PCP prescribed two antibiotics for 10 days, recommended continuing daily dressing changes, and requested the patient follow up in 2 months.

³ Bipolar disorder involves periods of elevated or irritable mood, alternating with periods of depression.

⁴ Risperidone is a medication used to treat the symptoms of bipolar disorder.

⁵ Iodoform gauze is a type of sterile gauze treated with iodoform (an antiseptic). The gauze is placed in wounds to help the wound drain.

⁶ Tunneling is a narrow opening or passageway underneath the skin that can extend in any direction through soft tissue and results in dead space with potential for abscess formation.

⁷ Purulent drainage is thick, yellow, green, or brown in color with a pungent, strong, foul odor.

The home health RN continued to document that the ulcers were not healing, had large amounts of purulent drainage, and had tunneled deep into subcutaneous tissue.⁸ After 2 weeks, the RN requested a consult for surgical incision and drainage.

Three days later, a CBOC physician entered a fee-basis consult at the request of the RN for surgical incision and drainage of tunneling abscesses. The consult was approved 15 days later in mid-December. The next day, the home RN scheduled an appointment with a fee-basis surgeon.

In Mid-December, the patient saw a fee-basis surgeon and reported to the home health RN that the surgeon did not prescribe an incision and drainage of the hip ulcers. The home health RN contacted the surgeon's office to confirm the surgeon's recommendations directly. The surgeon requested a home health wound care RN for daily wound care using saline irrigation and dry packing, rather than iodoform gauze, for optimal wound healing. The surgeon also requested a bone scan⁹ for the patient to rule out osteomyelitis.¹⁰ Home health daily wound care began the next day. A bone scan was completed the end of December.

Two days after the bone scan was completed, the patient presented to the CBOC with draining hip abscesses that were without redness or tenderness. The physician changed the diagnosis from pressure ulcers to abscesses. The physician ordered wound cultures, wound packing, and continuation of home health wound care. This physician prescribed a different antibiotic and requested an appointment for the patient to return in 4 days for wound checks and culture results.

In early January, on the day of the patient's scheduled follow-up appointment, the patient cancelled due to illness. On that same day, a CBOC physician reviewed the wound culture results that indicated the infection was not sensitive to the current antibiotics, and a CBOC RN called the location where the patient had the bone scan and obtained the results. The CBOC physician noted that the scan was suggestive of osteomyelitis in the left hip region and decided to admit the patient for treatment with intravenous antibiotics. The patient agreed with the physician's plan for hospital admission. Further testing during the hospital admission showed the patient did not have osteomyelitis.

Inspection Results

Issue 1: Delayed Diagnosis

We substantiated that the PCP did not diagnose the patient's fractured ankle when the patient first presented with ankle pain.

⁸ Subcutaneous tissue is the third layer of the three layers of skin and contains fat, connective tissue, larger blood vessels, and nerves.

⁹ A bone scan is a nuclear imaging test that helps diagnose and track several types of bone disease, including bone infection, that are undetectable on a standard x-ray.

¹⁰ Osteomyelitis is an infection of the bone that is usually bacterial.

The LVN's note documented the patient "blacked out," fell, and was complaining of right foot pain. During our interview, the LVN stated that the PCP was informed of the patient's fall and foot pain. During a phone interview, the patient stated that the PCP examined his foot, assured him that there was nothing wrong, and that his right leg swelling was from water retention. The patient informed the PCP that the fall resulted from the episode of loss of consciousness. One week later, the patient returned to the clinic, the RN triaged the patient and obtained an x-ray of his ankle. A different PCP diagnosed an ankle fracture and referred the patient to orthopedic surgery. The orthopedic surgeon told us that the delay in diagnosis caused no adverse effects.

Issue 2: Inappropriate Treatment of Wounds

The concerns we had with this patient's care are that her abscesses (caused by intramuscular injections) continued to worsen without appropriate interventions. Specifically, the PCP continued to treat these lesions as if they were pressure ulcers, rather than abscesses. Although there was visiting nurse support, there was insufficient clinic follow-up, re-evaluation, and re-assessment. Ultimately, clinicians became concerned about the possibility of osteomyelitis and hospitalized the patient. Much of this may have been avoided with better wound care.

The CBOC had not implemented the facility Skin Integrity Management Program Policy for managing the skin integrity of outpatients as required. Local policy states that a clinic RN trained in wound care coordinates and assists the team with wound management and continuity of wound care in ambulatory care clinics. Although the policy targets the management of pressure ulcers, had it been implemented, this nurse would have been involved in the care of this patient when the PCP initially diagnosed the patient.

Issue 3: Fee-basis Consult Tracking

In October 2010, the CBOC became part of the new facility that does not have all specialty services readily available. The lack of in-house specialty care required the use of fee-basis care in the local community. To obtain fee-basis care a CBOC physician must submit a fee-basis consult for approval. VHA requires consults be addressed within 7 days.¹¹ Once the fee-based care is approved, the patient is notified and told to make an appointment with a community provider that can provide the specified care. The referring CBOC physician is not always aware if, when, or with whom an appointment is made. Further, the fee-basis provider's results that are sent to the clinic are not always present in the patient's medical record. During this episode of care, neither the surgical consult nor bone scan report were available to the CBOC physicians.

The facility and CBOC had identified opportunities for improving the fee-basis process prior to our review. The plan includes hiring and assigning a fee-basis clerk to each of the facility's CBOCs, assigning duties to primary care team members to facilitate

¹¹ VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008.

scheduling and obtaining results, and hiring specialty physicians at the facility to reduce the need for fee-basis consults.

Conclusions

A CBOC PCP failed to diagnose a patient's fractured ankle when he first presented with ankle pain; however, the facility took appropriate action prior to our review.

A CBOC PCP did not obtain wound cultures before prescribing antibiotics. The physician acknowledged that wound cultures should have been obtained prior to starting the course of antibiotics.

CBOC management did not implement the facility's Skin Integrity Management Program as required. Involvement of a CBOC RN trained in wound care early in this patient's care would have been prudent.

We found that it took 15 days to get fee-base approval for this patient to see a surgeon. In addition, the fee-basis bone scan report was not available to the CBOC staff until after they requested the report in early January. The facility is actively addressing these issues.

Recommendation

Recommendation. We recommended that the Medical Center Director ensure that the CBOC follow the Skin Integrity Management Program Policy.

Comments

The Veterans Integrated Service Network and Medical Center Directors concurred with our findings (See Appendixes A and B, pages 7-9, for the full text of their comments). We will follow up until the planned actions are completed.



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

Veterans Integrated Service Network Director Comments

Department of
Veterans Affairs

Memorandum

Date: September 2, 2011

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

Subject: **Healthcare Inspection – Quality of Care Provided at
Corpus Christi CBOC, VA Texas Valley Coastal Bend
HCS, Harlingen, Texas**

To: Director, Dallas Office of Healthcare Inspections (54DA)

Thru: Director, VHA Management Review Service (10A4A4)

1. Thank you for allowing me to respond to this Healthcare Inspection regarding the Quality of Care provided at the Corpus Christi CBOC, VA Texas Valley Coastal Bend HCS, Harlingen, Texas.
2. I concur with the recommendation and have ensured that an action plan has been developed.
3. If you have further questions regarding this inspection, please contact Judy Finley, Quality Management Officer at 817-385-3761 or Denise B. Elliott, VISN 17 HSS at 817-385-3734.

(original signed by:)

Lawrence A. Biro

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

Facility Director Comments

Department of
Veterans Affairs

Memorandum

Date: September 1, 2011

From: Jeffery L. Milligan, Director, VA Texas Valley Coastal Bend HCS (740/00)

Subject: **Healthcare Inspection – Quality of Care Provided at Corpus Christi CBOC, VA Texas Valley Coastal Bend HCS, Harlingen, Texas**

To: Lawrence Biro, Director, VA Heart of Texas Health Care Network (10N17)

1. I concur with the findings noted in this report. Action plans have been developed and monitoring will be conducted on a regular basis.
2. Should you require additional information, please contact Cathy Mezmar, Chief, Quality Management, 956-430-9343.

(original signed by:)

Jeffery L. Milligan

Director, VA Texas Valley Coastal Bend HCS (740/00)

**Director's Comments
to Office of Inspector General's Report**

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

OIG Recommendations

Recommendation. We recommended that the Medical Center Director ensure that the CBOC follow the Skin Integrity Management Program Policy.

Concur **Target Completion Date:** October 19, 2011

Facility's Response:

A mandatory training addressing PM 118-10-04 Skin Integrity Management Program Policy and basic wound management will be conducted by Nursing Education for Patient Aligned Care Teams (PACT) nurses, dietitians, social workers, and a designated physician at each CBOC.

Status: Open

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Cathleen King, MHA, CRRN, Project Leader Gayle Karamanos, MS, PA-C, Team Leader Larry Ross, MS Monika Gottlieb, MD, Medical Consultant Misti Kincaid, BS, Program Support Assistant

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Director, VA Texas Valley Coastal Bend HCS (740/00)

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U.S. House of Representatives: Blake Farenthold, Ron Paul, Mac Thornberry

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VA works to resolve problems after doctors, veterans complain about sluggish reimbursements for care

By Rhiannon Meyers

Posted March 18, 2012 at 6:40 a.m., updated March 18, 2012 at 10:36 a.m.

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Farenthold's letter to the VA

Read U.S. Rep. Blake Farenthold's letter urging the VA to resolve the backlog of claims



PHOTO BY RACHEL DENNY CLOW, CORPUS CHRISTI CALLER-TIMES

Rachel Denny Clow/Caller-Times Roy Stamper, a disabled veteran, spends his days playing solitaire and watching television while he awaits for treatment for his hips. Some local doctors have refused to accept a voucher that promised reimbursement for care from the U.S. Department of Veterans Affairs.

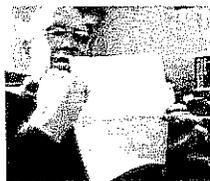


PHOTO BY RACHEL DENNY CLOW, CORPUS CHRISTI CALLER-TIMES

CORPUS CHRISTI — Disabled veteran Roy Stamper, 54, spends his days in front of a television, hobbling around his apartment on a cane and managing the constant sharp pain and numbness in his artificial hips with daily morphine pills.

For months, Stamper tried to find a local orthopedic surgeon to take a look at his hips and diagnose the pain, but over and over again, he found that doctors simply refused to accept a voucher that promised reimbursement for care from the U.S. Department of Veterans Affairs.

Some local doctors have stopped seeing veterans because the VA has taken too long to reimburse them for the treatment.

The VA now is working to resolve the backlog of claims after U.S. Rep. Blake Farenthold, R-Corpus Christi, complained that slow payments put local veterans at risk of not getting the care they need.

Officials with the regional VA health system treating Valley and Coastal Bend veterans say there are 12 outstanding claims to be processed. However, two Corpus Christi doctors say that they alone have more than 40 outstanding claims awaiting VA payment.

Froy Garza, spokesman for the VA Texas Valley Coastal Bend Health Care System, could not immediately explain the discrepancy.

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PHOTO BY RACHEL DENNY CLOW, CORPUS CHRISTI CALLER-TIMES

Rachel Denny Clow/Caller-Times Roy Stamper, a disabled veteran, spends his days playing solitaire and watching television while he awaits for treatment for his hips. The VA now is working to resolve the backlog of claims after U.S. Rep. Blake Farenthold complained that slow payments put local veterans at risk of not getting the care they need.

Rachel Denny Clow/Caller-Times Roy Stamper, a disabled veteran, holds up a voucher authorizing him to see a physician for knee and hip pain, but he says he can't find an orthopedic surgeon willing to accept the voucher due to a delay in payment processing by the U.S. Department of Veterans Affairs.



PHOTO BY RACHEL DENNY CLOW, CORPUS CHRISTI CALLER-TIMES

Rachel Denny Clow/Caller-Times Roy Stamper, a disabled veteran, spends his days playing solitaire and watching television while he awaits for treatment for his hips.

Farenthold's office staff, citing the confidentiality of constituent casework, declined to say how many complained or which providers were affected.

The VA in a prepared statement said that four veterans have complained about their inability to find doctors to accept VA vouchers, according to their patient tracking system. The VA issued 1,496 vouchers from Oct. 1 to Feb. 15 to veterans receiving primary care at the Corpus Christi clinic.

Stamper, who complained to both the VA and Farenthold about his inability to find an orthopedic surgeon willing to accept the voucher, blamed the VA for not making timely payments to doctors and making them skittish about taking the vouchers.

He said the VA plans to "substantially resolve" outstanding claims within three months and will report its progress to Farenthold and other stakeholders.

Farenthold urged the VA to meet that timeline in a Feb. 9 letter to the director of the VA health network that extends from the Oklahoma border south to the Rio Grande Valley.

"These delays are unacceptable," he wrote. "The VA has a responsibility to serve those who have served our country, and it is my hope that you and your colleagues will in fact remedy this situation within the 90-day time frame you mentioned."

Farenthold said Wednesday that he will round up veterans and doctors and hold a news conference on the VA's doorstep if outstanding claims aren't resolved in the coming weeks.

"We're going to call them out," he said.

Farenthold intervened after veterans and physicians contacted him and his staff numerous times to complain about the extraordinarily long delays. Because Corpus Christi does not yet have a VA specialty clinic, the VA has been offering vouchers to veterans to receive specialty treatment from local, private providers with the promise that those providers will be reimbursed by the VA for that care.

The voucher program was seen as an improvement over the former system. In years' past, veterans needing specialty care had to drive to VA hospitals in San Antonio or Houston for treatments, testing and hospitalizations.

The vouchers, however, have proved troublesome for some area veterans because reimbursements are slow coming. Farenthold said the VA owes physicians in his district almost \$1 million for services dating back several years. The VA could not immediately confirm the amount of outstanding claims.

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JAN

28

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Parlor Chat
Fulton Mansion State Historic Site

JAN

29

TUESDAY

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Georges Seafood Company, 5884 Everhart Road

JAN

30

WEDNESDAY

Speaker on BP Spill Dispersant at 7 p.m.

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"The service to the veterans, to put it mildly, is crappy," Stamper said.

Other veterans disagreed, saying service has improved in recent years and that they have no problems obtaining care with a voucher.

"From time to time, doctors didn't want to take the voucher," said Ram Chavez, a former Army combat medic and advocate for area veterans. "But the last time I heard a complaint about it was a few months ago."

Toby Cross, the Nueces County Veterans Service Officer, said the situation was far worse a year and a half ago.

"It's my understanding that some of the vouchers were being paid slowly by the VA and so area physicians were not as willing to accept those vouchers," he said. "I've attended workshops conducted by the VA and they are well aware of the problem and they are doing something about it."

Dr. Luis Armstrong, a Corpus Christi gastroenterologist, said he stopped accepting the vouchers in April 2010 because the VA was not paying him. He hired a biller to handle the problem, a big expense for a small provider, and still the VA hasn't paid 20 claims, including colonoscopies and hospital stays, he said.

Armstrong said it hurt him to turn away veterans because he owes his training to the VA system. That's why he continued to see veterans long after he stopped getting paid, he said. However, it's reached the point where he can no longer afford that, he said.

"Unfortunately, I cannot work without proper reimbursement," he said. "Economically, I cannot do it."

The slow payments haven't stopped The Orthopaedic Center of Corpus Christi from accepting vouchers, but the center is much more selective now about whom it will accept, said Linda Hernandez, clinic administrator.

"I don't think we're as apt to say, 'Yes, yes, yes' as we were in the past," she said. "We were saying yes to all of them. Again, you can only give out so much without having compensation back."

In a prepared statement provided by Garza, VA officials blamed the sluggish reimbursements on a greater-than-anticipated demand for vouchers and improper claims from providers.

Claims processing is delayed when providers submit claims the VA rejects for several reasons, such as using incorrect billing codes, submitting duplicate claims for the same care, providing treatment not preapproved by the VA or seeking reimbursements for more than the authorized rates, according to the VA.

The VA said it now has the right mix of improved initiatives and enhanced processes to successfully resolve outstanding claims. When asked to describe those initiatives and processes, the VA said in a prepared statement that it plans to report its progress to stakeholders at least once a month in the next 90 days.

Delayed reimbursements aren't uncommon and the VA has worked nationally to pay those claims quicker. VA standards call for 90 percent of all valid claims to be paid within 30 days, and the VA is working on a plan to further expedite the payment of electronic claims, said Patricia Gheen, deputy chief business officer for purchased care.

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On average, VA offices nationwide pay 80 percent of claims within 30 days, she said. As the regional VA works toward improving claims payments, local veterans likely will get better access to specialty care anyway after a new specialty clinic opens in Corpus Christi as early as June, according to the VA.

That new clinic will provide a variety of specialty care, from cardiology to physical therapy, and should improve access and timeliness to care, thus reducing the need for vouchers, the VA said.

As for Stamper, after months of searching, hours of phone calls and several trips to Farenthold's office, he finally found an orthopedic surgeon willing to see him.

He has an appointment 8 a.m. Wednesday. In San Antonio.

967

Number of vouchers issued between June 1 to Sept. 30 to veterans treated at Corpus Christi clinic

1,496

Number of vouchers issued between Oct. 1 to Feb. 15 to veterans treated at Corpus Christi clinic

12

Number of claims the VA says are outstanding

4

Number of veterans the VA says have complained about

the vouchers

90

Number of days

the VA says it will

take to resolve the backlog of claims

Source: U.S. Department of Veterans Affairs

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March 18, 2012
6:56 a.m.

Misanthropia writes:

The VA has been under a lot of scrutiny lately and for good reason. It's a horrible system. I don't know if it's poor management at the top or just a lack of empathy for our veterans.

Suggest removal

Reply to this post

March 18, 2012
7:27 a.m.

knotknessisary writes:

Or could it be the current Congress voting to cut funding for this and other programs?

Suggest removal

Reply to this post

March 18, 2012
8:45 a.m.

grandpa78412 writes:

I read into the story that the red tape makes it virtually impossible to get a claim correctly submitted the first try. You would think that a VA claim clerk could just pick up the phone, call the doctor, and get the situation resolved in a few minutes. It may also be the Obama administration delaying payments to generate interest on the money to help pay for more boondoggles. I have noticed that my Social Security checks are getting later and later also.

Suggest removal

Reply to this post

March 18, 2012
9:04 a.m.

jakespoon53#722975 writes:

Diagnosed with prostate cancer Nov.6,2012,issued voucher by CC VA outpatient clinic for radical prostatectomy.Applied MD Anderson for treatment and turned down. Reason quote "we have found that va does not pay in a timely manner and there is a backlog of vouchers un-paid. Viet Nam vet with service related agent orange PC. No excuse for having to hunt a qualified surgeon that would accept that voucher and mine is only one of many stories. As stated in the article the vet found help in San Antonio so did I after being in total panic that no surgeon would take the voucher. VA has been very helpful in many ways,but local outpatient clinics handling of vouchers is shameful,I know I had the same experience as the vet in the article. I'm glad he found help. He or no other vet should have that experience.Glad to see it exposed in the CC and i too will be contacting Farenthold.

Suggest removal

Reply to this post

March 18, 2012
10:32 a.m.

haceunano writes:

The VA has responded to my requests pretty quick; however, it appears that they are up to their gumpstumps in alligators at this time. There's rules that are set forth by the Congress, they must follow. I'm not defending the VA, surely our Veterans need all the help they can get and most certainly deserve.

Suggest removal

Reply to this post

P.S. (1) Blake needs to be gone, next election can't come soon enough! (2) Bring back the draft!

March 18, 2012
11:40 a.m.

DonnaMcClure writes:

Suggest removal

Reply to this post

Take a good look. This is government provided healthcare and it does not work. This what we will all have soon. The VA should be abolished and our veterans should have the exact same insurance card as our Congressmen - accepted everywhere. Nothing less is acceptable for those to whom we owe our freedom. AND it would cost less and work better and create real jobs.

March 18, 2012
12:45 p.m.

tumbleweed writes:

Suggest removal

Reply to this post

Here's my story of Vet treatment in Corpus Christi. I have six years service..three active and some active reserve years in another branch. I retired a few years ago and went to the clinic here to register last year. I was not asking for so much as an aspirin, only registering as a vet as I was told I would get a I.D. card and places like Home Depot and Lowes would grant me a slight discount in recognition of my service. I registered and was told to come back the next week to pick up my I.D. card. When I returned for the card, I was adised I was "de-registered". When I asked what that meant (to be de-registered after less than a week of being registered), I was sent to a "counselor" in the building. He informed me I had "too many assets". In other words, by answering the questions honestly and listing my 401k savings, I was found to have "too many assets" to qualify for the I.D. card recognizing my years of service. My final rank was E-7, and I have two honorable discharges, one from active duty in the USMC and one from the U.S. Army. I asked the counselor what I would have been eligible for had I become a drunken bum after serving in the Corps in the sixties and never saved a dime. His reply was that i would qualify for everything. If my memory serves me correctly, when I enlisted in the Marines at 17, I was not advised that I should not work so hard that i might accumulate some wealth and thus disqualify myself for being recognized as a veteran. It's a sad state of affairs where once again, some moderate success due to working hard for 50 years causes a vet to be ineligible. This is a true story and a testimony to how our government continues to decline into socialism. Those who work hard are punished and must contribute to those who don't. My complaint is not against deserving vets. To the contrary, disabled vets are first in line and should be treated well. However, to have served my country like I have and to be treated as I was here in this "vet friendly" town is just wrong.

March 18, 2012
1:41 p.m.

Riptide writes:

Suggest removal

Reply to this post

in response to grandpa78412:

I read into the story that the red tape makes it virtually impossible to get a claim correctly submitted the first try. You would think that a VA claim clerk could just pick up the phone, call the doctor, and get the situation resolved in a few minutes. It may also be the Obama administration delaying payments to generate interest on the money to help pay for more boondoggles. I have noticed that my Social Security checks are getting later and later also.

Regarding your Social Security check, I suggest that you switch to having the government direct deposit them to your bank account. When you use direct deposit they will always be there on the date that they are scheduled to be there.

March 18, 2012
5:15 p.m.

mawnpa#245297 writes:

Suggest removal

Reply to this post

After the Navy left NSI, using the property for a much needed hospital complex for our veterans, would have been a great choice. I'm not talking a clinic, but a full-fledged facility that could treat our wounded warriors, no matter the need. In many cases, our veterans are not being taken care of. There's lots of fat that could be trimmed from the national budget. Anything to do with our veterans care, should not be an option.

March 18, 2012
5:18 p.m.

grandpa78412 writes:

Suggest removal

Reply to this post

in response to Riptide:

Regarding your Social Security check, I suggest that you switch to having the government direct deposit them to your bank account.

When you use direct deposit they will always be there on the date that they are scheduled to be there.

Riptide, I do use direct deposit. The latest check was at least a week later than the normal deposit.

March 18, 2012

5:30 p.m.

gblumdds#284076 writes:

Suggest removal There is no dentist in the city that I am aware of that will take V.A. vouchers, assuming the patient can obtain one. The V.A. system is so back-logged or incompetent that our office has accounts that are shamefully overdue. And long-time patients cannot obtain vouchers for necessary continuing care. Our veterans deserve better.

March 19, 2012
10:53 p.m.

ejw-cc#713272 writes:

Suggest removal In the past, I had dental work done locally via a V A voucher. After the work was completed, numerous attempt were made by the doctor's office as well as myself in an effort to get the bill paid, to no avail. In order to stay in good standings with the doctor that had agreed to accept the voucher on my behalf, I eventually decided to pay the bill out of pocket,

For two full years I sent hard copies and faxes to the V A in an effort to get reimbursed for the dental payment. Not once did the V A respond to the inquires made about the status of my claim.

During a visit to the local V A clinic for other reasons, I explained my experience with the voucher to the female vet's liaison working there. It was not until after she (twice) hand delivered copies of the numerous inquiries (made by the dentist's billing office and myself) to the responsible office did I finally receive reimbursement for payment of the dental work, at government rate. By the time I was reimbursed almost 3 years had passed.. I wonder if the doctor would have had to wait that long for payment if I had not chosen to pay him out of pocket.

On the 28th of Feb. 2012 I drove to Harlingen Texas for a dental check up. After the examination the doctor wanted to write me a prescription for a voucher in order to have the work that I needed done locally (Corpus Christi). I requested having my dental work performed at the V A Clinic in Harlingen. Even though I suffer with chronic pain, I would rather drive to the valley Clinic to have the work done than deal with a voucher again.

March 20, 2012
3:59 p.m.

DINK-Nurse writes:

Suggest removal The average VA medical provider (nurse and doctor) cares very much for the veterans. The problem is with too many administration people carrying clip boards and staring at numbers. The VA needs to be audited by a successful hospital system and then have the clip board carriers either do some work or hit the road. Too many people like the Corpus Christi's city council are in the leadership of the VA.

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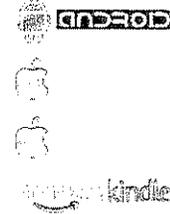
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