DEPARTMENT OF VETERANS AFFAIRS
Under Secretary for Health
Washington DC 20420

February 1, 2016

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-14-3705

Dear Ms. Lerner:

I am responding to your request for supplemental information on the Edward Hines Jr. Veterans Affairs (VA) Hospital, (the Medical Center) Hines, Illinois, regarding progress on the corrective actions undertaken by the Veterans Health Administration (VHA) and the Medical Center in response to the 11 VA recommendations in the original report of June 12, 2015.

This supplemental report presents detailed results of the contracted independent cardiological review recommended to VHA in the original report. VA substantiates the technical inadequacy of a substantial portion of the echocardiograms. Such inadequacy does not, however, necessarily rise to a finding of substantial and specific threat to public health and safety. In response to these findings, this report makes five supplemental recommendations to the Medical Center and three supplemental recommendations to VHA.

The Medical Center has completed three of its five corrective actions in response to VA's original report recommendations: the peer review of catheterization images, payment of refunds to Veterans for amounts paid in excess of their copayment liability, and correction of the productivity records of the cardiologists. The two corrective actions still pending are the facility's evaluation of the need for a quality assurance program and the conduct of a root cause analysis to identify coding problems.

VHA has conducted an independent review of the 50 cases and also completed the ongoing review of the 17 cases among the larger group of 50 cases. The actions resulting from the Office of Compliance and Business Integrity's audit are also included in this supplemental report. The evaluation of the need for a national control to

monitor copayments, the evaluation of inaccurate workload documentation, and the assessment of the need for retraining providers on coding and documentation are pending.

If you have any other questions, I would be pleased to address them. Thank you for the opportunity to respond.

Sincerely,

David J. Shulkin, M.D.

Enclosure

Office of the Medical Inspector
Supplemental Report
to the
Office of Special Counsel
Edward Hines Jr. VA Hospital
Hines, Illinois
OSC File No. DI-14-3705
January 27, 2016
TRIM 2015-D-6419

Background

The Interim Under Secretary for Health requested that the Office of the Medical Inspector (OMI) investigate allegations lodged with the Office of Special Counsel (OSC) concerning the Edward Hines Jr. Veterans Affairs (VA) Hospital, (hereafter, the Medical Center) located in Hines, Illinois. Whistleblower who consented to the release of her name, alleged that employees are engaging in conduct that may constitute violations of law, rule, or regulation, and gross mismanagement, and a substantial and specific danger to public health.

The whistleblower alleged that:

1. Deficiencies in cardiovascular care at the Medical Center resulted in unnecessary coronary surgeries and procedures performed on patients due to diagnostic errors. The root cause of these errors has not been addressed, and patients who underwent unnecessary surgeries due to these serious medical mistakes have not been notified;

2. Deficiencies in echocardiogram imaging and processing resulted in hundreds of useless studies, as well as a significant backlog of unread echocardiogram studies that caused life-threatening delays in treatment to patients; and

3. At least one physician, Physician 1 , recorded an inflated number of procedures he performed to falsely boost the appearance of his productivity.

On June 30, 2015, VA submitted a report of its investigation into these allegations to OSC. The original report contained 11 recommendations: 6 for the Veterans Health Administration (VHA) and 5 for the Medical Center. Three of the six VHA corrective actions have been completed; three are pending. Three of the five Medical Center actions have been completed; two are pending. This report summarizes the status of each of these actions.

Based on the outcome of the independent review of 50 cardiology cases (conducted in response to Recommendation 1 of VA's original report) and on the results of the Compliance and Business Integrity (CBI) audit of inappropriately charged copayments (conducted in response to Recommendation 5 of VA's original report), this supplemental report makes eight new recommendations, three for VHA and five for the Medical Center.

Original Report Recommendation 1 (for VHA):

Arrange for OMI to conduct an independent review of the 50 cases and recommend actions as appropriate.

Status:

OMI arranged for an independent, professional review of the cardiovascular care provided to the 50 Veterans, 49 of whom were identified by the VA Inspector General Office of Healthcare Inspection (see Attachment B of the original report); we identified the final Veteran during our investigation. VA contracted board-certified cardiologists, interventional cardiologists, and a vascular surgeon (none of whom are associated with VA) with experience in the procedures or studies under review and also with medical records review to examine the cardiovascular care provided to all 50 cases. In 17 of these Veterans, the quality of specific echocardiograms they underwent was reviewed (the echocardiogram cohort).[1] In 10, the quality of peripheral vascular procedures they underwent was reviewed (the peripheral vascular cohort).[2] In 22, the quality of cardiac catheterization procedures they underwent was reviewed (the cardiac catheterization cohort). In one, the quality of a pericardiocentesis he underwent was reviewed (the pericardiocentesis).[3] In each case, the opinion reported below is that of a single reviewer, and the determination of whether the standard of care had been met in the reviews of the peripheral vascular and cardiac catheterization cohorts is the opinion of that reviewer. Physician 1 performed the pericardiocentesis and all of the procedures on the 32 Veterans in the peripheral vascular and the cardiac catheterization cohorts.

As outlined in VHA Handbook 1100.19, *Credentialing and Privileging,* the Medical Center Director has the ultimate responsibility for credentialing and privileging within his or her facility.[4] As in all VHA facilities, the Medical Center has a specific, formal process to assist the Director in exercising the responsibility of granting or suspending, restricting or revoking a physician's privilege to practice, in whole or in part. At the Medical Center, the Professional Standards Board, composed of senior providers including the chiefs of departments, recommends privileging actions to the Medical Executive Committee, which in turn makes the final privileging recommendations to the Medical Center Director.

---

[1] As outlined in the original report, an echocardiogram is a diagnostic technique that uses ultrasound waves to produce images of the heart.

[2] From a cardiovascular specialist's perspective, the arterial system of blood vessels which supply oxygenated blood to the body can be conveniently divided into the coronary arteries which supply blood to the heart muscle and the peripheral vascular system supplies the rest of the body. For this review, a coronary artery procedure refers to a procedure performed in one of the coronary arteries while a peripheral vascular procedure refers to a procedure performed anywhere except in a coronary artery but is most frequently performed in the major arteries that supply the legs.

[3] The pericardium is a sac-like tissue covering of the heart. Fluid can collect between the inner layer and the outer layer of the pericardium. In some instances fluid accumulation may impede normal cardiac function. One treatment for such a collection of fluid is a procedure which withdraws the excess fluid through a needle. This procedure is a pericardiocentesis.

[4] VHA Handbook 1100.19, *Credentialing and Privileging,* October 15, 2012.

Professional Review Findings

For the 17 patients in the echocardiogram cohort, according to the external reviewer:

- The study was "technically inadequate" or "technically limited" for 14 patients (82.4%),
- The original study interpretation was not consistent with the external reviewer's interpretation on at least one major point for 9 patients (52.9%),
- The study was not adequate to address the stated clinical indication for 9 of the 16 patients (56.3%) whose study had a stated clinical indication[5], and
- The quality of the study was not adequate for 10 of the 17 patients (58.8%).

All of the studies were performed between March 17, 2010, and November 4, 2013.

For the 22 patients in the cardiac catheterization cohort, according to the external reviewer:

- The initial procedure was indicated for all patients,
- The original interpretation of the angiogram was not consistent with the external reviewer's interpretation for at least one major lesion for 9 patients (40.9%),
- The original recommended treatment plan was not consistent with the external reviewer's interpretation of the angiogram for 9 of 21 patients (42.9%), and
- The standard of care was not met for 6 patients (27.3%).

In all six procedures where the reviewer opined the standard of care was not met, the reviewer felt the severity of the coronary artery obstruction was overestimated. As mentioned in the original report, the fractional flow reserve (FFR) is a method to identify hemodynamically significant obstructions where angiographic images may be equivocal. In four of the six procedures, the reviewer recommended measurement of the FFR across the equivocally significant obstruction before treatment. All of the studies were performed between September 16, 2010, and July 10, 2012.

For the 10 patients in the peripheral vascular cohort, according to the external reviewer who is a practicing vascular surgeon:[6]

- The initial procedure was not indicated for 7 patients (70%) because the reviewer felt the preprocedure evaluation was deficient,
- The initial interpretation of the angiogram was not consistent with the external reviewer's interpretation of the angiogram on at least one major lesion for 5 patients (50%),
- The initial recommended treatment plan was not consistent with the external reviewer's interpretation of the angiogram for 8 patients (80%), and

[5] One of the 17 echocardiogram consultations did not have a clinical indication in the original referral, so only 16 clinical indications were assessed for adequacy.

[6] Both interventional cardiologists who perform percutaneous peripheral vascular procedures and vascular surgeons treat peripheral vascular disease. However, vascular surgeons are trained in the operative treatment of that disease while the interventional cardiologists are trained in the percutaneous treatment of peripheral vascular disease. These specialties treat the same disease but through a different approach.

- The standard of care was not met for 8 patients (80%).

Nine of the studies were performed between July 10, 2010, and November 29, 2011; the tenth was performed on February 10, 2015.

For the patient who had the pericardiocentesis, according to the external reviewer:

- The initial procedure was indicated, but the planned procedure was not completed, and
- In an assessment of the actions of the attending physician who performed the procedure, most experienced competent practitioners might have managed the case differently.[7]

This procedure was performed on October 20, 2011.

Medical Center Response to the Professional Review Findings

VHA Interventional Cardiology Review of the Peripheral Vascular Program

On November 20, 2015, the Medical Center secured the services of an interventional cardiologist experienced in performing percutaneous peripheral vascular procedures and the nurse manager responsible for cardiac catheterization laboratory nursing standards across the VHA to conduct an on-site review of its interventional percutaneous peripheral vascular program.

This team reviewed the percutaneous peripheral vascular care provided to both 9 of the 10 patients in the original peripheral vascular cohort and to 10 additional, randomly selected patients. The 10th patient's care in the original peripheral vascular cohort was not reviewed since the original reviewer stated that the standard of care for that patient had been met. They compared the care given to these 19 patients to the standards outlined in the Society for Cardiovascular Angiography and Interventions (SCAI) Expert Consensus statements for:

- Aorto-Iliac Arterial Intervention Appropriate Use,[8]
- Femoral-Popliteal Arterial Intervention Appropriate Use,[9] and
- Infrapopliteal Arterial Intervention Appropriate Use.[10]

The team noted that these SCAI guidelines are the standard of care for peripheral vascular procedures performed by interventional cardiologists.

---

[7] VHA Directive 2010-025, *Peer Review for Quality Management,* June 3, 2010, identifies three peer review levels used in assessing the Level of Care decisions made by a provider. Level 1 is the Level at which the most experienced, competent practitioners would have managed the case in similar manner. Level 2 is the Level at which the most experienced, competent practitioners might have managed the case differently. Level 3 is the Level at which the most experienced, competent practitioners would have managed the case differently.

[8] Klein AJ, et.al., Catheterization and Cardiovascular Interventions 84:520-528 (2014)

[9] Klein AJ, et.al., Catheterization and Cardiovascular Interventions 84:529-538 (2014)

[10] Gray, BH, et.al., Catheterization and Cardiovascular Interventions 84:539-545 (2014)

In 17 of the 19 patients whose care was reviewed, the team judged that most physicians would have treated the patient with the same care (i.e., care was definitely appropriate). In 2 of the 19 patients, the team judged that some physicians would have provided the same care (i.e., the care "may be" appropriate). In all of the reviewed cases, the team felt that the standard of care was met, and none of the practice patterns were outside of the standard of care.

However, the reviewers noted that none of these patients had additional evaluation with arterial duplex ultrasound (ADU) studies prior to their percutaneous peripheral vascular procedure.[11]

The team recommended that the Medical Center:

1. Hire additional vascular imaging technologists necessary to expand ADU imaging capability,

2. Purchase an additional vascular imaging ultrasound machine, if this is necessary for expansion of these services, and

3. Provide adequate space to accommodate the increased ADU imaging capability.

4. Institute a combined peripheral vascular conference requiring that all physicians performing peripheral vascular procedures, including the interventional cardiologist performing percutaneous peripheral vascular procedures, to review procedure indications and ensure they are appropriate.

The Medical Center reports that Physician 1 voluntarily stopped performing interventional percutaneous peripheral vascular procedures on October 15, 2015, when the results of the external reviewer became available. After the on-site review, the Medical Center reports that he resumed performing these procedures.

Supplemental Report Conclusions:

- VA **substantiates** that the majority of the echocardiograms reviewed for this investigation were technically inadequate. However, VA **does not substantiate** these technically inadequate studies constituted a substantial and specific threat to public health and safety. As was pointed out in the original report, technically adequate echocardiography is often dependent on favorable patient body habitus and the absence of comorbid conditions like obesity and lung disease. Other diagnostic tests like transesophageal echocardiography or radionuclide cardiac scintigraphy often can provide the diagnostic information that a technically

[11] ADU is a non-invasive diagnostic study that images the structure of an artery and simultaneously shows the flow of blood through the artery. This combined capability gives a more detailed picture of the extent of peripheral vascular disease in the imaged artery than either modality does alone.

inadequate echocardiogram cannot.[12] The availability of other diagnostic options like these ensures that the patient's cardiac evaluation is not constrained by a technically limited echocardiogram. Further, differences of opinion among equally qualified professionals attempting to read technically inadequate studies are common, and, in light of the additional diagnostic options available, do not constitute deviation from the standard of care. In spite of these additional diagnostic options, however, quality improvement efforts to reduce the rate of technically inadequate echocardiograms are warranted.

- Based on the opinion of the external reviewers, VA concludes all of the studies performed on the Veterans in the cardiac catheterization cohort were indicated and the majority of them met the standard of care although the opinion is that of a single reviewer. However, in those cases where the standard of care was not met, the external reviewer observed the same pattern of overestimating the significance of coronary artery obstructions as was identified in the VA Inspector General's report, "Questionable Cardiac Interventions and Poor Management of Cardiovascular Care, Edward Hines, Jr. VA Hospital, Hines, Illinois" (the OIG report). Although the procedures we reviewed were not those of the OIG report, all were performed during the same time period. As we pointed out in our original report, the Medical Center had taken several measures to address the deficiencies the OIG reported and those seen in the cases reviewed here. Specifically, based on the recommendations of the OIG report, the Medical Center has instituted the more frequent use of FFR measurements when coronary artery obstructions appear equivocally significant. The reviewers of the cardiac catheterization cohort here made the same recommendation in most of the cases where the standard of care was not met. Although VA **does not substantiate** a substantial and specific threat to public health and safety based on the corrective actions taken by the Medical Center in response to the OIG report, review of the care provided to the six Veterans where the external reviewer opined that the standard of care was not met is warranted, along with disclosures to the Veterans, as appropriate.

- With regard to the peripheral vascular cohort, the external reviewer and the on-site review team differed as to whether the standard of care was met in all cases. However, they agreed that most of the procedures performed on the Veterans in the peripheral vascular cohort may not have been indicated or may not have had an adequate preprocedure evaluation as indicated by the on-site team's recommendation to increase the use of ADU. Although the external reviewer did not agree with the interventional cardiologist's interpretation of the severity of arterial obstruction in at least 50 percent of the cases, the on-site review team did agree with the original interpretations, judging that the standard of care was met. VA

[12] Transesophageal echocardiography (TEE) is an echocardiogram in which the data collecting probe is inserted into the patient's esophagus rather than placed on his or her external chest wall. Technically adequate images are usually obtainable through TEE when echocardiography cannot adequate image the patient's heart. However, TEE requires patient sedation. Nuclear cardiac scintigraphy images the heart after injection of a small dose of radioactive imaging material. Again, adequate images of the patient's heart can be obtained with this diagnostic study despite the inability to obtain technically adequate echocardiograms.

concludes that at least some of the procedures in the peripheral vascular cohort may not have been indicated or may not have had a thorough pre-procedure evaluation.

- Although the external reviewer concluded that the most experienced practitioners might have handled the pericardiocentesis procedure differently, VA concludes that the care provided in this instance was reasonable and within the professional discretion of the VA provider.
  Action Complete.

Supplemental Recommendations to the Medical Center:

1. Review the care provided to the six Veterans in the cardiac catheterization cohort in which the external reviewer opined that the standard of care was not met to ensure appropriate follow-up care has been provided, taking appropriate action based on the outcome of this review. Determine whether any clinical or institutional disclosures are warranted (consistent with the terms of VHA Handbook 1004.08 (2012)); if so, take appropriate action.

2. Ensure all Veterans undergoing a percutaneous peripheral vascular procedure get a thorough preprocedure evaluation, including ADU as appropriate.

3. Institute a combined peripheral vascular conference attended by all physicians performing peripheral vascular procedures including the interventional cardiologist performing percutaneous peripheral vascular procedures to review procedure indications and ensure they are appropriate.

4. Review at least five percutaneous peripheral vascular procedure cases each month for at least 6 months to ensure appropriate care has been rendered.
   Actions Pending.

Original Report Recommendation 2 (for the Medical Center):

Complete the ongoing random review of percutaneous coronary intervention (PCI) cases from September 2014 to February 2015, and take appropriate actions based on results.

Status: Case files including the catheterization images were sent to the William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin for review by physicians who were not on the medical staff at the Medical Center. The cases were performed by both interventional cardiologists between September 2014 and February 2015. The reviewers evaluated a total of 92 cases. In 91 cases, the reviewers judged the cardiovascular care to be Level 1, and in the other, the reviewer judged it to be Level 2.

No further action is indicated regarding external review of the PCI cases. The cases will continue to be monitored at the Medical Center with peer review performed on any questionable cases.
Action Complete.

Original Report Recommendation 3 (for VHA):

Arrange for OMI to complete the ongoing review of the 17 cases among the larger group of 50 cases (cited in Recommendation 1 above) with concerns specific to echocardiography and recommend appropriate action based on the results.

Status: The 17 cases were reviewed by the external reviewer and reported under Original Report Recommendation 1 above. The status of the actions taken based on this review is reported under Original Report Recommendation 4, below.
Action Complete.

Original Report Recommendation 4 (for the Medical Center):

Evaluate the need for implementing a quality assurance program for the echocardiography laboratory.

Status: The Medical Center Cardiology Service reviewed cardiovascular ultrasound imaging protocols and the national quality measures of the American Society of Echocardiography and the American Registry for Diagnostic Medical Sonography and incorporated them into the Medical Center's Echocardiography Laboratory Quality Improvement Program on September 30, 2015.

The Medical Center Cardiology Service has updated its Cardiology Quality Improvement Plan to include competency validation of echocardiography technicians and a quality review of their studies and a competency validation of the Echocardiography Laboratory attending physician staff and a quality review of their interpretations. The Medical Center is also purchasing the Quality Assurance software package, *Echo Test and Teach,* sponsored by the American Society of Echocardiography. The software offers online testing of echocardiogram interpretations and measurements made by both technicians and attending physicians. This software will be implemented by February 15, 2016.
Action pending.

Original Report Recommendation 5 (for VHA):

Conduct a CBI Audit of the Cardiology Department at the Medial Center to determine the extent of copayments inappropriately charged to Veterans and, as appropriate, refund all payments received from Veterans for services that were not provided.

Status: The VHA CBI conducted a compliance review of the Medical Center's Cardiology Department, with collaboration from the Chief Business Office (CBO) and Health Information Management Service (HIMS), to determine the extent to which inappropriate copayments were charged to Veterans and to identify refunds for services not provided.

The CBI completed its audit on November 13, 2015, and found that 282 Veterans treated in the Medical Center's Cardiology Department received 317 inappropriate copayment billings and were due refunds totaling $13,131.95. Twenty-nine providers were responsible for the encounters with documentation deficiencies that resulted in the

inaccurate copayments billed to Veterans. The CBI categorized the individual providers into outlier statuses of "Very High," "High," and "Not an Outlier."[13] The four "Very High" outlying providers were responsible for 273 (84 percent) of the 324 visits with documentation deficiencies. Only the "Very High" and "High" outlying providers are listed below.

Provider Name	Title	Visit Count	Copay Amount	Outlier Status
Physician 2 MD	Cardiology Attending	123	$6,150	Very High
Physician 3	Cardiology Attending	71	$3,550	Very High
Physician 3 Physician 3				
Physician 1 MD	Cardiology Attending	46	$2,300	Very High
Physician 4 MD	Cardiology Attending	33	$1,650	Very High
Physician 5	Nurse Practitioner	7	$350	High
Whistleblower	Cardiology Attending	7	$350	High
Physician 6 Physician 6	Chief, Cardiology	6	$300	High

The CBI concluded that the documentation deficiencies resulting in inaccurate Veteran copayments were systemic across the Cardiology Department. Their audit data shows that the deficiencies extend, at a minimum, to other medical specialties at the Medical Center, and, to some extent, to primary (basic) care. Both VA and the Veterans served by the Medical Center may benefit from a facility-wide copayment examination as part of an Administrative Investigation Board (AIB); however, CBI expects to find similar results at the other VA medical centers they will be reviewing over the next 3 months.

However, CBI did not conclude that the documentation deficiencies or resulting copayment inaccuracies were intentional.
Action complete.

Supplemental Recommendations to VHA:

1. The VHA CBO should review the documentation for each inaccurate copayment charge identified in the audit and cancel each inaccurate charge in the VistA Integrated Billing package.

2. The CBO should process refunds to Veterans for payments made to inaccurate copayment billings, as appropriate.

[13] The outlier groupings are based upon the interquartile range of the *Visit Count* (number of encounters with documentation deficiencies resulting in inaccurate copayments to Veterans). The "Very High" outlier group providers have a *Visit Count* greater than three times the interquartile range while the "High" outlier group providers have a *Visit Count* greater than 1.5 times the interquartile range.

3. Where Veterans were charged for the wrong date-of-service and should have been billed for another date-of-service, CBO should establish accurate copayment charges for the correct date-of-service.
   Action Pending

Supplemental Recommendation to the Medical Center:

4. Provide education and retraining to the Cardiology Department providers and health administration staff related to clinic administration and clinical documentation practices to avoid future errors and complications.
   Action Pending.

Original Report Recommendation 6 (for VHA):

Determine the need for a national control to monitor copayments charged to Veterans.

Status: CBI will evaluate the risk of similarly inappropriate Veteran copayment charges at other VHA facilities and determine the need for nationally standardized controls to detect and prevent the inappropriate charges. CBI will conduct a focused review of three additional VHA facilities based on the findings of the review at the Medical Center, with collaboration from CBO and HIMS.

To complete actions on this recommendation, VHA will provide a final report summarizing the outcome of the three additional facilities reviewed. This report will include recommendations regarding the need for nationally standardized controls to monitor copayments charged to Veterans. This recommendation remains open and in process because it depends on completion of recommendation #5.
Action pending: Estimated completion date–March 2016.

Original Report Recommendation 7 (for VHA):

Subsequent to any additional OIG investigation and the outcome of the CBI audit, convene an AIB by persons not affiliated with the Medical Center or Veterans Integrated Service Network (VISN) 12 to review Interventional Cardiologist 1's inaccurate workload documentation practices and the impact on his performance pay.

Status: OIG declined to investigate this issue on July 8, 2015, after finding documentation that an interface malfunction between the hemodynamic monitoring system in the cardiac catheterization laboratory and the patient electronic health records system from 2006 to September 2014 resulted in recording of duplicate encounters for the same patient visits when that interface was down. The allegation that two physicians also intentionally inflated workload and productivity statistics during the same period appeared to be identical to the problem caused by the malfunction. OIG has determined that attempts to prove the level of individual criminal intent to inflate workload productivity statistics necessary for criminal prosecution would be futile. OIG suggests that this matter would be best addressed by VHA.

As there will not be an OIG investigation, the convening of an AIB to determine if there was provider intent to inaccurately document workload or if there was a beneficial impact on the provider's pay as a result of the inaccurately documented workload was deferred until the results of the root cause analysis in Original Report Recommendation 10 and the initial CBI audit of the Hines Cardiology Service in Original Report Recommendation 5 were completed. Both of these actions have been completed, and the Medical Center reports arrangements for the AIB are underway.
Action pending.

Original Report Recommendation 8 (for VHA):

Consider assessing the need for retraining providers on correct coding practices and workload documentation.

Status: VHA Office of the Deputy Under Secretary for Policy and Services is the lead office to take action on the recommendation to consider assessing the need for retraining providers on correct coding practices and workload documentation.

In September, VHA considered the need for retraining of providers on coding practices. Currently, VHA reviews, educates, and retrains providers on their correct coding on a continuous basis. Pending the outcome of the audit and focused review in recommendation 6, VHA will reassess the need for retraining providers in these areas.
Action pending.

Original Report Recommendation 9 (for the Medical Center):

Assist VHA in its CBI audit of the Cardiology Department to determine and refund all payments received from Veterans for services that were not provided.

Status: All encounters by the Interventional Cardiologist in which services were not provided were reviewed by the North Central Consolidated Patient Account Center (NCCPAC). Seven cases reflected inappropriate billing of copayments, which require refunds. The NCCPAC issued refunds to all seven Veterans.[14]
Action Complete.

Original Report Recommendation 10 (for the Medical Center):

Conduct a root cause analysis of the coding of echocardiograms to determine why work Relative Value Units (RVU) were assigned to physicians other than the interpreting physician, and take corrective action to prevent recurrence.

Status: In response to this recommendation, the Medical Center conducted a root cause analysis of the coding of echocardiograms. Coding of these procedures and the assignment of RVUs to providers is multifaceted. Beginning in 2000, the cardiology

[14] As a result of the original VA investigation, further, immediate investigation by the facility Compliance Officer identified seven Veterans who may have been inappropriately charged a co-payment for services they did not receive. The Medical Center and the NCCPAC concluded the Veterans had been inappropriately charged, and they issued a refund. This cohort of Veterans was identified earlier and differently than the larger cohort identified by CBI in Original Report Recommendation 5.

manager was instructed to "check out" Veterans who were undergoing echocardiography. This administrative, check-out process entailed the prepopulation of the encounter in VistA with the procedure code, diagnosis, and the name of the interpreting provider. If the provider performing the interpretation was not the same provider entered during the check out and did not correct that name to reflect the actual provider interpreting the echocardiogram, the original provider's name would incorrectly be documented as the interpreting physician. The encounter would then be closed with the prepopulated provider, not the actual interpreting physician. Full-time providers are now aware of proper processes for closing out encounters, including correct identification of the interpreting provider. Part-time providers, however, are less likely to be familiar with the process, hence may need cognitive aids to assist with correctly closing out encounters.

As a result of this analysis, the Medical Center has taken two actions. The first is to conduct a campaign to improve compliance with correctly selecting the provider who interprets the echocardiogram with the provider who is closing out the encounter. At the conclusion of this educational effort, the Medical Center will conduct 30 chart audits for 3 months to verify that the provider interpreting the echocardiogram is the provider listed in the encounter note. The second action is to modify encounter notes associated with echocardiograms in the Computerized Patient Record System to ensure that the form is not prepopulated with a "default" provider. The chart audit following the first action will also address effectiveness of this action.
Action pending: Estimated completion date–March 2016.

Original Report Recommendation 11 (for the Medical Center):

Correct the productivity records of the Interventional Cardiologist 1 and Staff Cardiologist 1 from FY 2011 through FY 2014.

Status: The Medical Center's Compliance Officer has reviewed the cardiologists' encounters from April 1, 2010, through June 1, 2015, and produced a list of duplicate encounters. The Medical Center worked with VHA Office of Productivity, Efficiency and Staffing (OPES) to try to correct the past productivity records of these physicians. However, on October 20, 2015, OPES confirmed that the data files for Fiscal Years 2011 through 2015 have been locked down and cannot be changed. The physician productivity for these fiscal years will continue to reflect this error.
Action Complete.