



U.S. OFFICE OF SPECIAL COUNSEL

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The Special Counsel

March 9, 2017

The President
The White House
Washington, D.C. 20500

Re: OSC File No. DI-14-3705

Dear Mr. President:

Pursuant to my duties as Special Counsel, I am forwarding to you two reports of investigation based on disclosures of wrongdoing at the Department of Veterans Affairs (VA), Edward Hines, Jr. VA Hospital (Hines), Hines, Illinois. I have reviewed the reports and, in accordance with 5 U.S.C. § 1213(e), provide the following summary of the reports, whistleblower's comments, and my findings.¹ The whistleblower, Dr. Lisa Nee, a former cardiologist at Hines, who consented to the release of her name, disclosed that serious deficiencies in cardiovascular care and echocardiogram imaging resulted in unnecessary invasive coronary procedures performed on patients and life-threatening delays in treatment. Dr. Nee further alleged that a physician falsely recorded the procedures he performed to boost the appearance of his productivity.

In February 2013, Dr. Nee reported all of these allegations to a union representative at Hines, prompting a congressional inquiry and an investigation by the VA's Office of Inspector General (OIG). OIG's investigation confirmed a number of deficiencies in cardiovascular care at Hines, including unnecessary coronary bypass surgery, inappropriate coronary interventions, and inadequate pre-operative planning. The VA took some corrective actions to improve cardiology care at Hines in response to the OIG investigation. However, despite these initial steps, Dr. Nee disclosed to OSC a number of unresolved issues, as described in detail below. Accordingly, in October 2014, after thoroughly reviewing Dr. Nee's disclosures and ongoing concerns, I referred this matter

¹The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the authority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions exists, she is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c). Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

The President
March 9, 2017
Page 2 of 10

to former Secretary Robert McDonald for further investigation pursuant to 5 U.S.C. § 1213(c) and (d). OIG interviewed Dr. Nee in January 2015 and concluded that no further work on its prior investigation was required. The VA then tasked its Office of the Medical Inspector (OMI) with conducting the investigation in response to my referral. VA submitted its initial report of investigation on June 30, 2015, to which Dr. Nee provided comments; it then issued another report on February 1, 2016, to which Dr. Nee also responded.² Based on my review of Dr. Nee's comments and inconsistencies in the VA's reports, I have determined that the agency's findings do not appear reasonable.

I. Dr. Nee's Allegations

Dr. Nee disclosed that, because of deficient cardiovascular care at Hines, approximately 30 to 40 patients underwent unnecessary coronary artery bypass surgeries and other invasive coronary procedures between January 2011 and March 2013. She alleged that these unnecessary procedures were performed based on the overestimation of coronary artery obstruction detected during cardiac catheterization, and noted that many of the instances of overestimation were attributable to one physician, identified as Interventional Cardiologist 1 in OMI's reports. Dr. Nee contended that the patients who underwent unnecessary coronary procedures were exposed to risks and potential adverse health effects and that Hines neither addressed the root cause of the errors nor informed the patients that they had undergone unnecessary or inappropriate procedures due to diagnostic errors, as required by VA rules.

Dr. Nee also disclosed that 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. When she arrived at Hines in January 2011, the echocardiogram laboratory (lab) had a one-year backlog of unread echocardiogram studies. She found that many of the patients had died or suffered cardiac complications before their studies were reviewed. She worked to reduce the backlog, which was resolved prior to her departure in April 2013. Dr. Nee also asserted that the lab lacked adequate quality assurance, which adversely affected the quality of the echocardiogram studies produced. Lab technicians did not receive adequate training or follow a standard study protocol, and there was no mechanism for compliance with written protocols.

Dr. Nee further alleged that Interventional Cardiologist 1 falsely recorded the number and type of procedures he performed in an effort to inflate his productivity metrics. She identified numerous cases in which Interventional Cardiologist 1 falsely

² Dr. Nee's disclosures to OSC addressed deficiencies in medical care as well as improper business practices at Hines. Because OMI had contracted for an external review of the medical care allegations, investigation of the improper procedure recording was likely to be completed before the completion of the investigation into the medical care issues. OSC and OMI therefore agreed that the VA would issue successive reports addressing its findings upon completion of the investigation in these respective areas.

The President
March 9, 2017
Page 3 of 10

coded or “charged” for procedures that he did not perform. This practice resulted in the inflation of Interventional Cardiologist 1’s relative value units (RVUs), a workload measure used to compare productivity, evaluate performance, and determine bonuses and awards. Dr. Nee also reported that, in several cases, Interventional Cardiologist 1 and the Chief of Cardiology were listed as the interpreting physicians on echocardiogram studies that Dr. Nee had actually interpreted.

II. The VA’s Reports

A. OMI’s Initial Report

1. OMI’s Findings

In its initial report of investigation dated June 30, 2015, OMI summarized OIG’s previous findings of deficiencies in cardiovascular care at Hines, including unnecessary coronary bypass surgery, inappropriate coronary interventions, and inadequate pre-operative planning. OMI found that Hines had implemented some of OIG’s recommendations to address the deficiencies, including convening a cardiology review by the VA’s National Cardiology program and forming a committee to examine reasons for differences in recommending coronary artery interventions; increasing use of the fractional flow reserve (FFR) method to measure coronary artery obstruction; initiating a review of percutaneous coronary intervention cases; and reinstating a cardiology/cardiothoracic surgery conference to exchange professional viewpoints. However, OMI substantiated that Hines had not informed the affected patients of the inappropriate care they received. Following OMI’s site visit, Hines disclosed OIG’s findings to 11 of the 12 patients, determining that notification of the 12th patient was not necessary. OMI also concluded that the backlog of unread echocardiogram studies that Dr. Nee had disclosed was resolved in 2012. However, OMI found that Hines still did not have a quality assurance program for its echocardiogram lab and that such a program could improve the quality of the echocardiograms. Consequently, OMI recommended that Hines consider adopting such a program.

With regard to Dr. Nee’s allegations concerning improper coding practices at Hines, OMI’s investigation substantiated that Interventional Cardiologist 1 improperly coded medical procedures and inflated his productivity measures. OMI found that, from 2011 to 2014, Interventional Cardiologist 1’s RVUs increased by 204 percent. By comparison, the RVUs for the other interventional cardiologist increased by 14 percent. OMI identified three improper coding patterns used by Interventional Cardiologist 1 that contributed to the significant increase in his encounters and productivity measures. The first pattern consisted of coding one or more encounters for services that were not provided according to the patient’s electronic health record (EHR). Hines management explained that there had been an interface malfunction between the hemodynamic monitoring system in the cardiac catheterization lab and the EHR system, which resulted

The President
March 9, 2017
Page 4 of 10

in duplicate coding of single encounters. OMI noted, however, that it would expect the proportion of duplicate encounters to be similar for the two interventional cardiologists; yet, OMI found that Interventional Cardiologist 1 had a much greater number of patient visits documenting services that were not performed than the other interventional cardiologist. OMI concluded that it could not fully explain this coding pattern based on the interface malfunction.

The second coding pattern involved Interventional Cardiologist 1 recording encounter codes for outpatient visits that did not occur. In one example, Interventional Cardiologist 1 documented that he left a telephone message for a patient, but recorded this encounter as an outpatient visit and received RVU credit for the visit. Under the third coding pattern, Interventional Cardiologist 1 entered a procedure note documenting the performance of a cardiology procedure and a separate outpatient visit note for the same day, creating the appearance of two separate encounters. Thus, Interventional Cardiologist 1 received additional RVU credit for separate outpatient visits that were already incorporated into the RVUs credited for the procedures performed. OMI also found that Interventional Cardiologist 1 and the Chief of Cardiology received RVUs for echocardiograms interpreted by Dr. Nee.

OMI substantiated that Interventional Cardiologist 1's improper coding for outpatient visits that had not occurred and services that were not performed artificially inflated his clinical performance and productivity metrics from 2011 through 2014. OMI found that he contributed to his inflated productivity measures by personally entering codes for services he did not provide, and that his performance awards for these years may have been inflated to an undetermined extent. OMI further substantiated that some veterans were improperly charged \$50 copayments for clinic visits that did not occur and care they did not receive. OMI concluded that Interventional Cardiologist 1's actions constituted mismanagement and a violation of VHA Handbook 1907. OMI also determined that these actions constituted a possible violation of 18 U.S.C. § 208, and referred this potential criminal matter to OIG, as required by 38 C.F.R. § 1.204. OIG declined to open a criminal investigation of this matter.

2. OMI's Initial Recommendations

OMI's initial report recommended that VHA and/or Hines: 1) complete an ongoing review of percutaneous coronary intervention cases as recommended by OIG; 2) conduct a Compliance and Business Integrity (CBI) audit to determine the extent of improper copayments and reimbursement owed to veterans; 3) convene an Administrative Investigation Board (AIB) to review Interventional Cardiologist 1's inaccurate coding practices and the impact on his performance pay, following any additional OIG investigation and the CBI audit; 4) consider retraining providers on coding and documentation; 5) conduct a root cause analysis of echocardiogram coding to determine

The President
March 9, 2017
Page 5 of 10

why physicians other than the interpreting physician received RVU credit; and 6) correct Interventional Cardiologist 1's productivity records from 2011-2014.

B. OMI's Supplemental Report

1. OMI's Findings Concerning Cardiovascular Care at Hines

OMI initiated an independent review of 49 cardiovascular cases that Dr. Nee previously provided to the VA OIG, along with one case identified during OMI's site visit. Board-certified cardiologists, interventional cardiologists, and a vascular surgeon conducted this review; none of these was associated with the VA (external review/reviewers). The 50 cases included 17 echocardiogram studies and 33 cardiology procedures, including 10 peripheral vascular procedures, 22 cardiac catheterization procedures and one pericardiocentesis. Interventional Cardiologist 1 performed all 33 cardiology procedures.

According to this independent review, 82 percent of the echocardiogram studies were "technically inadequate." In more than half of the studies, the reviewer disagreed with the original interpretation and determined the study was not adequate to address the stated clinical indication. As to the cardiac catheterizations, the external expert agreed that the procedure was indicated in all cases, but disagreed with Interventional Cardiologist 1's original interpretation and recommended treatment plans in more than 40 percent of those cases. The independent review found that standard of care was not met for 27 percent of the patients, as the severity of the coronary artery obstruction was overestimated.

The independent review revealed that the peripheral vascular procedure was not indicated in 70 percent of the cases because the pre-procedure evaluation was deficient. The independent expert disagreed with the initial interpretation in 50 percent of these cases and with the recommended treatment plans in 80 percent of these cases and ultimately determined that the standard of care was not met. After receiving OMI's external review findings, Interventional Cardiologist 1 voluntarily ceased performing percutaneous peripheral vascular procedures.

In response to these independent medical review findings, Hines conducted its own assessment of peripheral vascular cases, including nine of the ten cases externally reviewed and ten additional cases. A VA interventional cardiologist and a VA nurse manager responsible for VHA's cardiac catheterization nursing standards carried out Hines's assessment. They determined that the care was "definitely appropriate" in 17 cases and "may be appropriate" in the remaining two cases. In contrast to the external review, the VA reviewers concluded that the standard of care was met in 100 percent of the cases and recommended increasing the use of additional ultrasound evaluations and convening conferences with physicians to review procedure indications. Following

The President
March 9, 2017
Page 6 of 10

Hines's on-site internal review, Interventional Cardiologist 1 resumed performing percutaneous peripheral vascular procedures.

Despite the serious deficiencies revealed by OMI's independent review, OMI nonetheless concluded that none of these deficiencies constituted a substantial and specific danger to public health or safety. Specifically:

- OMI did not find a danger to public health or safety with the peripheral vascular cases, despite the independent review findings that the procedures were not indicated in 70 percent of the cases and the standard of care was not met in 80 percent. Acknowledging the starkly different findings of Hines's questionable on-site review, OMI inexplicably tempered its findings and concluded that "at least some of the procedures . . . may not have been indicated or may not have had a thorough pre-procedure evaluation." Although OMI recommended that Hines prospectively review five percutaneous peripheral vascular cases per month for six months, there was no recommendation for further review of follow-up care or disclosure to the eight patients for whom the external reviewers determined the standard of care was not met.
- For the cardiac catheterization cases, where the external reviewers observed the pattern of overestimation of coronary artery obstruction, OMI did not ultimately find there was a substantial and specific danger to public health and safety. They based this determination on the corrective actions taken to address the deficiencies previously identified by OIG, including the increased use of the FFR measurement method to improve diagnostic accuracy in borderline cases of coronary artery obstruction.
- OMI substantiated that 82 percent of the echocardiograms were technically inadequate, but concluded that this did not pose a substantial and specific danger to public health and safety. OMI noted that differences of professional opinion in reading technically inadequate studies are common and, in light of the availability of alternative diagnostic tests, do not constitute a deviation from the standard of care. However, OMI did not say whether any alternative diagnostic tests were actually performed and failed to provide any information on patient outcomes in these cases.
- For the one pericardiocentesis, where the procedure was indicated but not completed, and the external review determined that most experienced practitioners might have managed the case differently, OMI concluded without explanation that the care provided was reasonable.

The President
March 9, 2017
Page 7 of 10

2. VA's Implementation of OMI's Initial Recommendations

In its supplemental report, OMI also addressed whether and to what extent the VA implemented the recommendations from its initial report. From March 2014 to February 2015, the VA conducted the recommended random review of percutaneous coronary intervention cases and concluded that the care provided in those cases was appropriate. Hines also implemented OMI's recommendation to establish a quality assurance program for the echocardiogram lab that includes competency validation of technicians and attending physicians.

Pursuant to OMI's recommendation, the VA conducted a CBI audit to determine the extent of improper copayments charged to veterans. The CBI audit revealed that the Cardiology Department charged 317 inappropriate copayments totaling roughly \$13,000. The auditors found that inaccurate copayments were attributable to 29 providers for encounters with "documentation deficiencies," and that the deficiencies extended to other medical specialties at Hines. The CBI auditors concluded that neither the deficiencies nor the copay charges were intentional. The report noted that the VA is reviewing copayment charges at other VA facilities to determine the scope of the problem and whether standardized controls are necessary. The VA confirmed that veterans who were improperly charged copayments by Hines have been reimbursed.

Additionally, the root cause analysis of echocardiogram coding recommended by OMI revealed that errors made in the administrative check-out process for echocardiograms resulted in providers other than the interpreting physician erroneously receiving credit for interpreting the echocardiograms. Hines has initiated steps to educate staff on the check-out process and avoid errors in the patient records system.

Prior to issuance of OMI's supplemental report, the VA had not conducted the AIB recommended by OMI to review Interventional Cardiologist 1's coding practices and the impact on his performance pay. However, OMI subsequently advised OSC that the AIB was completed and did not result in any action taken with respect to OMI's findings of Interventional Cardiologist 1's artificial inflation of his clinical performance and productivity.

Finally, OMI reported that OIG declined to investigate Interventional Cardiologist 1's improper coding practices for a possible criminal violation after finding documentation that the interface malfunction described by Hines resulted in recording duplicate encounters for the same patient visits. OIG determined that attempts to prove the level of individual criminal intent necessary for prosecution would be futile and suggested that VHA should handle the matter. Aside from whether there was sufficient evidence to support criminal prosecution, OIG's determination that the interface malfunction appeared to be the cause of the inflated productivity data is not consistent with the evidence and conclusions reached by OMI regarding Interventional Cardiologist

The President
March 9, 2017
Page 8 of 10

1's improper coding. As noted, OMI found that this physician engaged in multiple improper coding patterns that the interface malfunction could not explain, including coding for patient visits that never occurred and services he never provided. The VA has also taken the position that the Interventional Cardiologist 1's productivity records for 2011-2014 cannot be changed, as OMI recommended. Thus the erroneous productivity data remains in place.

3. *OMI's Supplemental Recommendations*

In its supplemental report, OMI made the following additional recommendations: (1) review the care provided to the six patients who underwent cardiac catheterization for whom the external reviewers determined the standard of care was not met to ensure appropriate follow-up care has been provided and determine whether any disclosures were warranted; (2) ensure that all veterans undergoing percutaneous peripheral vascular procedures receive a thorough pre-procedure evaluation; (3) institute a combined peripheral vascular conference with the 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 per month for six months to ensure appropriate care was provided; 5) ensure that all improper copayment charges are cancelled and veterans are reimbursed; and 6) provide education and retraining to staff on clinic administration and documentation. OMI confirmed that Hines has implemented all of these actions.

C. *OIG's February 2017 Report*

In its June 2015 report, the VA referenced an OIG review of more recent delays in administering echocardiograms and the quality of these studies. OSC requested a copy of the OIG analysis. On February 2, 2017, OIG provided its report, which substantiated delays in performing 1,226 of 1,979 echocardiogram studies in 2014.⁴ OIG found that, in one case there was a three-month delay in diagnosing a condition that required surgery. OIG concluded that the delay had the potential to cause harm, but no apparent adverse effects occurred. OIG found, however, that Hines had not disclosed this potentially harmful adverse event to the patient, in accordance with VA policy. Hines subsequently disclosed this information to the patient. OIG confirmed that it did not review 2015 data, but that Hines provided data from September to October 2016 showing that the average time for performing an echocardiogram was 11 days from the request.

OIG also substantiated deficiencies in the quality of echocardiograms. OIG found the quality of the majority of 50 sample echocardiogram studies performed between July

⁴OIG's Healthcare Inspection Report, *Echocardiography Scheduling and Quality of Care Concerns, Edward Hines, Jr. VA Hospital, Hines, Illinois*, is available on OIG's website at <https://www.va.gov/oig/pubs/VAOIG-15-01900-142.pdf>.

The President
March 9, 2017
Page 9 of 10

2014 and January 2015 was “poor” and may be attributable to the competency or skills of the lab technicians. OIG nevertheless concluded that all of the studies were sufficient for clinical decision-making. OIG found no evidence of a formal performance improvement process or any performance improvement activities for the lab technicians. OIG has since confirmed, however, that Hines implemented a Cardiology Quality Improvement Plan in September 2015 and provided information to OIG in November 2016 regarding the improvement opportunities and continuing education offered to the lab technicians, as well as data from the Quality Council Reports, staff meetings, and annual competency assessment.

III. Dr. Nee’s Comments to OMI’s Reports

Dr. Nee provided comments on OMI’s reports, expressing concern regarding the VA’s lack of accountability. She noted that neither OIG nor OMI addressed the additional allegations of patient harm she provided to OIG in her January 2015 interview and subsequently to OMI. She asserted that the outcomes reported by the independent review would be disturbing to any legitimate health care system, noting that they provide “overwhelming evidence” of inadequate medical testing, deficient evaluations, and harmful treatment plans based on erroneous medical conclusions. She noted that Hines’s response to these disturbing findings, *i.e.*, to launch its own review and reach different conclusions, denied the problems rather than address issues of patient harm.

Regarding the inadequate echocardiograms, Dr. Nee questioned how OMI could conclude that failing to interpret an essential cardiac test did not adversely affect patient outcomes, particularly where outcomes were not reviewed. She stated that none of the patients was offered additional diagnostic options and the VA charged for tests that were invalid. She further commented that OMI failed to report the outcome of the pericardiocentesis that was not completed and stated that this patient died. Dr. Nee also noted that the independent review confirmed the pattern of overestimation of coronary artery obstruction resulting in unnecessary invasive procedures that carry significant risks to the patients. Nevertheless, the VA did not find this to be a threat to patient health and safety.

Dr. Nee also commented on OMI’s substantiation of Interventional Cardiologist 1’s improper coding practices, emphasizing that an interface malfunction in a computer system used by all of the physicians would demonstrate proportionate numbers of excess encounters among the physicians, but it did not. Dr. Nee provided additional data on encounters per physician in the cardiac catheterization lab reflecting the disproportionate percentage of excess encounters for Interventional Cardiologist 1. She contended that the VA has attempted to use the interface malfunction and the CBI audit of copayments to distract from and undermine OMI’s findings and avoid accountability for fraudulent billing practices.

The President
March 9, 2017
Page 10 of 10

IV. Findings

I have reviewed the original disclosures, agency reports, and Dr. Nee's comments. I have determined that the reports contain all of the information required by statute. However, I do not find reasonable the VA's conclusion that none of the findings constitutes a substantial and specific danger to public health or safety. The reports confirm deficiencies in cardiovascular care at Hines, where, in many cases, the cardiac procedures performed on patients were not indicated and the standard of care was not met. The reports reflect that Hines has taken corrective actions and that more recent cases indicate some positive results. Nevertheless, the reports do not provide adequate information demonstrating that these corrective actions have addressed and resolved the substantiated deficiencies, such as the poor quality of echocardiograms and the pattern of diagnostic errors by Interventional Cardiologist 1.

Further, the VA has not addressed OMI's troubling findings regarding Interventional Cardiologist 1's improper coding for patient visits that did not occur and services he did not provide, and the resulting artificial inflation of his productivity measures. The CBI audit may have revealed a broader issue of improper copayment charges at Hines and other VA facilities; however, the audit findings neither alter nor negate the evidence provided and conclusions reached by OMI regarding Interventional Cardiologist 1's multiple improper coding patterns. Nevertheless, there is nothing in the VA's report suggesting that Hines took action to address these issues with Interventional Cardiologist 1. Dr. Nee's comments highlight the inconsistencies in the VA's findings, as well as the lack of accountability in this case, despite the significant findings by both OIG and OMI. Hines has demonstrated a pattern of recalcitrance, and further review is required to ensure the full resolution of the problems at Hines.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of this letter, the agency reports and whistleblower's comments the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of the redacted reports and whistleblower's comments in our public file, which is available online at www.osc.gov. OSC has now closed this matter.

Respectfully,



Carolyn N. Lerner

Enclosures