



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Alleged Mismanagement of the Fee Basis Program

VA Connecticut Healthcare System, West Haven, Connecticut

To Report Suspected Wrongdoing in VA Programs and Operations

**Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time,
Monday through Friday, excluding Federal holidays**

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Executive Summary

The purpose of this inspection was to determine the validity of allegations regarding the mismanagement of the Fee Basis Program at the VA Connecticut Healthcare System (the system), West Haven, CT. We substantiated that the pre-authorization process for fee-based care was flawed. However, managers initiated new procedures to improve the process prior to the inspection. We did not substantiate that VA physicians self-referred VA patients through the affiliate hospital or benefited financially from fee basis claims paid to the affiliate hospital. We did not substantiate that the system inappropriately utilized the affiliate hospital as a sole source referral center rather than putting scarce or complex medical services through a bidding process.

We concluded that there was an overall lack of oversight of the program by Business Office and Compliance and Business Integrity (CBI) managers; and ultimately, by senior managers, and this had a causal effect on the appearance of self-referrals and conflict of interest. We concluded that the absence of formal agreements, such as contracts, sharing agreements, or memoranda of understanding (MOUs) also contributed to the appearance of conflict of interest and may have resulted in some overpayments to the affiliate hospital. Additionally, we concluded that CBI managers needed to conduct regular audits of fee basis claims and ensure compliance with VA regulations.

We recommended improved oversight of the fee basis program and an assessment of services currently being paid through fee basis to determine if formal agreements for those services should be considered. Additionally, we recommended that Business Office managers provide trended program data to senior managers and that CBI managers conduct regular audits of the program and develop processes to ensure issues identified are monitored until they are resolved. We also recommended enhanced training for physicians regarding VA regulations governing self-referral and conflict of interest and that the training be documented.



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

TO: Director, VA New England Healthcare Network (10N1)

SUBJECT: Healthcare Inspection – Alleged Mismanagement of the Fee Basis Program, VA Connecticut Healthcare System, West Haven, Connecticut

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) reviewed allegations regarding mismanagement of the Fee Basis Program¹ at the VA Connecticut Healthcare System (the system), West Haven, CT. The purpose of the inspection was to determine the validity of the allegations.

Background

The system consists of two divisions located in West Haven and Newington, CT. The West Haven division provides medical, surgical, mental health, and long-term care services through a full range of inpatient and outpatient programs. The Newington division is an ambulatory care center that provides primary and specialty care services and is the site of the system's Fee Basis Program. The system is academically affiliated with Yale University School of Medicine and the University of Connecticut School of Medicine and School of Dentistry.

The complainant contacted OIG's Hotline Division on October 9, 2008 alleging that:

- The system's pre-authorization process for fee based care was flawed.
- Physicians on staff at the system and who also had clinical privileges at Yale New Haven Hospital (YNHH) referred patients for care to YNHH and then provided the care (known as self-referral). The complainant also alleged that the system paid these physicians professional fees for providing the services. The complainant specifically

¹ Fee basis allows VA to authorize veterans' medical care in the community when VA cannot provide all of the necessary care and services. Pre-authorization is required for both inpatient and outpatient fee based care.

identified sleep studies;² ear, nose, and throat (ENT) procedures; and Electrophysiology (EP) procedures.³

- The system utilized YNHH as a sole source referral center rather than putting scarce or complex medical services through the bidding process.

The complaint was forwarded to OHI February 11, 2009. Additionally, inspectors followed up on a related allegation that a part-time VA ENT physician who was also part time with Yale Medical Group (YMG) was referring patients to YNHH for audiology studies that could be performed by the system's Audiology Department.

Scope and Methodology

Inspectors interviewed the complainant by telephone on February 17 and conducted the initial site visit February 23–26, with a follow-up visit April 21–22. Inspectors interviewed the complainant, senior managers, the compliance officer, the Chief of Surgical Service, clinicians, and other employees pertinent to the complaint. They also reviewed a sample of fee basis claims provided by the complainant. In addition, they conducted telephone interviews with the Veterans Integrated Service Network (VISN) Business Office Manager and VA Central Office Deputy Chief Business Officer for Purchased Care. Inspectors also reviewed a sample of medical records related to the fee basis claims.

Inspectors conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: Pre-authorization Process

Inspectors substantiated that the pre-authorization process for fee-based care was poorly defined and difficult to track. Increased oversight of the Fee Basis Program began around September 2008 when the system's business office manager (BOM) became aware that there was a backlog of several months of unpaid claims. The BOM and other business office employees said that when payment claims were submitted for fee based care, they frequently could not establish who authorized the care. The process seemed to be that a clinician would request fee based care, the request would go to the Chief of Staff (COS) for approval, and the COS would sign an approval form (VA Form 10-0114A). Apparently, the approval was communicated to the requesting physician, but the form did not become part of the computerized patient medical record, and it was not forwarded to the Fee Basis Program. In fact, when asked what happened to the forms, no one seemed to know.

² A sleep study is a multiple-component test that electronically transmits and records specific physical activities while the patient sleeps. The recordings are analyzed by a specialist to diagnose various sleep disorders.

³ Specifically, pacemaker and cardioverter-defibrillator implants.

This process created a dilemma for fee-basis personnel who had a VA performance measure to pay fee basis claims within 30 days. They frequently had to conduct time-consuming chart reviews or searches for documents that showed that the billed services were authorized and were actually provided. This prevented them from meeting the performance measure and contributed to the backlog of unpaid claims. Inspectors verified the difficulty of finding pre-authorization and proof that services were performed by doing medical record reviews from a sample of the fee basis claims provided. Not only could inspectors not tell who authorized the care, but it was sometimes difficult to find documentation to support that the care was provided.

In October, the BOM brought the issues with the pre-authorization process to the attention of the system Director and proposed using the computerized consult package to document pre-authorization for fee based care, making the process transparent and easily traceable. Senior and clinical managers approved the process and implementation took place approximately 2 months prior to the February visit. The system Director asked the BOM to monitor compliance with the process; but the data provided were not trended in a meaningful way, such as by clinical section, requested service, or requesting provider.

Issue 2: VA Physicians Self-Referred and Received Professional Fees.

Sleep Studies

Inspectors did not substantiate that a full-time VA physician made self-referrals to the Yale Center for Sleep Disorders (YCSD) and then collected professional fees for interpretation of the studies. Sleep studies have two components, the test that is performed in a specially equipped sleep laboratory by trained technicians, and the interpretation of the test by a physician. The system performed sleep studies in its own sleep laboratory, but the demand for the studies became more than the system could manage. Consequently, the system began referring patients to the YCSD and to another community sleep center. Inspectors were told that YCSD could accommodate a higher volume of patients, so the majority of the studies were referred to that facility. However, the YCSD did not always provide the interpretation of the study, but sent the study back to the referring VA physician for interpretation. The BOM provided inspectors several claims for payment for sleep studies performed at YCSD. These claims were identified as demonstrating self-referral and payment for professional fees to the VA physician because the VA physician was named as the referring physician and the physician who provided the service.

Initially, inspectors were under the impression that these bills were for professional fees only and that the Fee Basis Program received separate bills that represented technical fees (use of the laboratory, equipment, and technicians). However, after further investigation, it was found that the claims included both professional and technical fees.

The medical record review showed that the VA physician was the interpreting physician for several of the studies, giving the appearance that the physician was benefiting financially from the referral of patients to YCSD. However, inspectors determined that YCSD sent one bill that combined the technical fees and professional fees. There was a special designation on the bill that allowed fee basis clerks to determine that the bill included both technical and professional fees. Depending on the Current Procedural Terminology (CPT®)⁴ code for a sleep study, the professional fee might be \$191.52 or \$205.71. Also depending on the CPT® code, the total amount paid for each study was at the Medicare rate and ranged from \$933.87 to \$1,207.14. This showed that the largest portion of the payment went toward technical fees. When asked why, based on the fee basis clerks review of claims, the professional fees were not deducted prior to payment; inspectors were told that the clerks were unaware that the physician named as the supplier of services was a VA physician. Inspectors determined that even though professional fees were included in the bills from YCSD, the VA physician did not receive those professional fees and the entire amount was received by YCSD. This actually resulted in overpayments to YCSD. The investigation also showed that a lack of oversight of the Fee Basis Program and the weak pre-authorization process for fee based services had a direct causal effect on the perception of self-referral.

Ear, Nose, and Throat Procedures

Inspectors did not substantiate that part-time VA ENT physicians referred patients to themselves at YNHH for ENT procedures or that the physicians referred patients for studies that could be performed by the system's Audiology Department. Inspectors reviewed 35 ENT consult and fee basis claims. The claims listed a part-time VA provider as being both the referring physician and the provider performing the services. With the exception of two claims, the services were for diagnostic audiology⁵ studies for patients exhibiting dizziness and loss of balance. As with sleep studies, specially trained technologists (audiologists) perform these studies. The studies also require specialized equipment. The Chief of Surgery confirmed that the audiology studies identified in the consults and claims could not be performed by the system's Audiology Department due to the lack of proper equipment; therefore, had to be performed at YNHH. The part-time VA ENT physician reviewed the results of the studies and initiated appropriate treatment. As with the sleep studies, the claims sent from YNHH were for both professional and technical fees, and there was no evidence to support that the physician directly benefited financially from the payments to YNHH. The Chief of Surgery also confirmed that there was no contract, sharing agreement, or memorandum of understanding (MOU) between the system and YNHH for audiology services. Thus, the overall lack of oversight of the Fee Basis Program, the weak pre-authorization process, and the lack of a formal agreement with YNHH for ENT services contributed to the perception of self-referral.

⁴ CPT® codes are the most widely accepted medical nomenclature used to report medical procedures and services under public and private health insurance programs.

⁵ Audiology: the science of hearing, especially diagnostic testing.

Electrophysiology Procedures

Inspectors did not substantiate that VA physicians made self-referrals for EP services performed at YNHH then inappropriately received payment for the performance of those services. The physicians named by the complainant were under contract and not VA employees. They were employees of the YMG affiliated with Yale University School of Medicine and YNHH. These contracted physicians conducted EP clinics one day per week at the system, and the contract was for specific CPT codes related to EP procedures, primarily pacemaker and cardiac defibrillator insertions.

Inspectors reviewed 16 claims for EP services that occurred over the past year. The BOM identified these claims as examples of self-referral. The actual consult process for EP services was that either the head of the cardiology clinic or the cardiology nurse practitioner would refer patients who they assessed to need EP procedures to the EP clinic. If the EP specialist concurred with that assessment, he/she would schedule the procedure. When the contract was negotiated in June 2006, the plan was that the procedures would be performed in the system's newly constructed cardiac catheterization laboratory; however, due to construction delays, the catheterization laboratory is still not operational, necessitating that the procedures be performed at YNHH.

Because the referral and pre-authorization process was not clearly defined, the claims coming from YNHH erroneously listed the contracted physicians as the referring physicians and the providers of the services, giving the appearance of self-referrals and conflicts of interest. The Inspection did reveal that the contract physicians were paid through the fee basis program rather than the contract and that the BOM was unaware of the EP contract. However, the differences between the fee basis and contract fees were minor. Inspectors concluded that more vigilant management oversight at the Business Office and senior management levels would have prevented payment through fee basis rather than the contract. By the time of the April visit, managers had taken action to pay for EP procedures under the contract.

Issue 3: Sole Source Referral

Inspectors did not substantiate that the system inappropriately referred medical services to YNHH. VHA regulations⁶ state that sole source awards with affiliates should be considered the preferred option whenever education and supervision of graduate medical trainees is required because training programs are direct contributors to a facility's productivity. An affiliation is a relationship between VA and an educational institution or other health care facility, such as YNHH for the purposes of enhanced education and patient care. The same regulations address conflict of interest guidelines for employees who have certain relationships with non-VA parties involved with procurements. The

⁶ VA Directive 1663, *Health Care Resources Contracting – Buying*, Title 38 U.S.C. 8153, August 10, 2006.

regulations require VA employees to sign an acknowledgement that they understand the conflict of interest rules. However, the inspection showed that this form was not routinely used and there was no training in place to ensure that physicians were aware of the potential for conflict of interest.

Other Issues

At the time of the February visit, inspectors found that the system's Compliance and Business Integrity (CBI) Office did not have processes in place to evaluate the system's fee basis practices as required by VA regulations.⁷ The first fee basis audit was dated January 2008 and concluded that controls for the program were in place and determined that conflict of interest did not exist for referring clinicians. The second audit, dated December 2008 was performed after the BOM brought the concerns about self-referral and the payment of professional fees to VA physicians to the system Director's attention. This audit focused only on the claims provided by the BOM and did find the appearance of self-referral and conflict of interest in 37 of 51 (73 percent) of the bills reviewed. According to the CBI Officer's position description, the CBI Officer "will use audits and/or other evaluation techniques to monitor compliance and to assist in the reduction of identified problem areas," and develop and implement "regular effective education training programs" for employees. While the CBI Officer was in that position since 2003, the first audit did not occur until January 2008. Additionally, while some CBI information was provided during new employee orientation, there was no process in place to specifically address conflict of interest issues with physicians; and physicians were not required to sign an acknowledgement attesting that they received and understood the regulations. During the April visit, we found that the system began to address these issues.

The inspection also showed that processes to track and trend fee basis practices for the purpose of identifying opportunities to improve those practices was lacking in both the CBI office and the business office. Even though the system Director asked the BOM to provide trended data; for example, to assess the effectiveness of the newly implemented pre-authorization process; there was no evidence that this was done. Also, the CBI and business office managers did not appear to have the type of collaborative relationship conducive to the timely identification of potential or real compliance issues and the implementation of corrective actions.

Conclusions

We concluded that the pre-authorization process for fee-based services was weak and not transparent. However, we also concluded that VA physicians were not self-referring or benefiting financially from claims paid to YMG or YNHH through the Fee Basis Program. We did determine that there was an overall lack of oversight of the Fee Basis

⁷ VHA Handbook 1030.01, *Compliance and Business Integrity (CBI) Program Administration*, July 31, 2006.

Program by the BOM, the CBI officer, and ultimately senior managers, which had a causal effect on the appearance of self-referrals. We also concluded that between the February and April visits, system managers began to put processes in place to improve oversight of the fee basis program; however, there needs to be a mechanism to ensure that this oversight is sustained.

We concluded that the absence of formal agreements also contributed to the appearance of conflict of interest and may have resulted in some overpayment to YNHH and/or YMG. The BOM needs to provide the system Director with trended data regarding high volume services currently paid through fee basis that might be better provided through such agreements. Other trended data necessary to ensure compliance with VA regulations needs to be identified through a collaborative effort by the Business Office, the CBI office, and senior managers.

The CBI Office needs to conduct regular audits of fee basis claims and ensure compliance with VA regulations. The claims should be chosen in such a manner that samples of all services paid for through the program are eventually represented. This office also needs to ensure that providers, especially those VA providers who have privileges at community facilities, receive information regarding VA regulations governing self-referral and conflict of interest; and those providers need to attest in writing that they received and understand the regulations.

Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the System Director requires improved oversight of the Fee Basis Program and the development of processes that will ensure that oversight is sustained.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires an assessment of services currently being paid through the Fee Basis Program to determine if contracts, sharing agreements, or MOUs for those services should be considered.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires the BOM provide trended Fee Basis Program data, the CBI Officer conducts regular audits of the Fee Basis Program, and processes are developed to ensure that issues identified are monitored until they are resolved.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires physicians receive information regarding VA regulations on self-referral and conflict of interest, that physicians attest to their understanding in writing, and that the signed attestation be placed in providers' training or credentialing and privileging files.

OIG Comments

The VISN and Healthcare System Directors agreed with the findings and recommendations of the inspection and provided acceptable action plans. (See Appendixes A and B, pages 9–13, for the full text of the Directors’ comments). We will follow up on the planned actions until they are completed.

(original signed by:)

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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 29, 2009

From: Director, VA New England Healthcare Network (10N1)

Subject: **Healthcare Inspection – Alleged Mismanagement of the Fee Basis Program, VA Connecticut Healthcare System, West Haven, Connecticut**

To: Regional Director, Office of Healthcare Inspections (54BN)

The Network concurs with each of the four (4) recommendations, concurrences, and the action for correction within the narrative summary for each.

(original signed by:)

MICHAEL F. MAYO-SMITH, MD, MPH

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 29, 2009

From: Director, VA Connecticut Healthcare System (689/00)

Subject: **Healthcare Inspection – Alleged Mismanagement of the Fee Basis Program, VA Connecticut Healthcare System, West Haven, Connecticut**

To: Regional Director, Office of Healthcare Inspections (54BN)

Thank you for the opportunity to respond to the findings of this Healthcare Inspection. We found the assessment to be thorough, fair and collaborative and we thank Katherine Owens for her professionalism and collegiality throughout the process. Below you will find concurrence on all four (4) recommendations and supporting narrative for the efforts that VA Connecticut Healthcare System has taken to begin to create meaningful controls to the Fee Basis Program.

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

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the System Director requires improved oversight of the Fee Basis Program and the development of processes that will ensure that oversight is sustained.

Concur.

In order to assure that there was consistency of process in place, the Medical Center Director established a Fee Basis Oversight Committee, chaired by the Chief Fiscal Officer. The charge of this interdisciplinary committee (composed of representatives from the Chief of Staff, Compliance, Business, Care Coordination and Director's Offices, respectfully) is to establish regular metrics that will be tracked over time to assure that processes are sustained and appropriately monitored according to the applicable rules and regulations of Fee Basis Care. The committee starts out by reviewing the prior month's authorization and the historical trend to establish if there is a need to consider an MOU, sharing agreement or contract if there has been a significant amount of fee basis by service. This is followed by a report from the COS office regarding MOUs, sharing agreements or contracts that are in progress. Next, the committee reviews business office data to establish if bills have been paid, if there were any perceived conflicts of interest and to understand the timeliness of claim payments. Finally, the committee reviews monthly audits from the compliance office as a check and balance of the aforementioned process.

All of this information is collected into meaningful minutes, coordinated by Quality Management and submitted through the chairperson to the Medical Center Director for approval, concurrence and, if necessary, action. It is our belief that this committee structure provides a robust, organized framework to assure that oversight is clear and sustained over time.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires an assessment of services currently paid for through the Fee Basis Program to determine if contracts, sharing agreements, or MOUs for those services should be considered.

Concur.

A comprehensive assessment has begun to understand which services paid for through the Fee Basis program that warrants a contract, sharing agreement and/or MOU for those services. This is accomplished at the monthly Fee Basis Oversight Committee where the Fee Basis Care Coordinator and COS office bring cogent, trended data on the services that are being fee based as well as status of contracts, MOUs and sharing agreements. Pursuant to this OIG review, several considerations have been made. To date, a contract has been drafted for endoscopy services and MOHS procedures as suggested by the OIG inspection team. Additionally, an MOU is in draft format for ENT services. We are still in the process of understanding if an MOU is needed for sleep studies or if this issue has resolved itself with the elimination of backlog for this service.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires the BOM provide trended Fee Basis Program data, the CBI officer conducts regular audits of the Fee Basis Program, and processes are developed to ensure that issues identified are monitored until they are resolved.

Concur.

Several controls have been put into place by the BOM and Compliance Officer to assure that trended, meaningful data are presented on the status of the Fee Basis Program (BOM) and this is validated through Fee Basis program audits (Compliance). For the business office, daily data for those claims that were not authorized appropriately began on March 1, 2009 and has been provided to the Facility Director and compliance officer daily. This process has now been expanded to an aggregated report presented monthly to the Medical Center Director through the Fee Basis Oversight Committee. This new process began May 1, 2009 and identifies the patient, provider, date the claim received and the scope of the services with trends over time. For the compliance office, this program has also been strengthened with the first random audit was completed on May 18th as well as the first concurrent Business Office audit completed on questionable bills on March 30th and reported to the Fee Basis Committee. The compliance office will continue Monthly Fee Basis Random audits using RAT-STATS methodology until December 2009 then twice a year thereafter. The Business Office Concurrent Audit on questionable bills will also continue monthly on any questionable bills as they are provided.

With these strengthened controls in place, this information is brought to a newly established Fee Basis Oversight Committee, chaired by the Chief Fiscal Officer with minutes and data being presented immediately after to the Medical Center Director for approval, concurrence and if necessary, action.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that physicians receive information regarding VA regulations on self-referral and conflict of interest, that physicians attest to their understanding in writing, and that the signed attestation be placed in providers' training or credentialing and privileging files.

Concur.

VA Connecticut Healthcare System has created a 2-pronged approach to this recommendation. Proactively, the compliance office has implemented three interventions to assure that physicians have been educated on VA regulations on self-referral and conflict of interests. These are:

1. Education on self referrals and Fee Basis Consults was given during the regular All Physician Meeting on March 20 2009.
2. The Assistant Chief of Staff has a Physician Brief flyer for all newly reporting Attending Physician's started on May 18, 2009.
3. The Compliance Officer will meet and discuss Self Referrals and Ethics with all newly reported Physicians as appointments can be made. The physicians will attest to the training and a copy of the attestation will be kept in the physicians' competency file at the service level. The originals will be kept in the compliance office. This training cycle will start during the week of May 26. The training will also be reported at the Fee Basis Committee.

Reactively, the committee looks at any perceived conflicts of interest or self-referral and makes recommendations to how an issue will be corrected after a service has been rendered. This process was initiated on May 15, 2009. To date, no additional conflicts of interest or self referrals have been identified by the Fee Basis office.

OIG Contact and Staff Acknowledgments

OIG Contact	Katherine Owens, MSN, Regional Director, Office of Healthcare Inspections (603) 222-5871
Acknowledgments	Anthony Murray Leigh, CPA, CFE

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