Department of
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Office of Inspector General

Combined Assessment Program Review
VA Medical Center
Manchester, New Hampshire

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VA Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) effort to ensure that high quality health care and benefit services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities and regional offices on a cyclical basis. CAP review teams perform independent and objective evaluations of key facility programs, activities, and controls:

- Healthcare Inspectors evaluate how well the facility is accomplishing its mission of providing quality care and improving access to care, with high patient satisfaction.
- Auditors review selected financial and administrative activities to ensure that management controls are effective.
- Fraud and integrity awareness briefings are provided to improve employee awareness of fraudulent activities that can occur in VA programs.

In addition to this typical coverage, a CAP review may examine issues or allegations that have been referred to the OIG by facility employees, patients, members of Congress, or others.

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Executive Summary

Introduction. The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of VA Medical Center (VAMC) Manchester, New Hampshire. The review was conducted from October 23 through October 27, 2000. The purpose of the review was to evaluate selected VAMC operations, focusing on patient care, quality management (QM), financial and administrative management controls, and fraud prevention.

VAMC Manchester is a 28-bed primary and secondary care facility, providing medical, surgical, and psychiatric care. The medical center also operates a 112-bed nursing home care unit. The VAMC's Fiscal Year (FY) 2000 budget was approximately $41.8 million and the staffing level was about 500 employees. In FY 2000, the VAMC provided care to 15,140 unique patients.

Patient Care and Quality Management. VAMC Manchester managers demonstrated a strong commitment to QM and performance improvement. The medical center had a comprehensive QM program that effectively coordinated patient care activities and provided strong oversight. We identified opportunities to further improve patient care services and QM. Managers agreed to take appropriate action to ensure: (a) clinicians visit patients in residential care programs monthly; and (b) adequate resources are available to treat all outpatients who need pain management services.

Financial and Administrative Management. The VAMC's financial and administrative activities were generally operating satisfactorily and management controls were generally effective. To improve controls management needed to: (a) ensure accurate coding and billing of outpatient encounters; (b) improve collection of Medical Care Collection Fund receivables; (c) reduce excess supply inventories; (d) ensure that signed means test forms are obtained from patients; (e) strengthen timekeeping for part-time physicians; (f) improve contract file documentation and reporting of clinical services contracts; (g) improve oversight of community nursing home rates and inspections; (h) strengthen controlled substance inspections and pharmacy security; (i) strengthen controls over agent cashier operations; (j) improve information technology security; and (k) strengthen controls over the purchase card program.

Fraud Prevention. Medical center managers fully supported fraud prevention efforts. As part of our review, we provided fraud and integrity awareness briefings to 85 medical center employees. We also reviewed records and met with personnel concerning the VA Police Uniform Crime Reports and the Workers' Compensation Program.

Medical Center Director's Comments. The VAMC Director concurred with the CAP review findings and recommendations. He provided acceptable plans to take corrective actions. We consider all CAP review issues to be resolved but may follow up on implementation of planned corrective actions.

(Original signed by:)

RICHARD J. GRIFFIN
Inspector General

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Introduction

VA Medical Center (VAMC) Manchester

VAMC Manchester provides primary, secondary, and psychiatric care, and supports programs in medical, surgical, extended care, and ambulatory care. Outpatient care is provided at the facility and at the Portsmouth and Tilton, New Hampshire community based outpatient clinics. The VAMC is one of eight facilities in the Veterans Integrated Service Network (VISN) 1. The VAMC's primary service area includes metropolitan Manchester and 10 contiguous counties in New Hampshire. The veteran population in the service area is approximately 140,250.

Programs. The VAMC has 28 intermediate beds, 112 nursing home beds, 3 observation beds, and operates several specialty medical programs. A continuum of services is provided through programs in primary care, nursing home care, hospital based home care, adult day care, and respite and hospice services. Outpatient services include substance abuse treatment and ambulatory surgery.

Affiliation. The VAMC is affiliated with Harvard University and Dartmouth University Medical Schools, as well as other institutions specializing in allied health care fields.

Resources. The Fiscal Year (FY) 2000 budget was about $41.8 million, 3.2 percent less than the FY 1999 budget. FY 2000 staffing totaled 504.4 full-time equivalent employees (FTEE), and included 24 full-time and 2.9 part-time physician FTEE and 98.7 nursing FTEE.

Workload. In FY 2000, the VAMC treated 15,140 unique patients, an 8.8 percent increase from FY 1999. Inpatient care was provided to 515 unique patients, a 55.2 percent decrease in the number of patients treated from FY 1999. The decrease in patients treated occurred because all of the medical center's acute care beds were closed in November 1999. The inpatient average daily census for FY 2000 was 25. The VAMC provided a total of 128,627 outpatient visits.

Objectives and Scope of the Combined Assessment Program (CAP) Review

The purpose of the CAP review was to evaluate selected clinical, financial, and administrative operations, and to provide fraud and integrity awareness briefings to VAMC employees.

Patient Care and Quality Management (QM) Review. We reviewed selected clinical activities to evaluate the effectiveness of the facility's performance and patient care management practices. The QM program consists of a set of integrated processes designed to monitor and improve the quality of patient care and to identify, evaluate, and correct actual or potentially harmful circumstances that may adversely affect patient

safety and treatment. QM includes risk management, utilization review, performance improvement, and patient safety. Patient care management is the process of planning and delivering patient care and includes patient provider interactions, coordination between care providers, and ensuring staff competence.

To evaluate the QM program and patient care management, we inspected patient care areas, reviewed pertinent clinical and QM records, and interviewed managers, employees, and patients. We also used questionnaires and interviews to survey employees' and patients' opinions and perceptions about the quality of care and other matters such as waiting time and satisfaction with care received. We reviewed the following programs and patient care areas:

Quality Management
Intermediate Medicine
Credentialing and Privileging
Patient and Employee Satisfaction
Residential Care Program
Pain Clinic

Financial and Administrative Management Review. We also reviewed selected financial and administrative activities with the objective of evaluating the effectiveness of management controls. These controls are the policies, procedures, and information systems used to safeguard assets, to prevent and detect errors and fraud, and to ensure that organizational goals and objectives are met. In performing the review, we inspected work areas, interviewed managers and employees, and reviewed pertinent financial, administrative, and clinical records. The review covered the following activities and management controls:

Contract Beneficiary Travel
Employee Debt Collection
Unliquidated Obligations
Insurance Coding, Billing, and Collection
Supply Inventory Management
Means Testing Procedures
Part-Time Physician Timekeeping
Contract Administration
Controlled Substance Inspections
Agent Cashier Operations
Information Technology Security
Purchase Card Program

Fraud Prevention. Medical center managers are supportive of fraud prevention. We provided five fraud and integrity awareness briefings to 85 VAMC employees. The briefings included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery. We also reviewed records and met with personnel concerning VA Police Uniform Crime Reports and the Workers' Compensation Program.

Scope of Review. The CAP review covered VAMC operations for FY 1999 and FY 2000. The review was done in accordance with the Inspector General's Standard Operating Procedures for Combined Assessment Program Reviews.

Results and Recommendations

Patient Care and Quality Management

Indicators of Reliable Monitors and Good Healthcare Programs

Quality Management Monitors. VAMC Manchester's patient care and QM programs were comprehensive and generally well managed. We reviewed patient incident reports, root-cause analyses/focused reviews, administrative boards of investigation, and follow-up activities on previous external review recommendations.

QM employees effectively track and follow-up on patient incidents and recommendations of both internal and external reviews. QM employees also trend VA patient quality monitors to ensure compliance with Veterans Health Administration (VHA) established goals.

Transition from Acute Care to Intermediate Care. The medical center currently has only intermediate care, nursing home care, and observation beds. In November 1999, medical center managers closed all of the facility's acute care beds. VHA determined that intensive and complex surgical care would be more effectively provided by community facilities or other tertiary care facilities within VISN 1 such as VAMCs Boston, White River Junction, and Bedford. Patients who require urgent care and are not stable for transfer to other VAMCs are referred or transferred to local hospitals.

Credentialing and Privileging (C&P). We reviewed nine staff physician and three resident physician C&P folders, and the nine staff physicians' official personnel files (OPFs). The C&P files for the nine staff physicians were in excellent order and contained all of the required documents. Resident physicians did not have official C&P files at the medical center. Instead, there was a folder for each resident physician containing a letter from the affiliated medical school certifying that the resident physician's licenses, education etc. were verified and on file at the affiliate. All of the staff physician OPFs contained fingerprint documents and security clearances.

Patient and Employee Satisfaction. Patients and employees were generally satisfied with the care provided at the facility. We interviewed 73 patients while on site. We also sent survey questions to 210 randomly selected full-time employees; of which 129 (61 percent) responded. For example, 100 percent of the patients rated the quality of care provided to patients as good, very good, or excellent. Similarly, 96 percent of the employees rated the quality of care as good, very good, or excellent. One hundred percent of the patients and 82 percent of the employees would recommend treatment at the VAMC to family members or friends.

Recommendation for Improving Healthcare

Residential Care Program – Monthly Visits Should be Conducted. Community Residential Care Programs provide supervised medical care to veterans who do not require hospital or nursing home care. VHA Directive M-5, Part III, Chapter 1, Paragraph 7.03a states that "The program coordinator will assure that each resident is visited at least monthly by a VA health care professional. Residents who have special needs should be seen more frequently as determined in their statements of needed care, or as their needs change." Medical Center Policy 122-2, "Community Residential Care Program," dated April 19, 2000, does not comply with VHA policy and states that "clinical casework services to all veterans participating in the Community Residential Care Program will be provided on an as needed, case by case basis." Program managers acknowledged that, because of limited resources, clinicians were not making monthly visits as required by VHA policy.

Recommendation 1. The Director should take action to ensure that clinicians conduct required monthly visits to each resident and that medical center policy is revised to comply with VHA policy requiring the monthly visitations.

Medical Center Director's Comments: The Director concurred with the recommendation and corrective actions are being developed to ensure that Social Work and nursing staff are assigned to visit each resident at least monthly. Medical center policy will be revised to document the change and the target date for policy revision will be January 31, 2001.

Office of Inspector General Comments: The comments and planned corrective actions are acceptable and we consider this issue resolved. We may follow up on the implementation of planned actions.

Suggestion for Management Attention

Pain Clinic Resources Should be Assessed. The medical center employs a part-time nurse practitioner (NP) to manage and see the patients in the Pain Clinic. The Pain Clinic meets once a week and schedules between 30 and 40 patients for appointments. In addition to this scheduled workload, the NP generally sees one or more walk-in patients. We concluded that the Medical Center Director needed to assess Pain Clinic workload to ensure staffing is adequate to meet patients' needs in a timely manner.

Subsequent to our CAP review the Medical Center Director informed us that this issue has now been resolved with the assignment of physician coverage to the Pain Clinic. Additionally, the primary care staff is now responsible for managing routine pain management issues at their level and the more difficult cases are referred to the managing physician. According to the Director, this new system has resulted in positive customer feedback from both the patients and staff, and few complaints regarding

access to pain specialists have been received. As a result of improvements made, we consider this issue resolved.

Financial and Administrative Management

Management Controls were Generally Effective

VAMC management had established a positive internal control environment, the financial and administrative activities reviewed were generally operating satisfactorily, and management controls were generally effective.

Contract Beneficiary Travel Operations Were Generally Sound. Audit tests indicated proper controls and procedures were in place to ensure that only entitled beneficiaries were provided transportation at VA expense and that controls were in place to ensure billed services had been provided. The Travel Office was effective in screening travel requests for documented medical necessity and administrative eligibility before scheduling the travel. Both the Travel Office and Fee Basis Office had effective certification procedures in place to ensure that billed services had been provided. The contract beneficiary transportation cost for FY 2000 was $356,017.

Employee Debts Were Aggressively Pursued. Finance Operations had effective controls for pursuing delinquent employee accounts receivable. We reviewed 15 accounts receivable (valued at approximately $19,000) that were older than 90 days as of September 30, 2000, and found no deficiencies. We found that receivables that had recovery potential were aggressively pursued through collection letters, recovery plans, telephone contacts, and research of last known addresses. We noted that receivables that did not have recovery potential were appropriately written off as uncollectable.

Unliquidated Obligations Were Generally Reviewed Monthly and Cancelled When Not Needed. As of August 31, 2000, the VAMC had 509 unliquidated obligations valued at approximately $3.7 million. To determine if Finance Operations technicians reviewed obligations each month and cancelled delinquent obligations when appropriate, we reviewed a judgement sample of 7 obligations (3 accrued services payable valued at $52,259 and 4 undelivered orders valued at $15,403). We found that Finance Operations had properly reviewed the 7 unliquidated obligations and that they remained valid.

Recommendations for Improving Management Controls

Coding and Billing of Outpatient Encounters – Accuracy Needs to be Enhanced. Bills sent to insurance carriers for reimbursement must contain Current Procedural Terminology (CPT) codes for reporting services performed by physicians and other approved providers, such as NPs, clinical pharmacists, and dieticians. CPT codes identify the procedures or services performed by the providers and are used in computing the charges. Proper coding depends upon accurate documentation in the patients' medical records.

We selected a judgmental sample of 24 outpatient bills sent to insurance carriers that were released during July and August 2000. We reviewed these bills to determine the accuracy of coding and billing of outpatient encounters.

Coding. We reviewed the coding of outpatient bills with the Manager, Health Information Management (HIM) and found coding problems in five cases. We found that 3 (12 percent) of the 24 cases were coded at a lower level (downcoded) than applicable to the services provided. Downcoding results in a lower payment than the medical center was entitled to for the care provided. The remaining two cases (8 percent) pertained to services that were provided but not coded or billed. Details follow:

- In two cases, a colonoscopy and a sigmoidoscopy, biopsies were performed but the codes that were assigned did not include the biopsy procedures.
- In a third case, an emergency room visit involved more detailed care than indicated by the selected code.
- In the remaining two cases, anatomic pathology examinations of biopsy specimens were not coded. Employees were unaware that these procedures were not coded by the laboratory workload package. This also greatly impacts the ability to bill for these procedures.

Billing. We reviewed the billing of outpatient visits for the 24 bills with the Patient Accounts Manager. We found that 5 (21 percent) of the 24 cases were incorrectly billed. The following illustrates the five incorrect bills:

- In one case, care provided by an NP was billed at 100 percent ($171) of the charges instead of the 85 percent ($145.35) level prescribed by VA for certain providers other than physicians. The NP had not been properly identified as such in the files. This bill has been corrected and resubmitted.
- Two cases that were not billable related to: (a) care provided by a registered nurse as an adjunct to a physician encounter; and (b) care provided for a service-connected condition. These two bills were cancelled.
- In two cases, pathology examinations of biopsy specimens referred to above were not billed due to a system problem. The laboratory package was designed to capture workload and does not capture CPT codes for many of the laboratory tests performed, including biopsy specimen examinations. Discussions with VA Central Office (VACO) officials disclosed that they were aware of the system problem and that the laboratory package was being modified. In the interim, guidance has been given to medical centers that coders should identify these types of cases to assign proper CPT codes so that they can be billed. The medical center had not identified these procedures for billing purposes and as a result care valued at $312 went unbilled. Both veterans in these cases have insurance that only pays at a rate of 20

percent; therefore the loss of revenue for these 2 cases is $62.40. These visits have been rebilled.

We reviewed the biopsy log for the period January 2000 through September 2000 to determine the number of potential billable biopsy cases. A review of the log showed that biopsies had been performed in 1,021 cases. Management estimated that 30 percent of veterans treated at VAMC Manchester have insurance; which translated to approximately 306 biopsy cases (1,021 x 30 percent) that could have been reimbursed by third party payers. We estimated that had biopsy cases been properly coded for the above period, at least $9,486 in potential revenue would have been collected and available for VAMC needs. (The $9,486 estimate was calculated by applying a conservative reimbursement rate of $31 per case to the 306 potentially billable cases.)

It should be noted that some insurance policies reimburse at a rate of 80 percent, which would result in a higher payment of approximately $125 per case. Additionally, some of the cases appearing on the log had multiple biopsies and some would require higher levels of physician work that would also result in higher payments.

Further, we also reviewed a sample of outpatient visits to evaluate the effectiveness of the facility's efforts to meet Medicare billing compliance regulations. We reviewed evaluation and management codes for 40 outpatient visits (20 non-billable and 20 billable visits) that occurred during the second quarter of FY 2000. Of the 40 coded visits, 17 (42 percent) were incorrectly coded (2 were under-coded, 13 were over-coded, and 2 were incorrectly coded consultations). Of the 20 billed visits reviewed, there were nine (45 percent) billed in error (eight over-billings and one under-billing). Managers indicated that coders and cost recovery staff received additional training since our review and they believe this has strengthened their coding compliance.

Recommendation 2. The Director should ensure that action is taken to improve the accuracy of CPT coding and improve the integrity of the billing process. Coders should identify and code anatomic pathology examinations correctly to assure that these cases can be properly billed.

Medical Center Director's Comments: The Director concurred with the recommendation and reported that beginning October 1, 2000, 100 percent of all Ambulatory Surgery cases are being coded by a Certified Coding Specialist within HIM. Special attention will be paid to those cases in which specimens/biopsies were obtained and interpreted by the pathologist.

Office of Inspector General Comments: The comments and planned corrective actions are acceptable and we consider this issue resolved. We may follow up on the implementation of planned actions.

Medical Care Collection Fund (MCCF) – Health Insurer Accounts Receivable Should be Pursued More Aggressively. We evaluated VAMC controls for pursuing MCCF third-party accounts receivable from health insurers. The Omnibus Budget Reconciliation Act of 1986 authorizes VHA to collect from health insurance companies for the cost of treating insured non-service connected (NSC) veterans. VHA is also authorized to collect from insurers for the cost of treating service-connected veterans for NSC conditions. Public Law 105-33 authorized the establishment of the MCCF to allow VHA to retain collections for the purpose of patient care and expenses incurred under the MCCF program. VA Manual MP-4, Part VIII, Chapter 19, provides that at the time the third collection notice is sent, telephone follow-up should be made with the third–party payer. The MCCF Coordinator acknowledged that staff had not aggressively pursued MCCF third-party accounts receivable.

As of September 30, 2000, the VAMC had 303 active MCCF third-party accounts receivable (over $1,000) with a total value of approximately $1.8 million. Of these, 150 with a total value of approximately $1.1 million (61 percent of the total value) were more than 90 days old. To evaluate the collection efforts applied to these receivables, we reviewed 30 receivables (valued at $1 million) owed by health insurers for inpatient services provided to VAMC patients. Based on our review of third party receivables and discussions with MCCF management, we concluded that 14 (47 percent) of the 30 sample receivables (valued at $507,521) required more aggressive collection. MCCF had sent collection letters but had not called the health insurance companies to determine why payments had not been made. An example of the benefit of contacting health insurers follows:

- At our request, an MCCF staff member telephoned the insurance carrier for a bill valued at $104,017 that was established on May 22, 2000, and was informed by the carrier that the claim could not be located. MCCF staff resubmitted the claim to the third-party payer on October 18, 2000. Earlier telephone contact with the insurance carrier could have detected this lost claim and provided potential revenue to the facility sooner.

The MCCF Coordinator agreed that more aggressive follow-up on active third-party receivables is needed and stated that a newly hired employee in the accounts receivable section will be dedicated to follow-up with third-party insurers.

Recommendation 3. To improve the collection of MCCF accounts receivable, the Director should ensure that: (a) MCCF staff establishes effective controls for aggressively pursuing MCCF accounts receivable; and (b) the 14 MCCF accounts receivable identified in our sample are pursued aggressively.

Medical Center Director's Comments: The Director concurred with the recommendation and reported that an employee was recently added who is directly responsible for monitoring accounts receivable and taking the appropriate action to resolve claims issues. The facility is in the process of re-activating their agreement with the collections company Transworld Systems, Inc. by referring problem claims in excess

of 120 days old and greater than $100. Accounts receivable identified by OIG review have been resolved or are awaiting insurance companies' final responses.

Office of Inspector General Comments: The comments and implementation plans are acceptable and we consider this issue to be resolved. We may follow up on the implementation of planned actions.

Supply Inventory Management – Excess Inventories Should Be Reduced and Controls Enhanced. Employees did not effectively use the Generic Inventory Package (GIP), VA's automated inventory management system, to manage and control the Supply, Processing and Distribution (SPD) and Supply Fund warehouse inventories. VHA guidelines require the use of GIP to manage and control supply inventories. GIP data must be accurate for the program's automated management features to identify excesses and shortages. Inventories should not exceed a 30-day maximum supply.

VAMC Manchester has two primary inventories: an SPD inventory contained within the main hospital building; and a warehouse inventory stored in a leased warehouse nearly eight miles from the facility. During the period from September 1999 through August 2000, VAMC Manchester spent approximately $740,000 on SPD and Supply Fund medical supplies, and warehouse storage.

<u>Excess Stock.</u> We assessed the stock levels for the combined SPD and warehouse primary inventory points recorded in GIP. We found that 895 (91 percent) of 985 of medical supply items on hand exceeded the 30-day stock level. The value of the combined excess stock was $302,936.

- The SPD primary inventory had 830 line items on hand valued at $307,914. Based on the Days of Stock on Hand Report, 796 (96 percent) of the 830 line items exceeded the 30-day level and the value of these medical supplies was $289,937.

- The warehouse primary inventory had 155 line items on hand valued at $33,361. The reported inventory exceeded a 30-day supply in 99 (64 percent) of the 155 line items and the value of stock in excess of a 30-day supply totaled $12,999.

Managers agreed that many of the stock levels in the inventories were too high based on the levels of utilization.

<u>Warehouse Lease.</u> The medical center leases 5,000 square feet of warehouse space to store medical supply items. Lease and utility expenses for the warehouse total approximately $45,000 annually. We found that the value of the stored items meeting the 30-day maximum stock level totaled only $20,362. Managers indicated they will initiate a review of the need for the warehouse space.

<u>Inventory Errors.</u> We performed a physical inventory of 20 judgmentally selected line items, 10 each from SPD and the warehouse. In 5 (50 percent) of the 10 SPD line items, the GIP inventory balances did not match actual stock on hand. Managers stated

that SPD GIP training had been inadequate and they agreed that the recording of stock issues and receipts had been erroneous or untimely, and therefore records were inaccurate. The physical inventory of all 10 of the warehouse items matched GIP data.

Recommendation 4. The Director should ensure that: (a) SPD staff are trained to timely and accurately record inventory receipts and disbursements; (b) a wall-to-wall inventory is completed at the SPD location; (c) inventory is aggressively monitored towards reducing line items to a 30-day level maximum level; and (d) a cost/benefit analysis is conducted in order to justify the warehouse lease contract.

Medical Center Director's Comments: The Director concurred with our recommendation and reported that beginning in February, two inventory management subject matter experts will be providing focused GIP training to selected individuals. An exchange/outlook inventory management mail group has been established to follow-up with trainees and provide continuous assistance. A secondary training session will also be completed after a six-month interval to ensure successful completion of training; a wall-to-wall inventory of the SPD location was completed at the close of October 2000. An additional wall-to-wall inventory is scheduled for January 27 and 28, 2001; the most recent wall-to-wall warehouse inventory identifies 100 percent accuracy for 155 line items, with an on-hand closing December 2000 balance value of $29,189. Regarding SPD's inventory, a continuously aggressive approach will be maintained until the desired results are achieved. The SPD primary inventory has been reduced to 652 line items on-hand from the previous 830. The total value of the stock on-hand has been reduced to $98,328, from the previously reported $307,914. The number of days of stock on hand over 30 days has improved to 70 percent, but obviously still requires additional work; and the long-term plan is to bring the warehouse function back onto VA premises. Effort is currently underway to determine the most appropriate means of accomplishing this, i.e., construction project, or, identification and renovation of existing space.

Office of Inspector General Comments: The comments and implementation plans are acceptable and we consider this issue to be resolved. We may follow up on the implementation of planned actions.

Means Testing Procedures – Forms Should Be Completed. As part of MCCF requirements, copayments are collected from certain veterans to offset costs of treatments provided for NSC conditions. Patients with incomes below certain thresholds are exempted from these copayments. To qualify for an exemption, each year veterans who receive care for NSC conditions must provide VHA with family income (means test) and health insurance information. By signing their means test disclosures, veterans attest to the accuracy of the income information provided and certify receipt of copies of the Privacy Act Statement. VHA facilities are required to retain signed means test forms in the veterans' administrative records.

We examined a sample of 31 means tests from a total of 207 patients whose means test data reported no income during FY 2000. We found there were no signed means tests in 6 (19 percent) of the 31 administrative records reviewed.

According to management, means test records were unavailable because: (1) some veterans had failed to complete the forms; and (2) VAMC Manchester clinics had treated and rescheduled patients for treatment who had not completed the means test forms. Clinic personnel had either ignored the means test requirement or had instructed veterans to complete the forms after treatments, and the patients had left the VAMC without completing the forms.

One signed means test was found where a veteran had refused to provide her financial data but had agreed to pay copayments. However, the veteran was erroneously classified as Category A (non-billable) rather than Category C (billable). As a result of this inadvertent clerical error, her billable episodes of care could not be identified. The classification error was promptly corrected.

Recommendation 5. The Director should establish controls to ensure that means test forms are completed, signed, and filed.

Medical Center Director's Comments: The Director concurred and reported that since the OIG review, a report is run daily to identify veterans with clinic appointments who require a means test. Further, an alert has been added upon accessing a patient's file to identify veterans requiring means tests so that employees can direct the veterans to the means test area to complete the application forms.

Office of Inspector General Comments: The comments and implementation plans are acceptable and we consider this issue to be resolved. We may follow up on the implementation of planned actions.

Part-Time Physician Timekeeping – Controls over Part-Time Physician Time and Attendance Should Be Strengthened. VAMC management needed to improve controls to ensure that part-time physicians were on duty as required and that absences were properly charged to the employees. Part-time physicians are physicians hired to work less than the normal 40-hour duty week. These physicians are hired to work 1/8th duty time increments, with a 1/8th increment equaling 5 hours of weekly work time. Timekeepers are required to ensure that timecards accurately reflect shortened and irregular tours of these individuals. VA Manual MP-6, Part V, Supplement 2.2, Paragraph 102.03 provides that timekeepers are responsible for completing timecards to show the part-time physicians' assigned tours of duty, the actual hours worked, and any charges to leave. A timekeeper's personal knowledge of physician attendance is a key element of the control for accurately reporting timecards.

To evaluate part-time physician timekeeping controls, we attempted to locate the facility's six part-time physicians during their tours of duty. We found that all six

physicians were on duty. However, we found that timekeepers for these physicians sometimes did not know their whereabouts based on the following.

- One timekeeper revealed that one part-time physician did not routinely use the electronic time and attendance (T&A) system to record his leave and there was no other reliable system in place to ensure that the timekeeper was notified when this physician was absent. As a consequence, when this physician's clinics were cancelled as a result of his absence, his time card did not reflect his absence. During FY 2000, this physician was not charged leave or authorized absences for a total of 7 days (70 hours). As a result of our review, the Human Resources Officer provided us documentation showing that corrected timecards were completed and that the physician was charged leave for the 7 days.

- During FY 2000, another part-time physician, who was a shared employee between VAMC Manchester and VAMC Boston, was reported as being present in the timekeeping system for 12 days, or 80 hours of work at VAMC Boston. Management at VAMC Manchester stated that the time was posted according to the physician's assertions of his VAMC Boston work schedule. The physician was not required to submit documentary evidence of attendance at VAMC Boston, nor was any independent verification made by the timekeeper to confirm the claimed off-station duty status.

In our opinion, the VAMC's part-time physician timekeeping practices present a risk for improprieties. To address this issue, the VAMC needs to establish controls to ensure the accuracy of timekeeping practices for part-time physicians.

Recommendation 6. The Director should ensure that: (a) clinical services establish effective controls to account for all part-time physician on-duty time; (b) all part-time physicians be required to use the electronic T&A system; and (c) all timekeepers for part-time physicians receive refresher training on the importance of submitting timecards that reflect actual hours worked.

Medical Center Director’s Comments: The Director concurred with this recommendation and corrective actions are being developed at this time to ensure that effective controls are in place for part-time physicians. Recommendations 6a and 6c will be implemented by developing a comprehensive training session for timekeepers that not only identifies the importance of timekeeper responsibilities but establishes expectations for the certifying officials in accounting for part-time physician time. Documentation of training will be required and maintained as part of the Medical Centers Education tracking system. Please note that at this time there are no part-time physicians still utilizing the manual SF-71 form. The training program is to be developed and provided by February 28, 2001.

Office of Inspector General Comments: The comments and implementation plans are acceptable and we consider this issue to be resolved. We may follow up on the implementation of planned actions.

Clinical Services Contracts – Controls Over Reporting and Contract Files Should Be Strengthened. As of September 30, 2000, the VAMC had 22 locally executed clinical service contracts. The total value of these contracts exceeded $2.8 million. We reviewed the files pertaining to six contracts with a total value of approximately $2 million, and interviewed the responsible contracting officials to evaluate compliance with contract requirements set forth by VHA policy.

We found that controls need to be strengthened to ensure clinical service contracts are reported to the VACO Office of Medical Sharing and Purchasing and that required documentation is maintained in contract files.

Local clinical services contracts. VHA Directive 10-95-108 states that copies of all local scarce medical specialist services (SMSS) and specialized medical resources (SMR) contracts should be forwarded to the VACO Office of Medical Sharing and Purchasing within five days of award to provide quality assurance and oversight of locally awarded contracts.

We found that none of the six clinical service contracts in our review were forwarded to the VACO Office of Medical Sharing and Purchasing for quality assurance review and oversight as required. The contracts were for cardiology (2), surgical, ophthalmology, home oxygen, and urology services.

Contract documentation. The Federal Acquisition Regulation (FAR) requires that contracting officials establish files containing records of all contractual actions. We found that contracting officials did not maintain documentation in contract files for two (33 percent) of the six contracts valued at approximately $1.1 million. The contracts for home oxygen and urology services did not contain price negotiation memoranda. This memorandum generally contains important elements of the contract negotiation process such as a description of the services being procured, purpose of negotiations, and an explanation of how prices were determined. Acquisition/Logistics Service staff indicated that supporting documentation relating to these two contracts was lost. It is critical that supporting documentation for each contract be safeguarded and maintained in the contract files.

Recommendation 7. The Director should ensure that: (a) the facility submits copies of all SMSS and SMR contracts, executed locally, to the Director, Office of Medical Sharing and Purchasing within five days of award; and (b) all relevant contract documentation be safeguarded and maintained in the contract files.

Medical Center Director's Comments: The Director concurred with our recommendation and has established bi-monthly meetings focusing attention on all sharing and scarce medical contracts. Acquisition staff will be accountable for reporting the status of contracts and forwarding copies through the Director's office prior to submission to the Office of Medical Sharing and Purchasing (175). Consistent with the above action, a Scarce Medical Contract checklist will be developed identifying the items necessary for contract completion. This list will be presented to the Director at his

scheduled bi-monthly sessions to report contract status. The respective Contracting Officer(s) will be held accountable for the accuracy of information reported.

Office of Inspector General Comments: The comments and implementation plans are acceptable and we consider this issue to be resolved. We may follow-up on the implementation of planned actions.

Community Nursing Home (CNH) Rates and Inspections – Management Should Improve Oversight. As of September 30, 2000, VAMC Manchester had 27 CNH contracts. During FY 2000, VAMC Manchester had spent $393,994 for CNH care, $295,789 locally and $98,205 on multi-state CNH contracts. We reviewed 10 CNH contracts to determine if negotiated rates were in compliance with Medicaid rates (for room, board, and routine nursing care) plus an allowable factor of 15 percent for ancillary costs. We also reviewed contract files for evidence that a multidisciplinary team conducted annual on-site evaluations. We found that management needs to improve oversight in these two areas.

CNH Rates. VHA Policy M-5, Part II, Chapter 3 requires an annual certification that CNH contracts conform with VHA's rate policy as well as specific approval of rates that exceed Medicaid rates plus 15 percent. VA medical centers must justify exceptions when a rate within this range cannot be established and when the CNH team determines that a contract with the nursing facility is in the best interests of the care of veterans. The CNH team is responsible for developing information required for exceptions and for submitting the information to the facility Director for review and approval.

We reviewed 10 negotiated CNH contracts and found that all rates exceeded the Medicaid plus 15 percent rate by as much as 30 percent. Daily rates ranged between $7.52 and $56.17 above the authorized Medicaid plus 15 percent rate. Although contract files contained exception approval letters for 8 (80 percent) of the 10 CNH contracts, all but one were prepared months after the contracts were approved. For example, two contracts executed in December 1999 had approval statements dated October 17, 2000. Files also contained no documentation on which to base the exception approvals. The medical center has also not prepared an annual certification for several years certifying that each CNH contract met the rate policy or had been given an exception.

CNH Inspections. We reviewed the contract files of five CNHs to determine if inspections were conducted annually. VHA requires an annual multidisciplinary team on-site evaluation of CNHs, unless they are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), prior to initiating a contract renewal. Three (30 percent) of the five CNHs we reviewed were JCAHO accredited. While the remaining two files contained evidence that annual on-site evaluations were conducted, they did not contain all of the required data such as: copies of the most current State licenses; CNH coordinator recommended action to the contract specialist

for contract renewals; and evidence that CNH inspection team members reviewed prior State survey results and followed-up on the noted deficiencies.

Recommendation 8. The Director should ensure that: (a) CNH contracts are negotiated in compliance with VHA policy; and (b) CNH contract files contain all required documents needed for contract renewal such as a copy of the current State license, CNH coordinator recommendations for contract renewal, and evidence of follow-up on State survey noted deficiencies.

Medical Center Director's Comments: The Director concurred with our recommendation and reported that, presently, all VISN 1 CNH contracts have been transferred and are the responsibility of VAMC Northampton. This effort in consolidating acquisition workload and disseminating it to perceived centers of excellence appears not to be working as well as expected. Recommendation to the appropriate VISN 1 Official will be made to return CNH contracts for local site development, award, and administration.

Consistent with the above action plan for clinical contracts, a strict reporting mechanism will be established for CNH agreements. At a minimum, items for review will be status of State license, recommendations of CNH coordinator, and documentary evidence of follow-up on State or VA survey noted deficiencies.

Office of Inspector General Comments: The comments and implementation plans are acceptable and we consider this issue to be resolved. We may follow up on the implementation of planned actions.

Controlled Substance Inspections – Monthly Inspection Procedures and Pharmacy Security Need To Be Improved. VHA Handbook 1108.2 requires that VA medical facilities conduct monthly unannounced inspections of all Schedule II-V controlled substances. The purpose of these inspections is to properly account for all controlled substances. Inspectors should physically count the quantities of controlled substances on-hand and reconcile these quantities to inventory records. A sample of dispensing entries should be compared to patient records to verify that amounts removed from the wards and clinics were supported by doctors' orders and drug administration records. A program for orientation and training of inspecting officials should be established and followed. Each medical center must maintain documentation on all orientation and training provided. Written records of all inspections must be maintained and inspection results should be trended to identify potential problem areas for improvement. All excess, outdated, unusable, and returned controlled substances must be stored in sealed containers in a locked area of the pharmacy while awaiting disposal. These controlled substances must be inventoried monthly and should be disposed of at least quarterly.

To access VAMC Manchester's inspection program, we reviewed records of the inspections conducted during the 12-month period October 1999 through September 2000. We identified the following weaknesses:

- Inspections were not conducted during the months of April and July 2000. In addition, the Operating Room was not inspected in June 2000.

- Inspectors did not verify dispensing entries in all clinics and ward areas as required to ensure that amounts removed from clinic and ward inventories were supported by doctors' medication orders and drug administration records. On five inspections, they had verified dispensing on the three inpatient units only. No verification had been done on the remaining seven inspections.

- There was no documentation of formal training for the inspectors. Inspectors work in teams of two. Management indicated that training is "on-the-job" with the experienced team member training the newcomer.

- Inspection results were not trended to identify potential problem areas for improvement.

- All excess, outdated, unusable, and returned controlled substances were disposed of on a quarterly basis. These drugs were held in a locked area of the pharmacy while awaiting disposal. However, they were not stored in sealed containers and were not inventoried as part of the monthly inspections as required.

We also found that the physical security requirements in the pharmacy areas were not met. Each facility must install electronic access control systems in pharmacies to monitor access to controlled substances. The systems should have the ability to provide for periodic or on demand printouts of names and time/dates of individuals accessing the secured areas. Although controlled substances were stored and dispensed in locked areas, there was no means of documenting access to the areas as required. The push-button combination locks in use provided no access tracking ability.

Recommendation 9. The Director should ensure that: (a) all areas with controlled substances in stock are inspected monthly; (b) inspectors are trained to conduct inspections in accordance with VHA regulations, including verification of patient records; (c) inspection results are trended to identify potential problem areas for improvement; (d) controlled substances held in the pharmacy and awaiting disposal, are placed in sealed containers and inventoried during regular monthly inventories; and (e) improvements are made to the pharmacy security system to provide a means to document and track access to the secured areas.

Medical Center Director's Comments: The Director concurred with the recommendation and corrective actions are being developed at this time to ensure that items (a) through (e) are corrected. Specific actions include that the chairperson of the narcotics inspection team has been changed and the new chairperson has been trained to understand the VHA requirements regarding monthly inspections. The target date for completing the action is January 31, 2001. The chairperson of the narcotics inspection team will provide general training to inspection teams regarding the requirements for the

inspection process with specific emphasis on the verification of patient records. Documentation of training will be entered into Medical Center Education tracking system. The target date for completing the action is January 31, 2001. The chairperson of the narcotics inspection team will ensure information derived from inspection reports is trended and reported to the Pharmacy and Therapeutics Committee. The target date for completing the action is January 31, 2001. The Local Care Line Manager, Diagnostics and Support Service will ensure the security of controlled substances awaiting disposal in the pharmacy. The chairperson of the narcotics inspection team will provide general training to inspection teams regarding the requirements for the inspection process with specific emphasis on the requirement to inspect the narcotics ready for disposal that are maintained in the Pharmacy. Documentation of training will be entered into the Medical Center Education tracking system. The target date for completing the action is January 31, 2001.

The Local Care Line Manager, Diagnostics and Support Service will ensure that the process for daily dispensing of narcotics be modified to ensure that dispensing is conducted from the pharmacy vault as this area provides for the appropriate level of security. Local policy will be reviewed and modified if appropriate. This is a temporary solution to the problem. An alternative solution with an electronic card reader will be evaluated over the next 90 days in conjunction with Recommendation 11. The target date for completing the action is February 1, 2001.

Office of Inspector General Comments: The comments and implementation plans are acceptable and we consider this issue to be resolved. We may follow up on the implementation of planned actions.

Agent Cashier Operations – Controls Need to Be Enhanced. We evaluated controls over agent cashier operations and determined that various aspects of the agent cashier function required management attention. We found that unannounced audits were not performed randomly and at least every 90 days; audits were not conducted by at least two employees skilled in fiscal or auditing techniques; audits consistently identified excess cash on hand based on actual agent cashier needs; and auditors did not include a reconciliation between cash received in the mail and recorded in the registry log.

<u>Unannounced Audits.</u> VA policy requires an unannounced audit of the agent cashier's advance at least every 90 days. The dates and times of unannounced audits should be varied to prevent establishing a pattern and to ensure the element of surprise. We reviewed the results of audits performed from October 1998 through September 2000. We determined that elapsed days between audits ranged from 68 to 132 days and that four audits exceeded the 90-day requirement. Audits were conducted on different days of the week, but all were done between 9:00 and 9:30 AM. To ensure surprise and provide more effective control, managers should schedule unannounced audits at least every 90 days, varying the scheduling dates and times in a random manner. Cash and other assets maintained by the agent cashier are made more vulnerable to theft or misappropriation when random, unannounced audits are not performed as required.

Qualifications of Auditors. VA policy requires that the unannounced audits be performed by two station employees skilled in fiscal or auditing techniques. One of the employees, if possible, should be an employee outside the fiscal activity. There have been 10 unannounced audits performed since October 6, 1998. An accounting technician participated in each of the audits with an employee from outside the fiscal activity. The latter was not skilled in fiscal or auditing techniques.

Advance Level. VA policy requires that unannounced audits include assessments of the level of advances based on cash disbursements made during the last 3 consecutive months. The facility's agent cashier advance has been $6,500 since October 6, 1998. Unannounced audits consistently identified excess cash on hand based on actual agent cashier needs. The average monthly demand for cash during FY 2000 generally did not exceed $5,000. Excess cash increases the risk for theft or misappropriation and excess funds could be put to better use. Management was aware of the excess cash on hand and was taking steps to reduce the advance.

Cash Received in the Mail. VA policy requires auditors to perform reconciliations between cash received in the mail and recorded in the registry log. Unannounced audits conducted during the last 2 fiscal years did not include this reconciliation. Cash received in the mail is made more vulnerable to theft or misappropriation when this reconciliation is not performed as part of the unannounced audits. Management stated that procedures would be changed to facilitate the reconciliation.

Recommendation 10. The Director should ensure that: (a) unannounced audits of the agent cashier are conducted by at least two employees skilled in fiscal or auditing techniques; (b) audits are randomly scheduled at least every 90 days; (c) the level of the advance is reduced based on the average monthly demand; and (d) audits include reconciliations of cash received in the mail and recorded in the registry log.

Medical Center Director's Comments: The Director concurred with the recommendation and reported that: employees skilled in fiscal or auditing techniques would conduct agent cashier audits; unannounced audits need to be performed in a more random manner and as required by VA policy at least every 90 days; management will closely monitor this activity to ensure that audits are conducted within 90 days and that a pattern is not established; a log has been developed to record all cash and checks received and opened in the mailroom which will allow for the completion of accurate reconciliations with minimal effort; and the facility is currently evaluating various bank services to pick up daily deposits which should allow the agent cashier advance to be adjusted to the appropriate level.

Office of Inspector General Comments: The comments and implementation plans are acceptable and we consider this issue to be resolved. We may follow up on the implementation of planned actions.

Information Technology (IT) Security – Controls Over Physical Security and Information Systems Access Need to Be Enhanced. During our review of IT security, we found controls were adequate in the areas related to security awareness training, contingency planning, risk assessment, and implementation of a strong password policy. In addition, the facility had policies covering IT security issues such as an overall security plan, user access, remote access, and Internet access. However, two areas of IT security need management attention.

Computer Room Security. VHA Directive 6210 states that controlled and restricted areas are to be protected by physical security appropriate for the sensitivity and/or criticality of the system. We found that physical security in the computer room can be improved. Specifically, no electronic or manual log existed to monitor individuals accessing the computer room. The log should record the names, dates, and times individuals enter the computer room. We were informed that two doors leading to the computer room were not routinely locked during the evenings. We also noted that the doors were not equipped with alarms. The Information Security Officer (ISO) agreed to initiate corrective actions.

Veterans Health Information Systems and Technology Architecture (VISTA) User Access. VHA Directive 6210 also specifies procedures for protecting automated information system resources from unauthorized access, disclosure, modifications, destruction, and misuse. It further states that each user's access and privileges must be reviewed at least every 90 days for a determination of appropriate level and continued need of access. We obtained and reviewed a current list of 316 VISTA users that included test accounts, as well as employees who may no longer need VISTA access. We discovered that 22 (7 percent) VISTA users no longer needed access and should be terminated from the VISTA system. Based on our review, the ISO took immediate action to terminate these accounts.

Recommendation 11. The Director should ensure that: (a) all access to restricted areas is logged as required by VHA policy; (b) the doors to the computer room be locked and alarmed in the evenings to reduce the risk of damage to facility servers; and (c) VISTA user access be periodically reviewed in order to terminate those users who no longer need such access.

Medical Center Director's Comments: The Director concurred with the recommendation and reported that as a temporary measure, a manual log is being established to comply with VHA policy. A long-term solution of installing an electronic card reader to track entry to the room will be investigated within the next 90 days. The doors to the computer room proper are always locked in the evening. Further, a policy is being implemented on February 1, 2001, that users who have not accessed VISTA within the last 90 days will have their accounts terminated.

Office of Inspector General Comments: The comments and implementation plans are acceptable and we consider this issue to be resolved. We may follow up on the implementation of planned actions.

Suggestion for Management Attention

During our review, we noted an issue that warranted management attention. We made a suggestion for improvement in the following area.

Purchase Card Program – Controls Over Purchases Should Be Strengthened. Controls over the purchase card program were generally effective. However, cardholders were splitting orders to stay within their single purchase limits. VA medical centers are required to use government purchase cards for small purchases of goods and services (usually $2,500 or less). The FAR prohibits splitting purchases to avoid exceeding dollar thresholds. Further, VHA Handbook 1730.1 requires approving officials to monitor usage to ensure that purchases are not split or fragmented to stay within cardholder limits.

The purchase card program at VAMC Manchester included 46 purchase cardholders and 23 approving officials. Purchase cardholders processed 10,325 transactions totaling approximately $1.2 million from October 1998 through August 2000. During the first 11 months of FY 2000, cardholders made 5,076 purchases**.** We identified multiple orders placed to vendors on the same day by the same cardholders. Out of 5,076 purchases, 175 (3 percent) fell into this category. We sampled 29 of the 175 orders and identified 3 cardholders that had split 3 orders totaling approximately $25,000 into 9 orders to apparently avoid exceeding single purchase limits and seeking competition for the procurements. The following two examples illustrate purchase splitting:

- A cardholder purchased various pieces of ophthalmology supplies and equipment on April 7, 2000, from the same vendor. The cardholder placed 3 orders totaling $18,435 to the same vendor within a 23-minute time span for orders valued at $8,423, $1,156, and $8,856, respectively. The cardholder held a $10,000 warrant for single purchases.

- Another cardholder purchased various pieces of electrical and mechanical products on April 5, 2000, from the same vendor within a 6-minute time span. The 2 orders totaled $3,919, and were valued at $2,328 and $1,591, respectively. The cardholder held a single purchase limit not to exceed $2,499.

The purchase card coordinator stated that purchases were periodically monitored to determine whether purchases had been split or fragmented. The coordinator was aware of the split purchases made by one of the cardholders identified in our sample and stated that the cardholder had already lost her card privileges.

We concluded that the purchase card coordinator needs to strengthen controls to ensure that approving officials and cardholders comply with FAR and VHA guidelines.

The coordinator should continue to relieve cardholders and approving officials of their purchase card duties if purchases are split or fragmented to keep within thresholds.

Subsequent to our CAP review the Medical Center Director advised us that a plan of action had been developed which includes the scheduling of unannounced audits of cardholders and approving officials. According to the Director, officials will continue to take appropriate action if any abuse of the Government credit card program is identified. As a result of actions taken, we consider this issue resolved.

Fraud Prevention

Managers Fully Supported Fraud Prevention and Detection

VAMC managers fully supported fraud prevention and detection efforts. The OIG's hotline referral number was posted for the information of employees, claimants, and visitors, and 85 VAMC employees attended our five 60-minute fraud and integrity awareness training sessions.

Following the fraud and integrity awareness training, an employee provided information concerning an allegation of an employee threat. Interviews were conducted, and with the permission of the complainant, this matter was brought to the attention of the VA Police & Security Service as well as VAMC management.

While on site, we also reviewed records and met with personnel concerning VA Police Uniform Crime Reports and the Workers' Compensation Program, as discussed below:

VA Police Uniform Crime Reports. We reviewed the VA Police Uniform Crime Reports for the period January 2000 through October 2000. Our review disclosed that there was one drug theft involving a controlled substance and two thefts of Government property valued at $1,000 or above. The drug diversion involved the theft of Clonazepam, and was unsolved. The two thefts of Government property involved a veteran who stole a video cassette recorder from the Canteen Service and a laptop computer from Physical Therapy. This veteran is being prosecuted by the State. The VAMC reported these matters to the U.S. Attorney's Office, but not to the OIG. We advised the VA Police Chief of matters that the OIG would like to be notified about and will follow-up this conversation with a letter.

Workers' Compensation Program. We reviewed the Office of Workers' Compensation Program (OWCP) Quarterly Chargeback Report for the period July 1, 1999, through June 30, 2000. There were 49 claimants on the chargeback report, and 21 of those claimants collected compensation pay totaling $293,237 for the period. We met with the Chief, Human Resources Management Service who provided information concerning a particular claim that contained indicators of fraud. The medical center had already referred this claim to the VISN 1 OWCP Coordinator.

Fraud and Integrity Awareness Briefings

As part of the CAP review, we conducted five 60-minute fraud and integrity awareness briefings, which included a discussion of the OIG's role in investigating criminal activity, and question and answer opportunities. In all, 85 VAMC employees attended the briefings. The information presented in the briefings is summarized below.

Requirements for Reporting Suspected Wrongdoing. VA employees are encouraged, and in some circumstances, required to report suspected fraud, waste, or abuse to the OIG. VA Manual MP-1, Part 1 delineates VA employee responsibility for reporting suspected misconduct or criminal activity. Employees are encouraged to report such concerns to management, but reporting through the chain of command is not required. Employees can contact the OIG directly, either through the OIG's Hotline or by speaking with an auditor, investigator, or healthcare inspector. Managers are required to report allegations to the OIG once they become aware of them. The OIG depends on VA employees to report suspected fraud, waste, and abuse. All contacts with the OIG are kept confidential.

Referrals to the OIG. The Office of Investigations has two divisions that investigate allegations of wrongdoing. The Administrative Investigations Division is responsible for investigating allegations of employee misconduct that are not criminal in nature. An example of such misconduct would be misuse of a government vehicle by a senior VA official.

The Criminal Investigations Division (CID) is responsible for investigating alleged criminal activity. When an allegation is received, CID employees assess it and decide whether to open an official investigation. Not all referrals are accepted. An accepted referral is assigned to a case agent, who then conducts an investigation. If the investigation substantiates only misconduct, the matter is referred to the appropriate VA management official, who then determines whether administrative action, such as suspension or reprimand, is warranted.

If the investigation substantiates criminal activity, the matter is referred to the Department of Justice (DOJ), usually through the local U. S. Attorney. DOJ determines whether to accept the case for prosecution. DOJ does not accept all cases referred by the OIG. If DOJ accepts the case, an indictment or criminal information is used to charge an individual with a crime. The individual then must decide whether to plead guilty or to go to trial. If the individual pleads guilty or is found guilty by trial, the final step in the criminal prosecution process is sentencing.

Areas of Interest for OIG Investigations. The CID conducts investigations of a broad range of criminal activities that involve VA programs and operations. Areas of particular interest to the CID are procurement fraud, benefits program fraud, and healthcare-related crimes. Procurement fraud includes bid rigging, defective pricing, over billing, false claims, credit card fraud, and violations of the Sherman Anti-Trust Act. Benefits-related fraud includes fiduciary fraud, compensation and pension fraud, equity

skimming, and loan origination fraud. Healthcare-related crimes include homicide, assaults, sexual abuse, theft and diversion of pharmaceuticals, illegal receipt of medical services, fraudulent fee-basis billings, and conflicts of interest. Other areas of interest include bribery, gratuities, workers' compensation fraud, travel voucher fraud, false statements by employees and beneficiaries, and other misconduct that involves employee integrity.

Important Information to Include in Referrals. When referring suspected misconduct or criminal activity to the OIG, it is very important to provide as much information as possible. The more information the OIG has before starting the investigation, the faster it can be completed. If possible, referrals should include the following five items of information:

- **Who** -- Names, position titles, connection with VA, and other identifiers.
- **What** -- The specific alleged misconduct or illegal activity.
- **When** -- Dates and times the activity occurred.
- **Where** -- Where the activity occurred.
- **Documents/Witnesses** -- Documents and witness names to substantiate the allegation.

Importance of Timeliness. It is important to promptly report allegations to the OIG. Many investigations rely heavily on witness testimony, and the more time between the occurrence of the crime and the interview of witnesses, the greater the likelihood that witnesses will not be able to recall important information. Over time, documentation may be misplaced or destroyed. In addition, most Federal crimes have a 5-year statute of limitations, which means that if a person is not charged with a crime within 5 years of its commission the person normally cannot be charged.

Appendix II

Monetary Benefits in Accordance with IG Act Amendments

Report Title: Combined Assessment Program Review VA Medical Center Manchester, New Hampshire

Project Number: 2000-02860-R1-0010

Recommendation Number	Category/Explanation of Benefits	Better Use of Funds	Questioned Costs
2	Better use of funds through improving the accuracy of CPT coding of outpatient encounters.	$9,486	
4	Better use of funds through reducing medical supply inventories would ensure excess stock and inventory costs are minimized.	$302,936[1]	
		$312,422	

[1] This estimate was made to demonstrate the local impact that implementation of GIP/better supply management would have at VAMC Manchester. The projected monetary benefits of implementing GIP on a nationwide basis were previously reported in OIG Report No. 9R8-E04-052, dated March 9, 1999.

Medical Center Director Comments

Department of Veterans Affairs

Memorandum

Date: February 21, 2001

From: Director (608/00), VAMC Manchester

Subj: DRAFT REPORT: Combined Assessment Program Review-VAMC Manchester

To: Assistant Inspector General for Auditing (52)

1. Included in pertinent sections of the subject report are the VAMC Manchester's responses to the OIG Team's observations and recommendations resulting from your visit October 23 – October 27, 2000. We have reviewed the report findings and concur with the eleven recommendations. We also concur with the OIG estimate of monetary impact regarding better use of funds through reducing medical supply inventories.

2. Although not required for reporting purposes, VAMC Manchester is in agreement with the suggestions made by the CAP team. Appropriate follow-up actions are underway.

3. If you require any additional information or further clarification, please feel free to contact Mr. John Forti, Staff Assistant to the Director, at 603-624-4366, ext. 6222.

/signed/

MARC F. LEVENSON

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