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SPECIAL COUNSEL
WASHINGTON, D.C.

DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

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SPECIAL COUNSEL
WASHINGTON, D.C.

2015 JUL -2 PM 2: 10

June 30, 2015

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

RE: OSC File No. DI-14-3705

Dear Ms. Lerner:

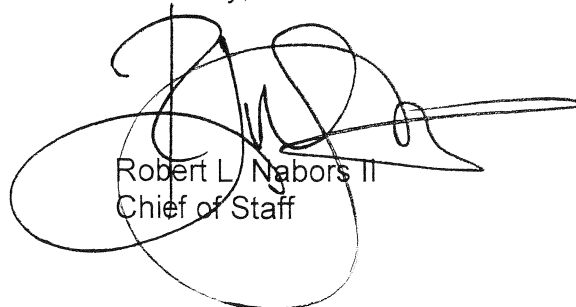
I am responding to your letter regarding allegations made by a whistleblower at the Edward Hines, Jr. Department of Veterans Affairs (VA) Hospital (hereafter, the Medical Center) in Hines, Illinois. The whistleblower alleged that the echocardiology laboratory was in disarray, a backlog of echocardiograms had built up, and that a practitioner was falsely documenting his encounters with Veterans. The Secretary delegated to me the authority to sign the enclosed report and take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

The Secretary asked that the Interim Under Secretary for Health refer the whistleblower's allegations to the Office of the Medical Inspector who assembled and led a VA team on a site visit to the Medical Center April 6-10, 2015. VA did not substantiate the first, but did substantiate the remaining two of the whistleblower's three allegations.

VA made 11 recommendations in all, 5 for the Medical Center to complete reviews, conduct a root cause analysis, review the encounters of the practitioner, assist in the Audit of inappropriate copayments by Veterans, and correct falsified records; and 6 for VHA to arrange for an independent review of cases, consider retraining providers on proper coding, conduct a Compliance and Business Integrity Audit of the Cardiology Department, and possibly convene an Administrative Investigation Board to look into the documentation practices of the practitioner. Findings from the investigation are contained in the report, which I am submitting for your review.

Thank you for the opportunity to respond.

Sincerely,



Robert L. Nabors II
Chief of Staff

Enclosure

**DEPARTMENT OF VETERANS AFFAIRS
Washington, DC**

**Report to the
Office of Special Counsel
OSC File Number DI-14-3705**

**Department of Veterans Affairs
Edward Hines Jr. VA Hospital
Hines, Illinois**



Report Date: June 12, 2015

TRIM 2015-D-215

Executive Summary

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

Allegations

The whistleblower alleged:

1. Deficiencies in cardiovascular care at the Medical Center resulted in unnecessary coronary surgeries and procedures performed on patients due to diagnostic errors. The root cause of these errors has not been addressed, and patients who underwent unnecessary surgeries due to these serious medical mistakes have not been notified;
2. Deficiencies in echocardiogram imaging and processing resulted in hundreds of useless studies, as well as a significant backlog of unread echocardiogram studies that caused life-threatening delays in treatment to patients; and
3. At least one physician, Dr. Robert Dieter, recorded an inflated number of procedures he performed to falsely boost the appearance of his productivity.

VA **substantiated allegations** when the facts and findings supported that the alleged events or actions took place and **did not substantiate allegations** when the facts and findings showed the allegations were unfounded. VA was **not able to substantiate allegations** when the available evidence was not sufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

After careful review of findings, VA makes the following conclusions and recommendations.

Conclusions for Allegation 1

- VA **did not substantiate** that the Medical Center failed to address the deficiencies in cardiovascular care identified in the Office of Inspector General (OIG) report of April 8, 2014, entitled "Questionable Cardiac Interventions and Poor Management of Cardiovascular Care, Edward Hines, Jr. VA Hospital, Hines, Illinois" (the OIG report). In fact, the Medical Center implemented at least three recommendations made by the VA committee and pursuant to the OIG report: greater use of fractional flow reserve (FFR) measurements to improve the diagnostic accuracy of borderline coronary artery obstructions on angiography; random case reviews, including review

of angiographic images by Cardiology specialists not affiliated with the Medical Center; and reinstitution of the combined Cardiology/Cardiothoracic Surgery Conference.

- VA **substantiated** that at the outset of our investigation, the Medical Center had not disclosed the results of the OIG report to the patients whose care was cited as questionable in that report. However, the Medical Center has reported that staff physicians have since disclosed the findings of the report to 11 of the 12 patients. VA concludes the decision not to disclose the findings of the OIG report to the remaining patient was reasonable.

Recommendation to VHA:

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

Recommendation to the Medical Center:

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

Conclusions for Allegation 2

- VA **substantiated** that the Medical Center had a backlog of unread echocardiograms in 2010–2011 that was subsequently resolved in 2012, based on interviews.
- VA **did not substantiate**, based on interviews, that the quality of echocardiogram image acquisition was poor at the Medical Center, pending our review of the 17 patients, the quality of whose echocardiograms the whistleblower questioned. Although there is no VHA policy requiring a quality assurance program for echocardiography laboratories, VA concludes that the Medical Center could improve its echocardiograms by implementing such a program.

Recommendation to VHA:

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

Recommendation to the Medical Center:

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

Conclusions for Allegation 3

- VA **substantiated** that the volume of Interventional Cardiologist 1's workload was inaccurately documented, thereby artificially inflating his productivity measure from fiscal year (FY) 2011 through FY 2014. We also found that this cardiologist contributed to his inflated productivity measures by personally entering current procedural terminology (CPT) codes for services he did not provide. We found that these actions possibly violate 18 USC § 208. Based on our findings, we referred this potential criminal matter to the Office of Inspector General on June 8, 2015, as required by 38 CFR 1.204.¹
- VA **substantiated** that the clinical performance pay of Interventional Cardiologist 1 may also have been inflated to an undetermined extent from FY 2011 through FY 2014; however, his base pay was not affected by the artificial inflation of his workload.
- VA **substantiated** that some Veterans were inappropriately charged copayments for care they did not receive.
- VA **substantiated** that Interventional Cardiologist 1 and Staff Cardiologist 1 received work relative value units (RVU) for echocardiograms interpreted by the whistleblower.
- VA **substantiated** that Interventional Cardiologist 1's inaccurate workload documentation constituted mismanagement and violated the provisions of VHA Handbook 1907, June 27, 2011 and September 2012.

Recommendations to VHA:

5. Conduct a Compliance and Business Integrity Audit of the Cardiology Department at the Medical Center to determine the extent of copayments inappropriately charged to Veterans and, as appropriate, refund all payments received from Veterans for services that were not provided.
6. Determine the need for a national control to monitor copayments charged to Veterans.
7. Subsequent to any additional OIG investigation and the outcome of the Compliance and Business Integrity Audit, convene an Administrative Investigation Board by persons not affiliated with the Medical Center or Veterans Integrated Service

¹ **38 CFR 1.204** "VA management officials with information about possible criminal matters involving felonies will ensure and be responsible for prompt referrals to the OIG. Examples of felonies include but are not limited to, theft of Government property over \$1000, false claims, false statements, drug offenses, crimes involving information technology systems and serious crimes against the person, *i.e.*, homicides, armed robbery, rape, aggravated assault and serious physical abuse of a VA patient."

Network (VISN) 12 to review Interventional Cardiologist 1's inaccurate workload documentation practices and the impact on his performance pay.

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

Recommendations to the Medical Center:

9. Assist VHA in its Compliance and Business Integrity Audit of the Cardiology Department to determine and refund all payments received from Veterans for services that were not provided.
10. Conduct a root cause analysis of the coding of echocardiograms to determine why work RVUs were assigned to physicians other than the interpreting physician, and take corrective action to prevent recurrence.
11. Correct the productivity records of Interventional Cardiologist 1 and Staff Cardiologist 1 from FY 2011 through FY 2014.

Summary Statement

OMI has developed this report in consultation with other Veterans Health Administration (VHA) and VA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, the Office of General Counsel (OGC) has provided a legal review, and the Office of Accountability Review (OAR) has examined the issues from a Human Resources (HR) perspective to establish accountability, when appropriate, for improper personnel practices. VA found possible violation of law, violations of VA and VHA policy, and mismanagement. Subject to independent review of the 50 cases mentioned above, VA did not find a substantial and specific threat to public health.

Table of Contents

Executive Summary	ii
I. Introduction	1
II. Facility Profile	1
III. Allegations	1
IV. Conduct of Investigation	1
V. Findings, Conclusions, and Recommendations.....	4
VI. Summary Statement.....	17
Attachment A	18
Attachment B	20
Attachment C	21
Attachment D	24
Attachment E	25

I. Introduction

The I/USH requested that OMI assemble and lead a VA team to investigate allegations lodged with OSC concerning the Medical Center. The whistleblower alleged that employees are engaging in conduct that may constitute violations of law, rule, or regulation, and gross mismanagement, and a substantial and specific danger to public health.

II. Facility Profile

The Medical Center, part of VISN 12, offers primary, extended, and specialty care to 56,000 Veterans. While the Medical Center currently operates almost 500 beds, primary care is the focus of its community-based outpatient clinics (CBOC) in Kankakee, Elgin, Oak Lawn, Aurora, LaSalle, and Joliet. Over 630,000 patient visits occur at the Medical Center annually. The Medical Center is institutionally affiliated with Loyola University of Chicago, Stritch School of Medicine, and it maintains an affiliation with the University of Illinois College of Medicine, Chicago. Specialized clinical programs in areas such as Blind Rehabilitation, Spinal Cord Injury, Cardiovascular Surgery, Traumatic Brain Injury, and Residential Care are examples of additional services provided at the Medical Center.

III. Allegations

The whistleblower alleged:

1. Deficiencies in cardiovascular care at the Medical Center resulted in unnecessary coronary surgeries and procedures performed on patients due to diagnostic errors. The root cause of these errors has not been addressed, and patients who underwent unnecessary surgeries due to these serious medical mistakes have not been notified;
2. Deficiencies in echocardiogram imaging and processing resulted in hundreds of useless studies, as well as a significant backlog of unread echocardiogram studies that caused life-threatening delays in treatment to patients; and
3. At least one physician, Dr. Robert Dieter, recorded an inflated number of procedures he performed to falsely boost the appearance of his productivity.

IV. Conduct of Investigation

The VA team conducting the investigation consisted of Edward Huycke, MD, Deputy Director for National Assessments Division, Hala Maktabi, PhD, MPH, Epidemiologist, Gladys Felan, MSN, RN, BSN, CPUR, Clinical Program Manager, Brigitte Booker, BS, MA, Health Systems Specialist, all from OMI; and Mary Johnson, RHIT, CCS-P of VHA Health Information Management (HIM). VA reviewed relevant policies, procedures, reports, memorandums, and other documents, a full list of which is in Attachment A.

The VA team interviewed the whistleblower by telephone on April 2, 2015, and conducted a site visit to the Medical Center on April 6–10, 2015. We held an entrance briefing with the Medical Center leadership:

- Michelle Y. Blakely, FACHE, Acting Director
- Jack Bulmash, MD, Chief of Staff (CoS)
- Marianne Locke, Associate Director for Patient Care Services
- Kenny Sraon, FACHE, Assistant Director
- Sandy Reynertson, MD, Associate Chief of Medicine
- Germaine Clarno, President, American Federation of Government Employees (AFGE) Local 781
- Gail Robinson, Director of National Nurses United
- Lorene Lang-Moody, Associate Director of National Nurses United
- Aaron Carlson, FACHE, Health Systems Specialist (HSS) to the CoS

The VA team toured the Cardiology Service and the Cardiac Catheterization Laboratory.

The team interviewed the following Medical Center employees during the site visit:

- Michelle Blakely, FACHE, Acting Medical Center Director
- Jack Bulmash, MD, CoS
- Brian Schmitt, MD, Chief of Medicine
- Colleen Novak, Acting Chief of Quality
- Patricia Hagenbart, Risk Manager
- Brian Hertz, MD, Associate Chief of Staff for Ambulatory Care
- Lonnie Edwards, MD, Chief of Cardiology and Director of the Echocardiography Laboratory (Staff Cardiologist 1)
- Sandy Reynertson, MD, Associate Chief of Medicine and Staff Cardiologist
- Mark Hollander, Chief Financial Officer
- Farah Ford, Chief of HIM
- Robert Dieter, MD, Interventional Cardiologist (Interventional Cardiologist 1)
- Jayson Liu, MD, Director of the Cardiac Catheterization Laboratory and Interventional Cardiologist (Interventional Cardiologist 2)
- Carol Chen-Johnston, MD, Cardiologist
- Joseph Cytron, MD Cardiologist
- Sandy Alcala, RN, Cardiology Department
- Charlene Fletcher, Credentialing and Privileging Coordinator
- Daphne Lenton, Coding Supervisor
- Linda McClendon, Medical Instrument Technician, Cardiac Catheterization Laboratory

- David Przychocki, Diagnostic Radiology Technician (currently employed at the Jesse Brown VA Medical Center)
- Linda Duran, Echocardiogram Technician (ET)
- Wayne Gabry, ET
- Valerie Byrne, Manager of ETs
- Philip Howard, ET
- Geraldine Blue, Coder/Auditor
- Ed Caro, Decision Support Systems Site Manager
- Curtis Kuss, VISN DSS Manager
- Karen McLean, Nurse Manager, Cardiac Catheterization Laboratory
- Katherine Miskovic, ET
- Germaine Clarno, President, AFGE, Local 781

On April 10, we held an exit briefing with Medical Center leadership:

- Michelle Y. Blakely, FACHE, Acting Director
- Jack Bulmash, MD, CoS
- Marianne Locke, Associate Director for Patient Care Services
- Daniel Zomchek, FACHE, PhD, Associate Director
- Kenny Sraon, FACHE, Assistant Director
- Aaron Carlson, FACHE, HSS to the CoS

The VA team interviewed the following individuals by telephone after the site visit:

- Larry Ohms, RN, Cardiac Catheterization Laboratory (Retired 3/20/14)
- Valerie Wodzinski, Patient Safety Manager
- Kimberly Sue Delcour, MD, former cardiology trainee, currently in private practice
- Margaret Kelly, RN, Medical Intensive Care Unit (MICU)
- Shaneka Campbell-Alexander, Compliance Officer, Office of Compliance and Business Integrity (CBI)

The VA team again interviewed the whistleblower by telephone on May 20, 2015.

The VA team attempted to interview Sheldon Freeberg, MD, a former cardiology trainee currently in private practice, by telephone. We contacted his office and left voicemail messages seven times but we were unable to arrange a telephone interview. The VA team also attempted to contact Nuraj Parakh, a former cardiology trainee currently in private practice, by telephone but was unable to arrange a telephone interview with him. Finally, we attempted to contact Ms. Johanna Lazarski, a former Medical Center employee, but were unable to do so by telephone. We sent her a certified letter asking to arrange a telephone interview; however, the letter was returned to us as undeliverable and without forwarding address.

V. Findings, Conclusions, and Recommendations

Allegation 1

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

Findings

Deficiencies in Cardiovascular Care

The VA OIG Office of Healthcare Inspections conducted two site visits during May 21–23 and July 16–19, 2013, to evaluate the quality of cardiovascular care provided to Veterans at the Medical Center between July 1, 2010 and June 30, 2013. In their report of April 8, 2014, entitled “Questionable Cardiac Interventions and Poor Management of Cardiovascular Care, Edward Hines, Jr. VA Hospital, Hines, Illinois” (the OIG report), OIG substantiated that:

- two patients had questionable indications for coronary bypass surgery;
- coronary interventions may have been inappropriate for nine patients who had undergone cardiac catheterizations during that time; and
- preoperative planning was inadequate for one patient who underwent coronary artery bypass surgery.

We did not investigate these cases further. However, we have initiated a clinical review of 50 previously uninvestigated cases as described below. We also verified that the Medical Center has put the following quality improvement measures in place since 2013 to address deficiencies in cardiovascular care and the root causes of previous errors.

- In February 2014, pursuant to the OIG site visit, the Medical Center convened a committee, chaired by the Chief of Cardiology from VA New York Harbor Healthcare System, of 10 VA interventional cardiologists (the VA committee), to examine reasons for differences in recommending coronary artery interventions. The Medical Center also convened a cardiology review by VHA’s National Cardiology program in April 2014.
- The decision to perform coronary artery interventions, such as a PCI or coronary artery bypass graft surgery (CABG), is typically based on angiographic results that allow the visual evaluation of the inner diameter of blood vessels. In ischemic heart disease, in which the heart is not getting enough blood flow and oxygen, deciding which narrowing is hemodynamically significant and in need of intervention is not always clear. The FFR coronary artery catheter measures pressure differences across a narrowing of the artery to determine the likelihood

of the narrowing being hemodynamically significant enough to impede oxygen delivery to the heart muscle. In this manner, the FFR catheter can identify hemodynamically significant obstructions where angiographic images may be equivocal.

- Pursuant to the VA Committee's recommendation, the Medical Center encouraged the use of FFR measurements to help delineate which cases with visually borderline coronary artery obstructions would benefit from intervention. On interview, both interventional cardiologists, as well as other cardiac catheterization laboratory employees, acknowledged that they have increased the use of FFR measurements in cases where the necessity for intervention may be in question.
- In March 2014, the Medical Center began conducting a prospective external review, by the Jesse Brown VA Medical Center and the Clement J. Zablocki VA Medical Center, of cases for which PCI was recommended by the two interventional cardiologists on staff. Five cases each month were randomly selected for each interventional cardiologist through February 2015. During the first 6 months of reviews, the external reviewer verified that all cases were performed for appropriate indications and included proper pre-procedure evaluation for the subsequent PCI. The review of cases of the second 6 months is ongoing.
- Finally, the Medical Center reinstituted the combined Cardiology/Cardiothoracic Surgery Conference which had not been held for years prior to the OIG report. These conferences allow the exchange of professional viewpoints that can be particularly helpful when the decision to proceed to CABG is borderline. On interview, the cardiologists confirmed that the conference had been reinstituted and they regularly participated.

Patient Disclosures

The CoS confirmed that the 12 patients whose interventions had been cited as questionably indicated in the OIG report had not been informed of the results of that review. Immediately following our site visit, the Medical Center disclosed these results to 11 of the 12 patients, including the 2 who underwent CABG for questionable indications and the 9 who underwent possibly inappropriate cardiac catheterizations with PCI.

The Medical Center decided not to disclose the report results to the twelfth patient on the grounds that while the patient's preoperative cardiac evaluation had been appropriate, technical difficulties encountered while performing an echocardiogram in the operating room (OR) led to suspicion of an unanticipated cardiac condition that was subsequently determined to be absent. Cardiology staff who responded to the OR to clarify the echocardiogram result did not confirm the suspected condition and affirmed that the preoperative cardiac evaluation was appropriate. The CoS wrote, "I think in this

instance there was some confusion within the OR secondary to an echocardiogram performed by anesthesia [in the OR] which presumably demonstrated a valvular insufficiency not suspected [on an] earlier [echocardiogram performed by the Cardiology Department].² However, when a cardiologist was brought into the OR and the echocardiogram was repeated with the proper gain settings, no such insufficiency was detected. The OIG inspection and report did uncover potential room for improvement in our preoperative assessments which were implemented. Specifically retraining of our anesthesiologist in the performance of echocardiograms and the resumption of our multidisciplinary CV/Cardiology conferences for review and discussion of the films, clinical presentation and planned operative intervention before the Veterans are scheduled for surgery.”

Additional Cases with Quality of Care Concerns

Following publication of the OIG report, the whistleblower provided a list of 49 patients about whom she had concerns regarding echocardiography, peripheral vascular interventions, and cardiac catheterizations (Attachment B). We also received an additional case with quality of care concerns during our site visit. We have initiated a professional independent review external to the VA of all 50 cases. We will provide the results in a subsequent report.

Conclusions for Allegation 1

- **VA did not substantiate** that the Medical Center failed to address the deficiencies in cardiovascular care identified in the OIG report. In fact, the Medical Center implemented at least three recommendations made by the VA committee and pursuant to the OIG report: greater use of FFR measurements to improve the diagnostic accuracy of borderline coronary artery obstructions on angiography; random case reviews, including review of angiographic images by Cardiology specialists not affiliated with the Medical Center; and reinstitution of the combined Cardiology/Cardiothoracic Surgery Conference.
- **VA substantiated** that, at the outset of our investigation, the Medical Center had not disclosed the results of the OIG report to the patients whose care was cited as questionable in that report. However, the Medical Center has reported that staff physicians have since disclosed the findings of the report to 11 of the 12 patients. VA concludes the decision not to disclose the findings of the OIG report to the remaining patient was reasonable.

Recommendation to VHA:

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

² Cardiac valvular insufficiency is a condition of a cardiac valve in which there is abnormal retrograde blood flow across the valve. In some cases, the insufficiency should be corrected by surgery.

Recommendation to the Medical Center:

2. Complete the ongoing random review of PCI cases from September 2014 to February 2015, and take appropriate actions based on the results.

Allegation 2

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

Background

Echocardiography is a diagnostic technique that uses ultrasound waves to produce images of the heart. It is generally used to diagnose abnormalities in the heart muscle and valves. Adequate echocardiogram image acquisition relies on a variety of technical factors, including effective ultrasound equipment, competent ETs, and consistent methods of acquisition. In addition, patient factors such as obesity and lung disease can interfere with transmission of the ultrasound waves and degrade image quality. Although incomplete visualization results in a “technically limited” echocardiogram that may restrict the assessment of heart function or cardiac valvular function, often the limited cardiac views are adequate to answer the clinical question that prompted the referral for the test. While it is expected that a proportion of echocardiograms will be “technically limited” for the reasons outlined above, we did not find published criteria for an acceptable proportion.

Findings

The OIG report affirms that the Medical Center had a backlog of unread echocardiogram studies during 2011. In their examination of the timeliness of echocardiogram readings at the Medical Center from January 1, 2012, to April 30, 2013, OIG did not find significant delays in the interpretation and reporting of outpatient echocardiograms, indicating that the backlog had been resolved. Further, the report did not substantiate the allegation that the quality of echocardiogram image acquisition was poor during this period.

The Chief of Cardiology and Director of the Echocardiography Laboratory confirmed that there had been a backlog in 2011, and that it was subsequently resolved. Consistent with the OIG report, he agreed that the quality of echocardiograms at Medical Center was not poor, describing it as “clinically sufficient,” despite limitations attributable to equipment inadequacies and patient factors. Nevertheless, he could not articulate the proportion of “technically limited” echocardiograms or any quality assurance program that minimizes them.

The whistleblower’s list of 49 patients included about 17 with concerns specific to echocardiography. In addition to our pending review of these prior cases, OIG has

undertaken a review into present delays in echocardiograms and their quality, which is ongoing (Attachment C).

Conclusions for Allegation 2

- VA **substantiated** that the Medical Center had a backlog of unread echocardiograms in 2010–2011 that was subsequently resolved in 2012, based on interviews.
- VA **did not substantiate**, based on interviews, that the quality of echocardiogram image acquisition was poor at the Medical Center, pending our review of the 17 patients, the quality of whose echocardiograms the whistleblower questioned. Although there is no VHA policy requiring a quality assurance program for echocardiography laboratories, VA concludes that the Medical Center could improve its echocardiograms by implementing such a program.

Recommendation to VHA:

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

Recommendation to the Medical Center:

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

Allegation 3

At least one physician, Dr. Robert Dieter, recorded an inflated number of procedures he performed to falsely boost the appearance of his productivity.

Background

Coding and Billing of Outpatient Cardiology Visits

An encounter is “a professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient’s condition. Encounters occur in outpatient and inpatient settings. Contact can include “face-to-face interactions or those accomplished via telecommunications technology” (VHA Directive 2009-002, January 2009; VHA Directive 1082, March 2015). VHA uses encounters to track health care provider workload. Outpatient cardiology encounter notes are completed by the provider at the time and location of the encounter. For each encounter, the provider enters a clinical note and one or more CPT codes that describe the medical, surgical, laboratory, evaluation and management, or other services he or she provided. In cases where a patient sees multiple providers or receives multiple services on the same day, he or she may generate multiple encounters for the same outpatient visit.

VHA collects revenue from private health insurers for non-service connected care provided to Veterans with third party medical insurance. VHA Handbook 1907.03 states: "The goal of a clinical coding program is for continuous accuracy of coded data contained within national databases (VHA Handbook 1907.03, paragraph 4a, June 27, 2011 and September 2012)". According to the HIM and Consolidated Patient Account Center Service Level agreement of October 2013, VHA's HIM department is responsible for the accurate and timely coding and validation of all outpatient cardiology visits that generate bills sent to health insurers. VHA also collects copayments for outpatient care from Veterans whose conditions are not service connected (VHA Directive 2011-022). Copayments charged to Veterans are automatically generated by the Integrated Billing software administered by VHA's Chief Business Office (CBO). Other than relying on the accuracy of the automated billing software, VHA does not monitor the appropriateness of copayments charged to Veterans.

Productivity

VHA measures physician productivity using the Resource-Based Relative Value Scale (RBRVS), which is the health care industry standard also used by Medicare. Under this scale, an RVU represents a combination of physician work (work RVUs), a practice expense factor, and a malpractice expense relative value. In VHA, malpractice and practice expenses are not included in physician productivity calculations, since VHA practitioners are not responsible for their malpractice insurance and do not have financial responsibility for the practice expenses. Therefore, only work RVUs are used to measure the productivity of VHA physicians.

Work RVUs represent the time, technical skill, physical effort, mental effort, judgment required, and the stress experienced by the physician performing the service. Each CPT code is assigned a work RVU according to the annual Medicare RVU files from the Centers for Medicare and Medicaid Services (CMS). Each encounter is assigned a total work RVU value based on the CPT codes associated with it. Encounters requiring more skill and time, such as coronary interventions including PCI, accrue a greater number of work RVUs than a clinic visit. For example, CPT code 99211 for an "Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician, where the presenting problem(s) are usually minimal, and typically, five minutes are spent performing or supervising these services," is equivalent to 0.18 work RVUs. On the other hand, CPT code 92928 for the "percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch" is equivalent to 10.49 work RVUs. Physician productivity is based on the sum of the work RVUs across all encounters generated by an individual provider adjusted by the clinical hours that he or she worked in a given FY as follows:

$$\text{Productivity} = \text{Sum (work RVUs)} \div \text{Clinical hours worked in an FY}$$

Performance pay

According to the VA Handbook 5007

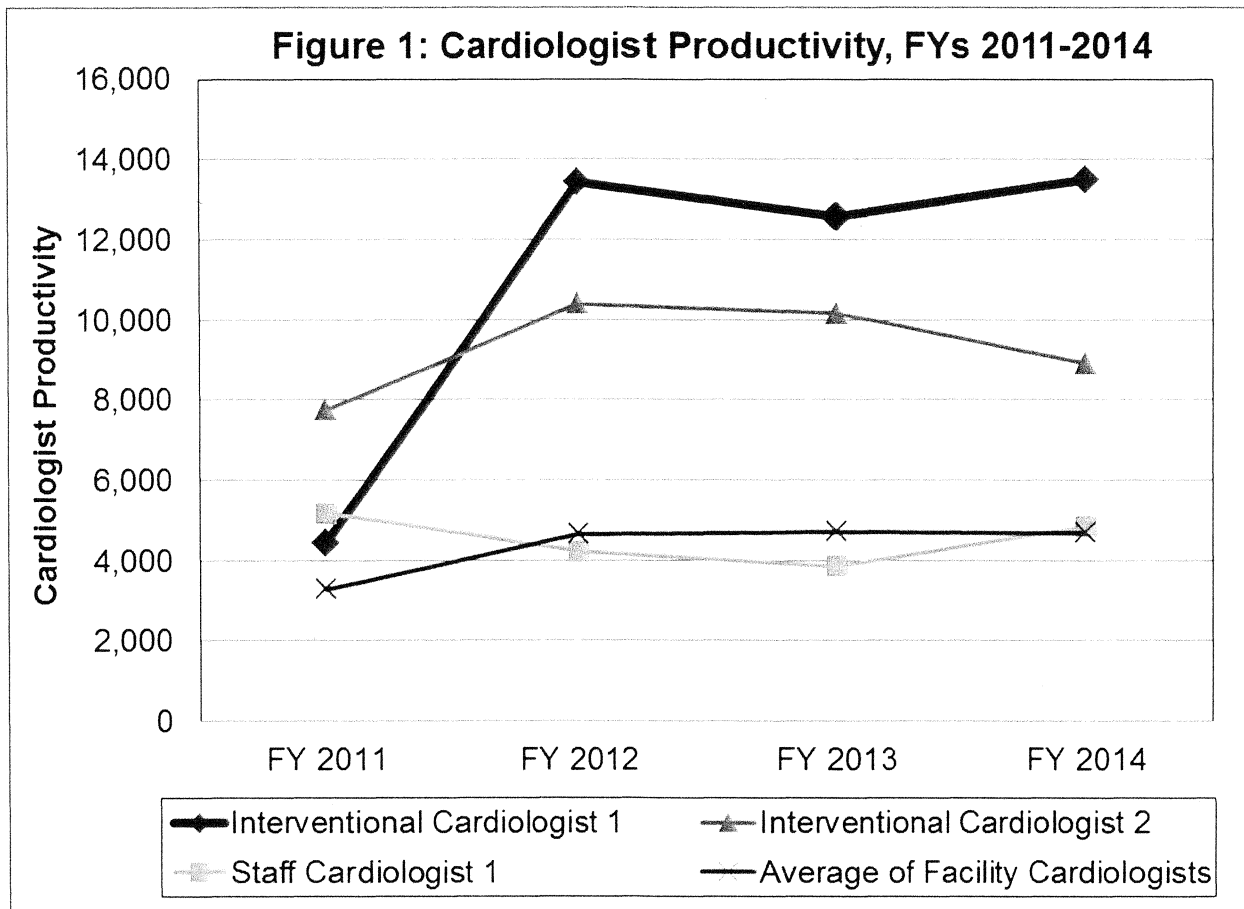
The pay of VHA physicians consists of three elements: basic pay, market pay, and performance pay. Basic pay is fixed by law or administrative action for the position held by an employee before any deductions, and exclusive of additional pay of any kind (e.g., market pay, performance pay, recruitment incentive, etc.) as prescribed under 38 U.S.C. 7431. Market pay is a component of basic pay intended to reflect the recruitment and retention needs for the specialty or assignment of a particular VHA physician. Performance pay is compensation paid to recognize the achievement of specific goals and performance prescribed on a FY basis by an appropriate management official. The purpose of performance pay is to improve the quality of care and health care outcomes through the achievement of specific goals and objectives related to the clinical, academic, and research missions of VA.

The Medical Center developed its own process to determine providers' annual performance pay independently of the RBRVS described above (Performance Pay Measures, Medicine Service Line, FYs 2011–2014). According to this process, performance pay is based on each provider's teaching, research, administrative, and clinical performance. Specifically, clinical performance, constituting an estimated 84 percent of the annual performance pay, is based on inpatient attending time, inpatient consults, emergency department assignments, procedures, and clinical visits. The maximum annual performance pay is the lower of \$15,000 or 7.5 percent of the provider's salary.

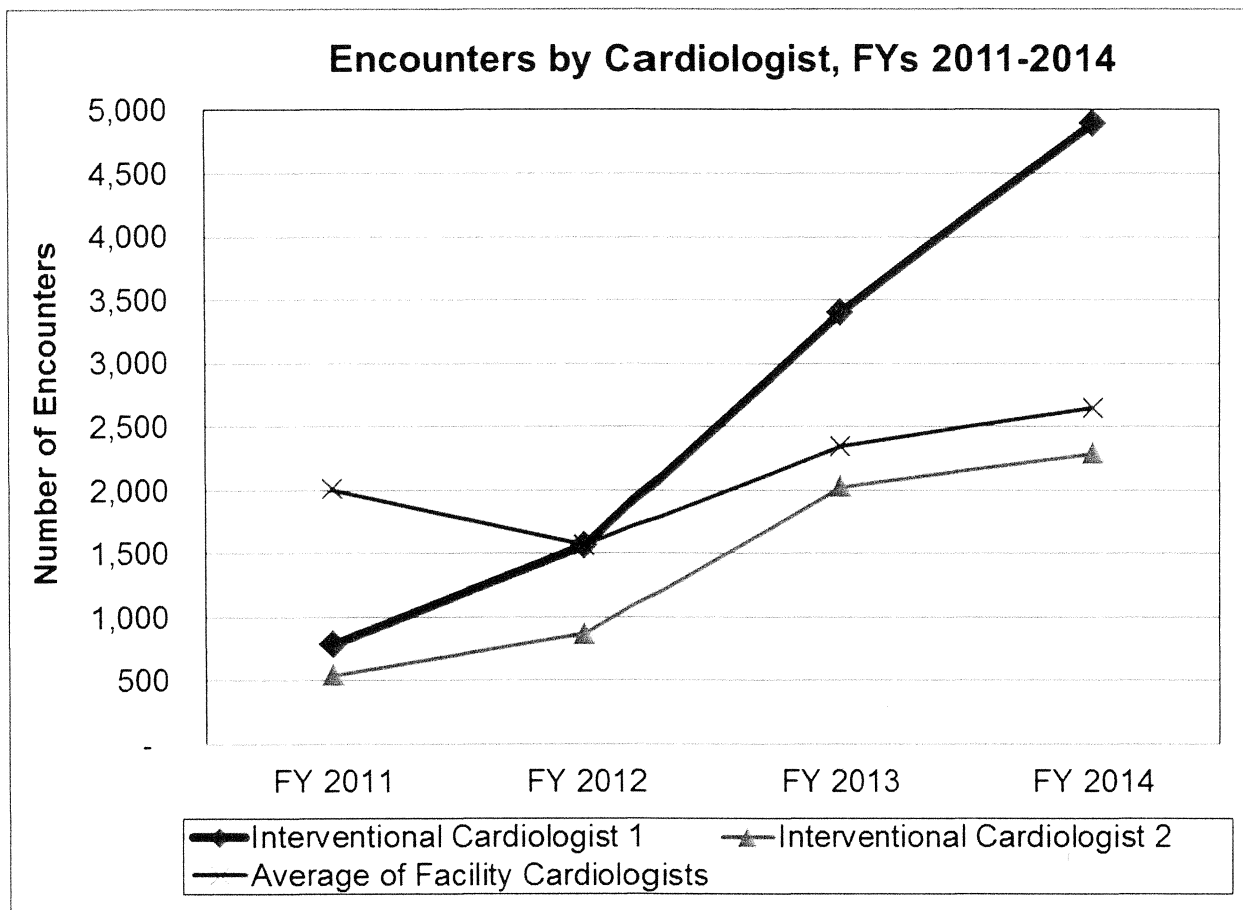
Findings

We examined cardiologist productivity trends at the Medical Center during FYs 2011–2014 (Figure 1).³ The productivity of Interventional Cardiologist 1 increased from 4,435 work RVUs in FY 2011 to 13,484 work RVUs in FY 2014, a 204 percent increase. In comparison, the productivity of Interventional Cardiologist 2, who has a similar practice, increased from 7,749 to 8,907 for the same period (a 14 percent increase) while the average productivity of all cardiologists at the Medical Center during this time period increased from 3,288 to 4,694 (a 43 percent increase).

³ Because of the heavily weighted work RVUs for interventional cardiologists, it is expected that the productivity measure of the two interventional cardiologists is higher than that of Staff Cardiologist 1 who is a non-interventional cardiologist.



Our examination of this large increase in Interventional Cardiologist 1's productivity measure showed a six-fold increase in the number of encounters, from 791 in FY 2011 to 4,891 in FY 2014 (Figure 2). In comparison, Interventional Cardiologist 2 increased his number of encounters from 539 in FY 2011 to 2,289 in FY 2014, a four-fold increase. The average number of encounters for all cardiologists at the Medical Center during this time period increased only from 2,006 to 2,646.

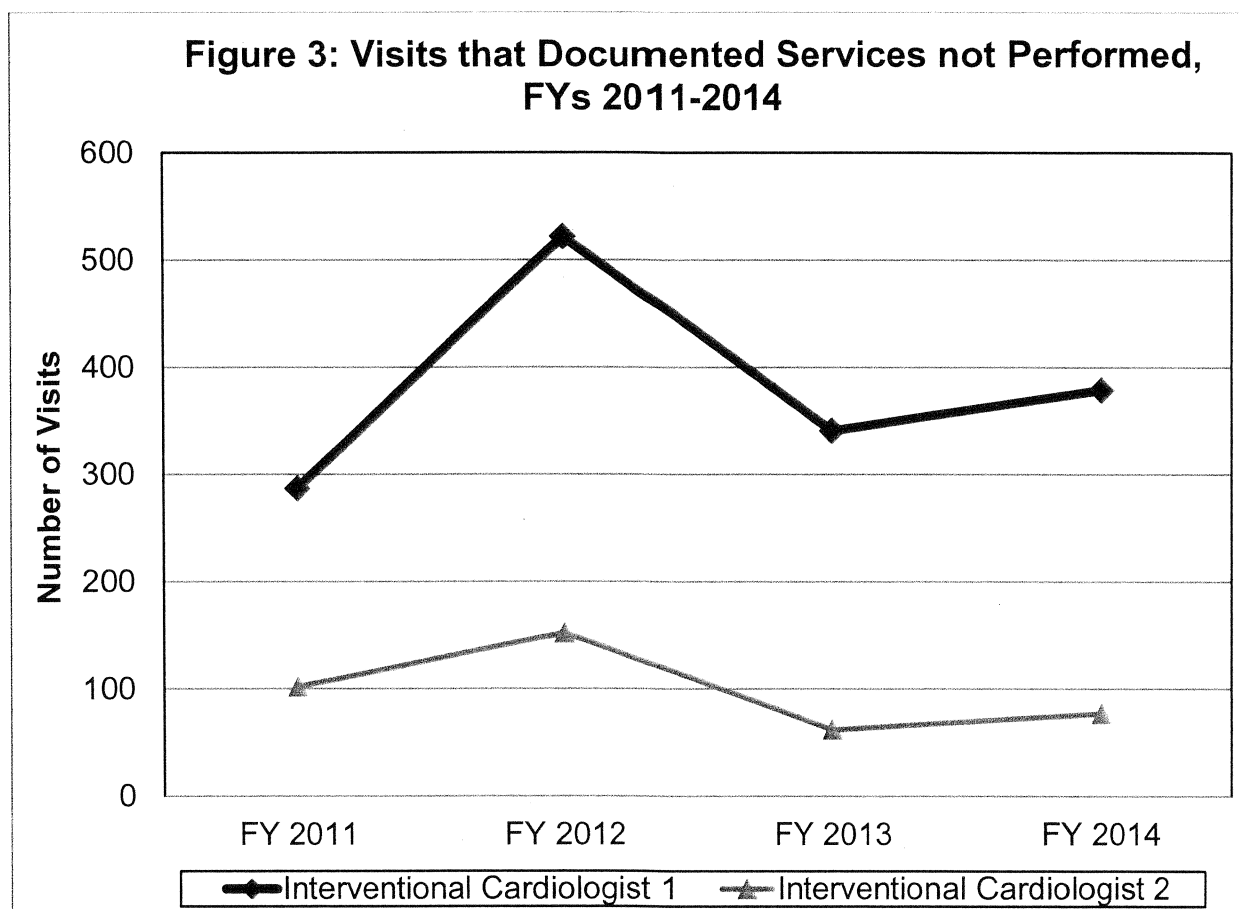


In reviewing the clinical documentation supporting Interventional Cardiologist 1's encounters, we identified three coding patterns that contributed to the observed increases in his encounters and productivity measures:

Pattern A consists of patient visits in which one or more encounters were coded for care that was not provided according to the patient's electronic health record (EHR). As an example of this pattern, the Medical Center Compliance Officer confirms that Interventional Cardiologist 1 assigned eight CPT codes to Patient A's visit on November 5, 2013 (Attachment D). We reviewed Patient A's EHR and found that four of these codes represented procedures that were not performed. For instance, CPT code 92928, representing a stent insertion, was coded twice; however Patient A's EHR reflects the insertion of a single stent. Similarly, CPT code 36252 representing a "bilateral catheter insertion" was coded twice; however Patient A's EHR reflected a single instance of the bilateral catheter insertion.⁴ Overall, each of four codes that were not supported by documentation in the patient's EHR was assigned a work RVU which resulted in Interventional Cardiologist 1 receiving twice the work RVUs supported by the EHR. These unsupported work RVUs contributed to his productivity measure.

⁴ A bilateral catheter insertion is the placement of a single catheter which is used to evaluate and possibly treat diseased arteries bilaterally, e.g., both renal arteries or both femoral arteries. The catheter is inserted through a single arterial entry usually by needle puncture. In the example above, a single bilateral catheter was inserted while two CPT codes for that procedure were entered.

On interview, the Director of the Catheterization Laboratory described an interface malfunction between the hemodynamic monitoring system in the cardiac catheterization laboratory and the patient EHR from 2006 to September 2014 that resulted in duplicate encounters for the same patient visit at times when that system was down. During this time, we would expect some duplicate encounters, but would expect the proportion of these entries to be similar for the two interventional cardiologists using the same system. However, Interventional Cardiologist 1 had a much greater number of patient visits that documented services not performed than did Interventional Cardiologist 2. For instance, in FY 2012, we found 522 patient visits documenting procedures that Interventional Cardiologist 1 did not perform compared with 152 for Interventional Cardiologist 2 (Figure 3). Accordingly, we could not fully explain this coding pattern based on the interface malfunction.



Pattern B consists of encounter codes for outpatient visits for patients who did not visit the Medical Center on that day. For example, a clinic note by Interventional Cardiologist 1 on January 21, 2015, documents a telephone message he left for the Patient B to call him back regarding test results. Although the note shows that the provider did not see the patient at the Medical Center that day, he coded this clinic note as an outpatient visit with CPT code 99211. As a result, Interventional Cardiologist 1 was credited 0.18 work RVUs for leaving a telephone message when it did not merit any

work RVUs (VHA Directive 2009-002, January 2009; VHA Directive 1082, March 2015). These unsupported work RVUs contributed to his productivity measure.

Pattern C consists of additional outpatient clinic notes recorded on the same day the patient underwent a procedure in the cardiac catheterization laboratory. Interventional Cardiologist 1 would enter both a procedure note documenting the performance of the cardiac catheterization, and an outpatient visit note for that day, creating the appearance of two separate encounters. As an example, Patient C's EHR shows an outpatient cardiology procedure note signed by this cardiologist on April 22, 2014 at 11:51 a.m. It also shows a clinic note on the same patient for the same procedure signed by the cardiologist at 8:50 a.m. that day, which he coded as an outpatient visit with CPT code 99211 (Attachment E). Since the clinic note content did not reflect an independent encounter for Patient C on that day, the note was part of the procedure and typically would not have been coded as a separate outpatient visit. Again, in this instance, Interventional Cardiologist 1 was credited an additional 0.18 work RVUs for the outpatient visit, which was already incorporated in the RVUs allocated for the cardiology procedure.

Billing Implications

We found several instances where Veterans were charged and paid a \$50 copayment for cardiology specialty clinic visits attributed to Interventional Cardiologist 1, when the patient had not visited the cardiology clinic. For instance, in the earlier example of Patient B, a clinic note documents a telephone message left by Interventional Cardiologist 1. The cardiologist coded this note as an outpatient visit, even though it shows that the patient was not at the Medical Center that day. As a result, the Veteran was charged—and paid—a \$50 copayment for a face-to-face clinic visit that did not occur.

Performance Pay Implications

In calculating individual provider performance pay, the Medical Center reported that:

“... the Medicine Service Line adopted a process of identifying and monitoring all clinical activities for each individual provider and then translating those activities into time. To do this a pre-determined time estimate is applied (the estimates used pre-date the arrival of [C]ardiologist 1 to [the Medical Center]) for each clinical activity. **Actual clinic visits (not phone calls or non-face-to-face interactions nor encounters) are used and taken from VistA.** [emphasis added] Inpatient attending (CCU) and inpatient consult service are taken from the inpatient rotation schedule and are not subject to manipulation. Interventional procedures are generated by the computer in the [cardiac catheterization laboratory] and validated by [C]ardiologist 2 (the [cardiac catheterization laboratory] director). Even if two or more encounters were entered for a single procedure—it is the single procedure that is used to estimate time. Cardiologist 1 has no opportunity to manipulate this data. Echocardiogram volume is determined by the chief of cardiology from VistA (Note: The volume

referenced here was not measured in a way that contributed to the inflated encounters/visits discovered in this review). The number of unique patients with an [echocardiogram] is also validated by a separate spreadsheet of data maintained by the [ETs] and compared to the VistA report to determine that the number of echocardiograms is correct. The above data is provided to the Chief of Medicine who then translates this data for each cardiologist into total hours. It is not RVU data that is gathered.”

Referring back to pattern B, we found evidence of telephone messages or contacts where Veterans did not visit the Medical Center which were captured by VistA as face-to-face outpatient clinic visits. These visits contributed to Interventional Cardiologist 1's number of clinic visits as collected in VistA, thereby artificially inflating the number of these visits. Accordingly, we found that Interventional Cardiologist 1's clinical performance was inflated from FY 2011 through FY 2014. However, we were not able to determine what percentage of his yearly awards was influenced by these inaccurate workload documentation practices.

Lonnie C. Edwards

The whistleblower also alleged that she observed other instances of data manipulation by Interventional cardiologist Robert Dieter, and chief of cardiology Lonnie Edwards, in an effort to boost their productivity. In particular, she reported that Dr. Edwards' and Dr. Dieter's names were recorded as the interpreting physician on echocardiogram studies that Dr. Nee had actually interpreted.

We reviewed the clinical documentation supporting echocardiogram interpretations for which Staff Cardiologist 1 received work RVUs, and found several instances where the EHR reflects that the whistleblower was the interpreting physician. Similarly, we found several instances where interventional Cardiologist 1 received work RVUs for echocardiograms interpreted by the whistleblower. In addition, we found multiple instances of echocardiogram interpretations for which both Staff Cardiologist 1 and Interventional Cardiologist 1 received work RVUs for the same echocardiogram. In one instance, the patient EHR reflected that the same echocardiogram done on December 15, 2010, was interpreted by Staff Cardiologist 1 on March 10, 2011, and a second time by Interventional Cardiologist 1 on May 31, 2011. These unsupported work RVU's contributed to the productivity measures of both Interventional Cardiologist 1 and Staff Cardiologist 1.

In contrast to Interventional Cardiologist 1, the productivity measure of Staff Cardiologist 1 remained steady during FYs 2011-2014, showing no unexplainable increases (Figure 1). We were not able to determine why work RVUs were credited to providers other than the interpreting physician.

Conclusions for Allegation 3

- VA **substantiated** that the volume of Interventional Cardiologist 1's workload was inaccurately documented, thereby artificially inflating his productivity measure from FY 2011 through FY 2014. We also found that this cardiologist contributed to his inflated productivity measures by personally entering CPT codes for services he did not provide. We found that these actions possibly violate 18 USC § 208. Based on our findings, we referred this potential criminal matter to the Office of Inspector General on June 8, 2015, as required by 38 CFR 1.204.⁵
- VA **substantiated** that the clinical performance pay of Interventional Cardiologist 1 may also have been inflated to an undetermined extent from FY 2011 through FY 2014; however, his base pay was not affected by the artificial inflation of his workload.
- VA **substantiated** that some Veterans were inappropriately charged copayments for care they did not receive.
- VA **substantiated** that Interventional Cardiologist 1 and Staff Cardiologist 1 received work RVUs for echocardiograms interpreted by the whistleblower.
- VA **substantiated** that Interventional Cardiologist 1's inaccurate workload documentation constituted mismanagement and violated the provisions of VHA Handbook 1907, June 27, 2011 and September 2012.

Recommendations to VHA:

5. Conduct a Compliance and Business Integrity Audit of the Cardiology Department at the Medical Center to determine the extent of copayments inappropriately charged to Veterans and, as appropriate, refund all payments received from Veterans for services that were not provided.
6. Determine the need for a national control to monitor copayments charged to Veterans.
7. Subsequent to any additional OIG investigation and the outcome of the Compliance and Business Integrity Audit, convene an Administrative Investigation Board by persons not affiliated with the Medical Center or VISN 12 to review Interventional Cardiologist 1's inaccurate workload documentation practices and the impact on his performance pay.

⁵ **38 CFR 1.204** "VA management officials with information about possible criminal matters involving felonies will ensure and be responsible for prompt referrals to the OIG. Examples of felonies include but are not limited to, theft of Government property over \$1000, false claims, false statements, drug offenses, crimes involving information technology systems and serious crimes against the person, *i.e.*, homicides, armed robbery, rape, aggravated assault and serious physical abuse of a VA patient."

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

Recommendations to the Medical Center:

9. Assist VHA in its Compliance and Business Integrity Audit of the Cardiology Department to determine and refund all payments received from Veterans for services that were not provided.
10. Conduct a root cause analysis of the coding of echocardiograms to determine why work RVUs were assigned to physicians other than the interpreting physician, and take corrective action to prevent recurrence.
11. Correct the productivity records of Interventional Cardiologist 1 and Staff Cardiologist 1 from FY 2011 through FY 2014.

VI. Summary Statement

OMI has developed this report in consultation with other VHA and VA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, OGC has provided a legal review, and the OAR has examined the issues from an HR perspective to establish accountability, when appropriate, for improper personnel practices. VA found possible violation of law, violations of VA and VHA policy, and mismanagement. Subject to independent review of the 50 cases mentioned above, VA did not find a substantial and specific threat to public health.

Attachment A

18 USC § 208, Acts affecting a personal financial interest

38 CFR 1.204, Information to be Reported to the Inspector General

VA Directive 0700, Administrative Investigations, March 25, 2002

VHA Directive 2011-022 - Copayment For Outpatient Medical Care Provided To Veterans By The Department Of Veterans Affairs, April 2011

VHA Handbook 1907.01 Health Information Management And Health Records
September 19, 2012

VHA Handbook 1907.01 Health Information Management And Health Records July 22,
2014

VHA Handbook 1907.03 Health Information Management Clinical Coding Program
Procedures, June 27, 2011

VHA Handbook 1907.03 Health Information Management Clinical Coding Program
Procedures, September 26, 2012

VHA Coding Guidelines, Version 11.0, August 10, 2011

VHA Directive 2009-002, Patient Care Data Capture, January 2009

VHA Directive 1082, Patient Care Data Capture, March 2015

VA Handbook 5007/45 Pay Administration, Part Ix. Pay For VHA Physicians And
Dentists, April 2, 2013

Questionable Cardiac Interventions and Poor Management of Cardiovascular Care,
Edward Hines, Jr. VA Hospital, Hines, IL, April 2014

Health Information Management and Consolidated Patient Account Center Service
Level agreement, October 2013

HIM Practice Brief #8, Guidelines for Coding Clinical Care: Telephone Calls/Encounters,
June 2013

Performance Pay Measures FY 2011, Medicine Service Line

Performance Pay Measures FY 2012, Medicine Service Line

Performance Pay Measures FY 2013, Medicine Service Line

Performance Pay Measures FY 2014, Medicine Service Line

Attachment B



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

February 25, 2015

MEMORANDUM

TO: Director, Edward Hines Jr. Hospital, Hines, IL

FROM: Assistant Inspector General for Healthcare Inspections

RE: Review of Cardiovascular Care

Reference: Questionable Cardiac Interventions and Poor Management of
Cardiovascular Care, Edward Hines, Jr. VA Hospital, Hines, Illinois, April 8, 2014

1. Following publication of the OIG report on cardiovascular care at Hines, a complainant provided specific information regarding patients treated in 2013 and earlier. The attached list describes 49 patients with issues regarding echocardiography (17), peripheral vascular interventions (10), and cardiac catheterization (22).
2. Please provide professional peer review of these cases by July 31.

Sincerely,

A handwritten signature in black ink, reading "John D. Daigh, Jr., M.D.".

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

Attachment C



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

APR 29 2015

The Honorable Mark Kirk
United States Senate
Washington, DC 20510

Dear Senator Kirk:

This letter is in response to your letter dated January 9, 2015, requesting that I appoint new inspectors to investigate complaints at the Edward Hines, Jr., VA Hospital (Hines), Hines, Illinois, first reported by former Hines cardiologist, Dr. Lisa Nee, regarding deficiencies in cardiovascular care and received by the Office of Inspector General (OIG) as a congressional inquiry on February 27, 2013, because Dr. Nee believes the earlier review was incomplete. Your letter further states that in a letter dated September 17, 2014, the Office of Special Counsel (OSC) directed the OIG to conduct another investigation into Dr. Nee's disclosures.

Before addressing Dr. Nee's allegations on the completeness of our review, let me clarify the dates and nature of the information from Dr. Nee that was provided to the OIG by Senator Richard Durbin and Representative Tammy Duckworth. The first information received by the OIG was an email message from Senator Richard Durbin's staff on February 13, 2013. Attached to that message was a one paragraph email dated February 9, 2013, from Dr. Nee to a union representative with Dr. Nee's general claims. In response, the OIG opened a case on February 13, 2013, and made multiple attempts to contact Dr. Nee directly and through the union representative to clarify the allegations and to identify specific cases of poor care. We closed the case after our unsuccessful efforts to have Dr. Nee provide more specific information regarding her complaint. Representative Tammy Duckworth wrote to the OIG in a letter dated February 28, 2013, describing similar issues, including those raised in Dr. Nee's one paragraph email, and we decided to pursue an inspection in the absence of specific information.

Another point in need of clarification is in regard to OSC's letter of September 17, 2014, to VA Secretary Robert A. McDonald. This letter was superseded by a letter dated October 21, 2014, from OSC requesting that the Secretary investigate three disclosures from Dr. Nee regarding unnecessary coronary surgeries, echocardiogram quality and backlog, and inflated productivity by a Hines physician. Neither the superseded September 17th letter nor the October 21st letter directed the OIG to conduct another investigation, and in fact the OIG has not reopened our prior review to investigate Dr. Nee's original allegations.

What we did agree to do following the Secretary's receipt of OSC's October 21, 2014, letter was to meet with representatives from OSC and the Veterans Health Administration (VHA), which occurred in December 2014. During that meeting, we discovered that OSC was

VA Deputy Inspector General Letter to Senator Mark Kirk

unaware that we never received information directly from Dr. Nee prior to closing our inspection, that Dr. Nee refused to be interviewed by us despite seven requests asking her to meet with us, and that the information she apparently provided us anonymously in 2013 through a union representative contained insufficient information to address some of her concerns. At OSC's request, we again attempted to interview Dr. Nee but continued to experience difficulty obtaining her agreement to be interviewed. It took one month and a call to OSC for the meeting with Dr. Nee to occur on January 9, 2015, at which time she provided us with names of patients who she believed received inadequate care and more detailed information about a Hines physician's alleged productivity inflation.

Following review of this information, we determined that additional work by the OIG was not warranted because we had already reviewed the care of many of the patients named by Dr. Nee, and moreover, the deficiencies in care were the same issues already addressed in our findings about the Hines Cardiology Service as a whole, namely that unnecessary cardiac surgery and inappropriate cardiac catheterization interventions had occurred in the Hines Cardiology Service. We provided the names of those patients whose care had not been previously reviewed during our inspection to VHA for review to determine what had occurred on an individual patient level. We also provided VHA with Dr. Nee's information regarding alleged productivity inflation because this issue was outside the scope of our healthcare inspection.

We disagree with Dr. Nee's opinion that our review was incomplete. The OIG reported the results of an exhaustive review of the Hines cardiology program in a report dated April 8, 2014, *Healthcare Inspection: Questionable Cardiac Interventions and Poor Management of Cardiovascular Care Edward Hines, Jr. VA Hospital, Hines, Illinois*. We briefed your and Senator Durbin's staff on the results of this review, the same day the report was published, April 8, 2014. Following receipt of your January 9, 2015, letter we arranged to again brief your staff on this report along with staff from the Senate Appropriations Subcommittee on Military Construction and VA. This briefing occurred on March 3, 2015.

We substantiated findings of unnecessary coronary bypass surgery for two patients, inadequate pre-operative planning for a patient who underwent coronary bypass surgery, and inappropriate coronary interventions for nine patients who had undergone cardiac catheterizations. Ten interventional cardiologists based outside of Veterans Integrated Service Network (VISN) 12 (the Hines facility is in VISN 12) evaluated coronary angiograms. Reviewing cardiologists are or were recently members of the Quality Assurance Committee of the Veterans Health Administration's Clinical Assessment Reporting and Tracking System for Cardiac Catheterization Laboratories.

Each patient's angiogram and report were independently evaluated by two cardiologists. In regard to the surgery issues, the OIG was assisted by the Chief of a VA Cardiothoracic Program outside of VISN 12 who accompanied our review team onsite. In addition, the OIG contracted with a world renowned private cardiothoracic surgeon to review the care provided and to advise the OIG on allegations of poor quality cardiac surgery.

VA Deputy Inspector General Letter to Senator Mark Kirk

We believe our review addressed the most important issues affecting cardiac care and accurately described the state of the Hines cardiology program and deficiencies in need of correction. We recommended and the facility followed up on actions aimed at preventing recurrences. In her response to our report on March 19, 2014, the Hines Director stated that the facility had already completed internal and external reviews, re-instituted cardiac catheterization conferences, and begun sending a random sample of cases out monthly for protected external review to assure adherence to accepted standards of care. We are monitoring the external reviews of cardiac catheterizations that have been ongoing since our May 2014 report and which are scheduled to continue through at least June 2015. In addition, the Hines Director requested a VA Central Office review of Hines cardiovascular care to identify additional opportunities for improvement, which was completed on April 29, 2014. We reviewed the VA Central Office cardiovascular report and found it was rigorous, comprehensive, and contained many recommendations for improvement.

In regard to echocardiograms, at the time of our report we did not have specific information about patients alleged to be adversely affected. The facility acknowledged that a backlog had occurred in 2011 due to staff shortages and technical issues. We verified that at the time of our review there was no current backlog. This was based on the review of 58 randomly selected echocardiograms performed from January 1, 2012, through April 30, 2013, that found no significant delays in the interpretation and reporting of outpatient echocardiograms. Based on our interview with Dr. Nee in January 2015, the OIG initiated a review into present delays in echocardiograms and their quality. We will provide the results of that review to you upon its completion.

In closing, we believe our review and report served as a powerful catalyst for change to the Hines cardiovascular program and improved the quality of care and patient safety. We found no basis to reopen our review following our January 2015 interview with Dr. Nee because our May 2014 report already addressed the most important issues affecting cardiovascular care at the Hines facility. We fully share your and Dr. Nee's interest in seeing that veterans treated at Hines receive high-quality cardiac care. Be assured that the OIG continues to closely monitor Hines' implementation of corrective action on a quarterly basis through the OIG Follow-Up program to ensure compliance with the recommendations outlined in our report.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,



RICHARD J. GRIFFIN
Deputy Inspector General

Attachment D



Physician Productivity CPT Detail Encounter Level Data

Data Definitions

Patient SSN	Visit Date	Fiscal Year	RVU Sum	Provider Name	CPT1	CPT2	CPT3	CPT4	CPT5
XXX-XX-XXX	20131105	2014	28.1	DIETER, ROBERT MD	36252	93461	92928	92978	
XXX-XX-XXX	20131105	2014	28.1	DIETER, ROBERT MD	93461	92928	92978	36252	

Attachment E

LOCAL TITLE: CARDIOLOGY ATTENDING - OUTPATIENT
STANDARD TITLE: CARDIOLOGY ATTENDING OUTPATIENT NOTE
DATE OF NOTE: APR 22, 2014@08:48 ENTRY DATE: APR 22, 2014@08:48:59
AUTHOR: DIETER, ROBERT MD EXP COSIGNER:
INSTITUTION: HINES, IL VAMC
DIVISION: EDWARD HINES, JR HOSPITAL
URGENCY: STATUS: COMPLETED

The patient was seen and examined with the housestaff. I agree with their findings, assessment and, plan unless otherwise indicated. The patient (and/or family) was explained and verbalized an understanding that the procedure may be performed under moderate sedation, industry representatives may be present for the procedure, and procedural risks include death, CVA, MI, renal failure+/-HD (patients with baseline renal insufficiency are at an increased risk for renal failure +/-HD), amputation, emergency surgery, emergency ad hoc procedures, the possible use of off-label devices, allergic reaction, vascular injury and, other unforeseeable risks; despite these risks and knowing the risks of not proceeding, wished to proceed.

The patient authorized discussion of his healthcare with: daughter, without limitations

INDICATION FOR PROCEDURE: impaired glucose tolerance, known CAD, dyspnea on exertion- 6 minutes peak on ETT which was positive.

/es/ Robert S Dieter MD RVT
Chief, Cardiovascular Med;Dir Vasc Med&PV Interv
Signed: 04/22/2014 08:50