



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Wound Care Management Boise VA Medical Center Boise, Idaho

To Report Suspected Wrongdoing in VA Programs and Operations:

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections evaluated the validity of allegations that VA physicians at the Boise VA Medical Center, Boise, Idaho, self-referred patients for wound care to private practices and skilled nursing facilities in violation of conflict of interest rules. The allegations were not substantiated.

The inspection revealed that there is only one community facility within 160 miles capable of providing hyperbaric oxygen therapy. The facility had previously reviewed conflict of interest concerns and involved Regional Counsel in the decision to utilize this community facility. There were no recommendations.



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

TO: Director, Northwest Healthcare Network (10N20)

SUBJECT: Healthcare Inspection – Wound Care Management, Boise VA Medical Center, Boise, Idaho

Purpose

The VA Office of Inspector General Office of Healthcare Inspections evaluated the validity of allegations that VA physicians at the Boise VA Medical Center, Boise, Idaho, self-referred patients for wound care to private practices and skilled nursing facilities in violation of conflict of interest rules. The purpose of the inspection was to determine if the allegations had merit.

Background

The Boise VA Medical Center (facility) is an acute care facility that provides inpatient and outpatient health care services. The facility is part of Veterans Integrated Service Network (VISN) 20 and serves a veteran population of about 85,000 in a primary service area that includes 26 counties in Idaho and Oregon.¹ The medical center provides acute medical, surgical, and psychiatric inpatient services and has 46 acute care and 32 extended care beds. Programs include primary and specialty care, ambulatory surgery, and women's health.

In June 2010, a complainant contacted OIG's Hotline Division regarding the fee basis² wound care services received by patients of the facility. The complainant specifically alleged that:

- A VA physician referred patients to the physician's private practice for wound care and to skilled nursing facilities where the physician provided care through his/her private practice, therefore violating conflict of interest rules.

¹ VHA Support Service Center (VSSC)

² Fee basis referrals for non-VA care allow for veterans to receive care when VA services are not available. Pre-authorization is required for both inpatient and outpatient fee basis care.

- A physician made inappropriate fee basis referrals of patients to the physician's private practice for wound care utilizing hyperbaric oxygen therapy and other specialized equipment.

Scope and Methodology

We interviewed the complainant by telephone prior to the site visit on September 1-2, 2010. While on site, we interviewed managers, clinicians, and other employees pertinent to the complaints. We reviewed relevant facility and VHA policies, as well as fee basis referred patient medical records from October 1, 2008, through July 31, 2010.

The review was performed in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: VA Wound Care Physicians Self-Referred Patients and Violated Conflict of Interest Rules

The allegation that VA wound care physicians referred patients to their private practices for wound care or to skilled nursing facilities where their private practices provide care and violated conflict of interest rules was not substantiated.

During on-site interviews, we determined that all community hyperbaric oxygen therapy (HBOT)³ physicians were salaried employees of the community facility and did not have a private practice. HBOT provided for veterans at the community facility did not involve substantial direct patient care by VA physicians.

VA physicians initiated HBOT for a limited number of veterans. In fiscal year 2009, there were 9 (0.15 percent) of 6,006 patients deemed at risk for amputation referred for HBOT.⁴

We reviewed medical records for all 25 patients referred for fee basis home health services from August 2009 through July 2010. VA wound care physicians are not affiliated with home health agencies providing care to patients referred to skilled nursing facilities.

³ Hyperbaric oxygen therapy involves breathing pure oxygen while in a sealed chamber that has been pressurized at 1.5 to 3 times the normal atmospheric pressure.

⁴ Preservation Amputation Care and Treatment (PACT) Annual Report for FY 2009, Boise VA Medical Center, Boise, Idaho.

We interviewed facility staff regarding potential conflict of interest rule violations. The facility provided records of correspondence with Regional Counsel from 2008 documenting review of potential conflict of interest involving VA physicians employed by the only community facility in the region capable of providing HBOT. Regional Counsel advised that referrals to the community facility should be made by physicians not employed at the community facility. Based on our review of medical records for the 39 patients referred for fee basis HBOT and specialized equipment from October 1, 2008, through July 31, 2010, we concluded that VA physicians adhered to defined guidelines.

Issue 2: VA Wound Care Physicians Inappropriately Referred Patients for Therapies

The allegation that VA wound care physicians inappropriately referred patients to their private practices for wound care utilizing HBOT and other specialized equipment was not substantiated.

Prior to our site visit, facility senior leadership reviewed 14 fee basis referrals for HBOT from October 2009 through May 2010 and concluded that all referrals were for evidence-based indications as defined by the Undersea and Hyperbaric Medical Society.⁵ The facility compliance officer reviewed 10 HBOT fee basis referrals and found that all cases were referred, approved, and paid appropriately.

We reviewed medical records for all 39 patients referred for fee basis HBOT and specialized equipment from October 1, 2008, through July 31, 2010. All patients referred for HBOT had appropriate indications for therapy. Fee basis referrals for specialized equipment were utilized only when equipment was not available through the facility and followed facility guidelines.

Conclusions

The complainant's allegations were not substantiated. The inspection revealed that there is only one community facility capable of providing HBOT to veterans within 160 miles. VA physicians employed by the community facility providing HBOT and wound care were salaried employees. The facility staff had previously reviewed conflict of interest concerns and involved Regional Counsel in the decision to utilize this community facility. There were no recommendations.

⁵ The Undersea and Hyperbaric Medical Society (UHMS) is an international nonprofit association that serves as a source of scientific and medical information pertaining to hyperbaric medicine involving hyperbaric oxygen therapy, www.uhms.org.

Comments

The VISN and System Directors' concurred with our findings. See Appendixes A and B, pages 5-6 for the full text of their comments.

(original signed by:)

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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: September 24, 2010

From: Director, Northwest Network (10N20)

Subject: **Healthcare Inspection – Wound Care Management, Boise VA
Medical Center, Boise, Idaho**

To: Director, Dallas Office of Healthcare Inspections (54DA)

I concur with the subject Office of Inspector General's inspection report and have no comments.

(original signed by:)

Susan Pendergrass, DrPH

**Department of
Veterans Affairs**

Memorandum

Date: September 21, 2010

From: Director, Boise VA Medical Center (531/00)

Subject: **Healthcare Inspection – Wound Care Management, Boise VA
Medical Center, Boise, Idaho**

To: Director, Northwest Network (10N20)

I concur with the subject Office of Inspector General's inspection report and have no comments.

(original signed by:)

DeWayne Hamlin

OIG Contact and Staff Acknowledgments

OIG Contact	Cathleen King, Associate Director Dallas Office of Healthcare Inspections (214) 253-3333
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Acknowledgments	Larry Ross, Team Leader Gayle Karamanos Misti Kincaid, Program Support Assistant Jerome E. Herbers, Jr., MD
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