



Department of Veterans Affairs Office of Inspector General

Audit of QTC Medical Services, Inc.'s Settlement Offer for Overcharges under Contract V101(93)P-2099

**To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244**

Contents

Executive Summary	i
Introduction.....	1
Purpose.....	1
Background	1
Scope and Methodology	2
Contract Pricing Structure.....	4
Kearney Audit.....	5
VA's Actions after Receiving Kearney's Draft Audit Report.....	6
QTC's Settlement Offer.....	8
Results and Conclusions	10
A. OIG's Questioned Costs and Recommended Recovery	10
B. Validation of Charges and Pricing	10
C. OIG's Evaluation of QTC's Settlement Offer	11
1. Findings 1 and 2.....	12
2. Finding 3	12
3. Finding 4	13
4. Finding 6.....	14
5. Undercharge Adjustments.....	14
D. CPT Code Issues not Previously Identified by VA, QTC, or Kearney	15
1. CPT Code 90801	15
2. CPT Codes 96117 and 96118	15
3. CPT Codes 92541 – 92546	17
E. Analysis of Improper Use of Current Medicare Rates and Proprietary Codes	17
1. Improper use of Current Medicare Rates for CLINs 6AA and 6AB	17
2. Improper use of Proprietary Codes	23
F. Adequacy of Internal Controls over Billings.....	24
1. Kearney's Audit	24
2. Improvements to Internal Controls over Billings	24
G. Other Matters	26
1. Provider Re-Credentialing	26
2. PTSD Examination Timeframes	27
3. Contract Appears to be Overpriced.....	28
a. Unanswered Questions About Pricing Reasonableness.....	28
b. Kearney Audit.....	29
c. Pricing for New Contract	30
4. Potential Cardinal Changes.....	31
5. Contract Clause 4.1	32
6. Listing of Medicare-based CPT Codes and Pricing.....	32

7. Communications need Improvement between Contracting and Program Offices	32
8. Statement of Work for Audit of Contract	33
Recommendations	35
Appendix A, Management Comments.....	37
Appendix B, Monetary Benefits	41
Appendix C, OIG Contact and Staff Acknowledgements	42
Appendix D, Report Distribution.....	43

Executive Summary

Introduction

The Office of Inspector General (OIG), Office of Contract Review, audited the Department of Veterans Affairs' (VA) Contract V101(93)P-2099, awarded to QTC Medical Services, Inc. (QTC) on April 18, 2003, with a contract start date of May 1, 2003. The contract is to provide medical disability examinations for veterans with claims being evaluated by VA's Veterans Benefits Administration (VBA). Currently, the contract is scheduled to expire on April 30, 2009, after a 1-year bonus period earned by QTC based on their performance. From May 1, 2003 through April 30, 2007, contract billings have totaled over \$267 million.

OIG conducted the audit after QTC's settlement offer to repay VA about \$3.2 million as a result of an audit conducted by a commercial Certified Public Accounting (CPA) firm. The CPA firm's audit identified over \$1.1 million in contract overcharges during the 1-year audit period, from June 1, 2005 to May 31, 2006. After this audit, QTC and VBA worked together to extend the \$1.1 million in monetary findings to the remaining contract period (from May 1, 2003 to May 31, 2005, and June 1, 2006 through September 15, 2006), resulting in the \$3,159,821 repayment offer by QTC. Over 80 percent of the identified monetary findings resulted from QTC's inappropriate use of "proprietary" Medicare Current Procedural Terminology (CPT) codes to bill VA for two Contract Line Item Numbers (CLINs), representing about a third of the contract billings.

Our audit covered the period of May 1, 2003 through April 30, 2007. The primary purposes of the audit were to determine: (i) the validity of QTC's settlement offer; (ii) the accuracy of contract billings; (iii) whether additional Medicare-based billing codes were misused; and (iv) the adequacy of internal controls over contract billings.

Results

For the pricing adjustments pertaining to QTC's settlement offer, our audit resulted in a net addition of over \$186 thousand (\$3,159,821 proposed versus recommended \$3,346,476). We also identified an additional \$28,362 in questioned costs based on the way QTC billed certain other CPT codes, which were outside the codes identified in the settlement offer. Lastly, we re-priced the contract to adjust the pricing of the Medicare-based CLINs to agree with 1998 Medicare rates, as stipulated in the contract. The monetary effect of this re-pricing is an additional \$2,636,911. In December 2007, we recommended that VA seek

reimbursement from QTC in the amount of \$6,011,749 for contract overcharges (\$3,346,476¹ + \$28,362 + \$2,636,911).

Our audit results showed that QTC is no longer billing VA based on the use of proprietary codes associated with Medicare-based CLINs. Additionally, we tested about 95 percent of the \$267 million in contract billings for the 4-year audit period and determined that contract billings were consistent with contract pricing for the non-Medicare based CLINs. However, billings for Medicare-based CLINs were inappropriately based on current years' Medicare rates. Although QTC bid the contract based on the use of 1998 Medicare rates, they billed the contract based on current years' Medicare rates. The contract stipulated the use of 1998 Medicare rates for the Medicare-based CLINs; however, based on advice from the General Counsel, VA is allowing the use of Medicare-based rates that are updated annually and is planning to modify the contract. We believe this modification constitutes a cardinal change to the contract. The contract clearly limits the base rate for these CLINs to 1998 Medicare rates. The documentation shows that both parties knew prior to award that the base rates were frozen at the 1998 rates and this was confirmed during our interviews. The contract language is not ambiguous on this issue and it impacted the pricing for the two affected CLINs.

Conclusions

We concluded that due to the lack of internal controls relating to the approval of invoices, VA was overcharged \$6,011,749. We also identified weaknesses in the description of services to be provided under certain CLINs, which we believe resulted in VA paying more than fair and reasonable prices for the services provided.

Recommendations

We made recommendations for improving internal controls in several areas. Controls over National Correct Coding Initiative (NCCI) edits need strengthening to prevent overbillings from occurring. To ensure billings for neuropsychological testing are based on actual hours, we recommend that the actual hours billed for such codes be shown on QTC's invoices. QTC's re-credentialing process needs continued VBA monitoring to ensure QTC consistently identifies contract physicians with disciplinary problems. Because QTC sometimes bills for Post Traumatic Stress Disorder (PTSD) examinations that have lasted less than the 1-hour minimum timeframe, we recommend tiered pricing be negotiated for PTSD examinations based on the number of stressors involved. Finally, VBA needs a control procedure to systematically test invoiced pricing as invoices are submitted to VA.

¹ The \$3,346,476 is the net amount owed stemming from QTC's settlement offer, as audited, and includes an offsetting \$277,753 that VA owes to QTC.

We have identified indicators that the contract may be overpriced. Prior to the award, VA's evaluation panel noted unresolved pricing deficiencies in the proposal, including locality adjustment provisions that were not related to locality costs of living. The CPA firm's audit recommended re-negotiation of contract pricing to combine pricing for related services such as dental examinations and associated x-rays, instead of having all services priced separately. We agree with the CPA firm's conclusion and recommend that the successor contract be priced with an all-inclusive approach, and with more realistic locality adjustments.

We recommend that the VA Contracting Officer delete contract clause 4.1 from the solicitation on the follow-on contract because the clause is inappropriate for a firm-fixed-price contract. Lastly, when a new contract is solicited, we recommend that the Office of Acquisition and Logistics and VBA establish a protocol to ensure all program and contract provisions are clearly understood and are accurate.

Under Secretary for Benefits and Assistant Secretary for Management Comments

The Under Secretary for Benefits and Assistant Secretary for Management provided a joint response in which they agreed with the findings and recommendations with the exception of the recommended dollar amount for the Bill of Collection. (See Appendix A, pages 37–40, for the full text of the joint response by the Under Secretary and Assistant Secretary.) We recommended a Bill of Collection in the amount of \$6,011,749 which included \$2,636,911 of overbillings because QTC incorrectly updated the Medicare rates to the current rates each year rather than bill at the 1998 rates as stipulated in the contract. The Under Secretary and Assistant Secretary did not concur with this recommendation citing an opinion by General Counsel which stated that the contract language is ambiguous; therefore, QTC is not liable for the \$2,636,911. On March 25, 2008, VA issued a Bill of Collection to QTC for \$3,374,838. As discussed in this report, the contract is not ambiguous. The rates for the two CLINs were clearly frozen at the 1998 Medicare rates and the evidence, including a statement by a QTC official, show that both parties were aware prior to award that the base rates were frozen at the 1998 Medicare rates. The Under Secretary for Benefits and Assistant Secretary for Management provided acceptable implementation plans for the remaining recommendations. We will follow upon the implementation of planned actions until they are complete.

(original signed by:)
MARK A. MYERS
Director, Division A
Office of Contract Review

Introduction

Purpose

The Office of Inspector General (OIG), Office of Contract Review, conducted an audit of Contract V101(93)P-2099 for the period May 1, 2003 through April 30, 2007. The purposes of our audit were to: (i) determine the validity of QTC Medical Services, Inc.'s (QTC) settlement offer under the contract through September 15, 2006; (ii) review the accuracy of billings from the inception of the contract through April 30, 2007; (iii) determine whether additional Medicare-based billing codes were misused; and (iv) evaluate QTC's internal controls related to billing/invoicing procedures and compliance with the contract's terms and conditions both before and after the audit conducted by the Certified Public Accounting (CPA) firm of Kearney & Company, Certified Public Accountants and Consultants (Kearney). We also conducted limited reviews of QTC's re-credentialing procedures, and QTC's procedures for informing Post Traumatic Stress Disorder (PTSD) examination providers of minimum examination timeframes. In addition to determining the amount owed VA, we determined what caused the overcharges to occur, why VA did not identify the overcharges in a more timely manner, and whether VA took appropriate action in response to the Kearney audit.

Background

Public Law 104-275 authorized VA to conduct a pilot program to contract for medical examinations from non-VA medical sources. Under the Public Law, VA awarded the first such contract, V101(93)P-1636, to QTC, of Diamond Bar, California, on February 23, 1998. On April 18, 2003, VA awarded a successor contract, V101(93)P-2099, to QTC. VA sought competition for the contract issuing a Request for Information (RFI) on March 1, 2002. VA received two responses to the RFI. On September 6, 2002, VA issued the Request for Proposals (RFP). Although VA had received responses from the RFI and had advertised the RFP in FedBizOps, QTC was the sole bidder.

The indefinite quantity contract is to provide medical disability examinations for veterans with claims being evaluated by VA's Veterans Benefits Administration (VBA). The disability examinations are provided to veterans at locations serviced by 10 VA Regional Offices (VAROs), and to active duty military members at several Benefits Delivery at Discharge (BDD) sites, including Forts Benning, Stewart, and Gordon, Georgia. The initial 1-year performance period under the contract (base year) was May 1, 2003 through April 30, 2004, and the contract had 4 option years thereafter, all of which have been awarded. Contract provisions

provided for a minimum 1 year, and a maximum 10-year contract depending on the contractor's performance. To date, the contract performance period has been extended for 1 year past the 4 option year periods, making April 30, 2009² the ending date for the contract. During the 4-year period of May 1, 2003 through April 30, 2007, QTC provided approximately 400 thousand examinations and evaluations of veterans and active duty service members at a cost to VA of over \$267 million.

Scope and Methodology

Our audit covered the period of May 1, 2003 through April 30, 2007. During this 4-year period, QTC billed VA \$267,228,579. Our audit covered \$266,527,501, 99.74 percent of contract costs,³ broken down by Contract Line Item Numbers (CLINs), as shown in Table 1.

Table 1—Audit Coverage

Description	Value	Coverage
Substantive Testing of Non-Medicare-based CLINs	\$177,773,889	66.53%
Substantive Testing of Medicare-based CLINs	75,447,213	28.23
Limited Testing of Line Items without identified station numbers	13,306,399	4.98
Totals	\$266,527,501	99.74%

We obtained QTC's sales data for the 4-year audit period. We performed selected analytical and testing procedures on the sales data, extensively utilizing the IDEA auditing software package in our analyses of the accuracy of contract billings. We interviewed VBA personnel associated with the contract, including the Contracting Officer's Technical Representative (COTR), VBA's Project Medical Director, and several VA Contracting Officers; officials from Kearney, the CPA firm that conducted an audit of QTC's contract; a former IBM (International Business Machines) employee who was involved in the technical evaluation of QTC's proposal; and several QTC officials and employees. We reviewed VA's contract files for the subject contract and the predecessor contract with QTC; and

² Although we have been advised that VA and QTC have an agreement to extend the contract an additional year as a performance bonus, the contract requires that a modification with negotiated prices be completed 8 months before the expiration of the 4th option year. The action was not completed within the contractual deadline.

³ We performed substantive tests on about 95 percent of the \$267 million in contract billings for the 4-year audit period. We performed limited testing of line items without identified station numbers to determine if the correct locality adjustment was applied.

VA's contract file on the Kearney audit engagement. We reviewed commercial literature and manuals to gain an understanding of QTC's use of Current Procedural Terminology (CPT) codes. We reviewed and followed up on other third party reviews conducted on QTC's use of CPT codes. We discussed technical/medical issues that arose with VBA's COTR and with VBA's Project Medical Director. We tested QTC's settlement offer amounts by comparing the results from our analysis of the sales data with QTC's calculations and reconciling the differences. Our audit included an evaluation of internal controls over contract billings. We extensively worked with QTC officials in the evaluation of QTC's settlement offer, and obtained their agreement with all findings associated with the offer.

The audit included the following substantive testing and analyses for the audit period:

- Using the contract price schedule and IDEA, independently tested for overbillings and correct contract pricing for \$253,221,102 of contract costs, representing about 95 percent of such billings.
- Verifying that correct locality adjustments were made to the \$13,306,399 in sales data line items that were missing locality codes.
- Analyzed and verified each of Kearney's findings, including no-shows, National Correct Coding Initiative (NCCI)⁴ edits, unauthorized QTC proprietary codes, and procedure codes inappropriately charged as lab codes. We ensured that all findings were expanded to cover the entire contract period through April 30, 2007.
- Verifying that correct contract pricing on a prospective basis is entered into QTC's system for CLINs representing about 95 percent of contract sales.
- Searching for and identifying abnormal billings and reconciling them to QTC's accounting records. We defined abnormal billings as: (i) individual billing amounts that appeared to be excessively high such as a billing of a CPT code at 50 percent higher than it should have been; or (ii) groupings of transactions at apparently incorrect prices, even if the pricing discrepancies were small.
- Examining those 184 CPT codes with contract costs of over \$10,000 in our evaluation of the accuracy of contract pricing—these codes represented 99.2

⁴ NCCI is Medicare terminology for National Correct Coding Initiative, which is designed to prevent certain CPT codes from being bundled for billing purposes because one of the codes is a component of a more comprehensive code.

percent of the costs associated with the two Medicare-based CLINs and included line items without locality identifiers.

- Determining the correct application of several CPT codes, including 90801, 96117, 96118, and 92541 through 92546, and identifying any overbillings.
- Verifying that QTC made correct invoice adjustments following Kearney's audit.
- Analyzing amounts where QTC's settlement offer indicated that VA owed to QTC underbillings that QTC made on invoice adjustments.
- Searching for any other invalid proprietary codes or invalid suffixes added to Medicare billing codes by extracting and analyzing all CPT codes with more than five digits.
- Obtaining and reviewing Kearney's audit working papers.
- Re-pricing the contract to be consistent with the 1998 Medicare rates stipulated in the contract.

Our audit included the following internal control compliance testing:

- Sampled 31 randomly selected veteran case files to ensure billings to VA were consistent with the veteran's condition and tests ordered by VA (this was also a compliance test conducted by Kearney).
- Tested compliance with QTC's Invoice Auditing Procedure by reviewing QTC's daily review for five randomly selected dates.
- Conducted limited compliance testing of QTC's Re-Credentialing policy by examining documents/reports generated by QTC's reviews.

Contract Pricing Structure

The contract is priced by the use of 25 CLINs. An additional 20 CLINs pertain to locality adjustments which are applied to the unit prices of 22 of the 25 CLINs referenced above. Attachment No. 1 of Section B of the contract is the pricing section (3rd Revision, December 3, 2002), which consists of the following:

- Twenty-four CLINS are for services related directly to the medical disability examinations. Twenty-one of the 24 fixed-priced CLINs for various medical

examinations contained prices for the base year which increased for each of the 4 option years of the contract. Another fixed-priced CLIN (0006AC), photographs for scar and skin conditions, remained at the same price for the base and option years. The remaining two CLINs for medical services were for procedures 0006AA (6AA), which was priced at a percentage above the contract's Medicare pricing formula, and for laboratory work 0006AB (6AB) which was also priced at a percentage above the 1998 Medicare rates. Baseline Medicare rates for both CLINs were frozen at the 1998 Medicare rate. The percentage mark-ups to the baseline Medicare rates remained the same for the base and option years.

- One fixed-priced CLIN (0007) is a service charge for no-shows, which includes cancellations less than 1 full workday prior to the scheduled examination.
- Ten CLINs provide locality adjustments to the 21 fixed-priced medical examination CLINs and range from 0 to 17 percent depending on where the services were provided. The locality adjustments remained the same for the base and each of the 4 contract option years.
- Ten CLINs provide locality adjustments for CLIN 6AA that range from 0 to 40 percent depending on the location of the services. The locality adjustment percentages remained the same for the base and each of the 4 contract option years.

The most substantial percentage of overcharges identified in the Kearney audit and our audit relate to the two CLINs that required the use of CPT codes, CLINs 6AA and 6AB. In addition to the issues identified by Kearney, we determined that QTC overcharged VA approximately \$2.6 million by using current year Medicare rates as the baseline for pricing instead of the 1998 Medicare rates as required under the contract.

Kearney Audit

On October 5, 2006, Kearney issued a draft audit report entitled "Financial Audit of QTC Medical Services, Inc."⁵ VBA had requested the audit due to frequent questions concerning QTC's billings and the identification of sporadic overbillings during VBA's invoice reviews. Kearney's audit covered the 1-year period from June 1, 2005 through May 31, 2006. Kearney identified nine findings totaling \$1,145,804 in overbillings during the 1-year audit timeframe, as summarized in Table 2.

⁵ At VA's request, Kearney did not issue a final audit report.

Table 2—Summary of Kearney’s Monetary Findings

Finding No.	Description of Finding	Amount
1	Duplicate billing for complete radiological examinations of the same foot using proprietary CPT codes.	\$326,000
2	Use of proprietary codes for lab handling fees and Venipuncture.	586,000
3	Comprehensive or Component Edits.	106,000
4	Various errors in billings for no-shows.	4,374
5	Billing for Miscellaneous Medical Services/Supplies using a proprietary CPT code.	10,700
6	Billing for CPT code 88141 as a laboratory code versus a procedure.	22,500
7	Overbilling for CPT code 99173, Screening for Visual Acuity.	31,000
8	Overbilling for CPT code 80074, Hepatitis Panel	59,000
9	Miscellaneous Pricing Issues	230
Total		<u>\$1,145,804</u>

As shown in Table 2, Findings 1, 2, and 5, totaling \$922,700, involved the use of proprietary CPT codes. Proprietary CPT codes are not recognized as valid codes by the American Medical Association, and therefore are not a valid basis for billing VA. The \$922,700 in questioned costs for using proprietary codes represented 80.5 percent of the \$1,145,804 in total overcharges identified by Kearney.

The substantive testing portion of Kearney’s audit was comprised of a statistical sample of 233 of the 72,309 invoices submitted to VA during the 1-year audit period. Kearney identified five of the nine findings to be “an endemic situation”, meaning that the sample error applied to each billing for the affected CPT code during the 1-year audit period. As such, Kearney’s monetary finding total of \$1,145,804 included all billings during the 1-year audit period for those findings representing endemic situations.

VA’s Actions after Receiving Kearney’s Draft Audit Report

The program office (VBA) and the Office of General Counsel (OGC) reviewed the draft audit report. In a November 16, 2006, Memorandum to the Under Secretary for Benefits, OGC recommended that the Contracting Officer present the findings from the Kearney report, but not the report itself, to QTC for a response. The

OGC Memorandum primarily addressed issues relating to the alleged misuse of the proprietary codes.

On November 17, 2006, the Contracting Officer sent a letter to QTC stating that it had come to her attention that QTC was billing VA for improper codes and making other billing errors. The Contracting Officer noted that the errors were routine, which suggest a lack of internal controls. The Contracting Officer attached a list of concerns that included the improper use of CPT or proprietary codes for invoicing. QTC was asked to respond within 14 calendar days. QTC sent an initial response on November 20, 2006, advising VA that QTC was finalizing its Quality Assurance Surveillance Plan and would submit it by December 1, 2006. The letter also included a new policy implemented by QTC on November 20, 2006, to improve the accuracy of invoices. QTC also requested a meeting with the Contracting Officer to review the findings. On December 6, 2006, a meeting was held in Washington, D.C. to discuss the issues. Attendees included QTC officials, VA contracting officials, VBA officials, and OGC. Based on subsequent e-mail correspondence, the meeting included a discussion of each party's understanding of the contractual language. The documentation provided by VA did not include minutes of the meeting.

On December 11, 2006, QTC submitted a response to the Contracting Officer's November 17, 2006, letter. In the letter, QTC raised the issue of using current Medicare rates as the baseline for pricing under CLINs 6AA, procedures, and 6AB, laboratory work, an issue not previously addressed by VA or Kearney. QTC also discussed issues raised in the Kearney audit: (1) the use of non-standard CPT codes; (2) charges for CPT codes with Medicare National Limit of zero dollars; and (3) billing for laboratory work versus procedures for specific services. QTC's response included recommendations on how to resolve each of these issues. Pending VA's review and approval of the recommendations, QTC proposed to perform adjustments.

VBA reviewed QTC's response and, on January 3, 2007, provided written comments to OGC. On January 12, 2007, OGC issued a Memorandum to the Under Secretary for Benefits addressing the issues.

After receiving OGC's recommendations, on January 26, 2007, VA responded to QTC's December 11, 2006 letter. VA agreed with all of QTC's recommendations to resolve the issues of overcharging and took the following actions:

- Allowed QTC to continue to use current Medicare rates as the baseline price for CLINs 6AA and 6AB. VA did not require that QTC reimburse VA and advised QTC that a contract modification was being drafted to allow the use of current Medicare rates.

- Agreed with QTC's recommendation to use the standard CPT code, 73630, for a complete x-ray of the foot, but without the internal QTC modifiers. Asked QTC to make price adjustments for the time period May 1, 2003 through October 15, 2006, for the overpayments caused by using the proprietary codes.
- Agreed with QTC's recommendation to use 99000 as the appropriate CPT code for messenger or similar service instead of proprietary code 8000. Asked QTC to calculate overcharges for the May 1, 2003 through October 15, 2006 time period.
- Agreed with QTC's recommendation to eliminate proprietary codes 8001/8002 for venipuncture and instead use CPT code 36415. Also agreed with QTC's recommendation to adjust prior billings using the Medicare midpoint rate of \$3.00 multiplied by the contract's laboratory adjustment rate. VA requested adjustment for the time period May 1, 2003 through October 15, 2006.
- Agreed with QTC's recommendation to use CPT code 80061 for lipid panels at an agreed upon rate, CPT code 80074 for hepatitis panels at an agreed upon rate, and CPT code 99173 for visual acuity screening at an agreed upon rate per procedure. Advised QTC that no adjustments were necessary for these laboratory tests.
- Agreed with QTC's recommendation to discontinue charging CPT code 99199 as a laboratory procedure for delivering PAP smear kits. Asked QTC to reimburse overcharges from May 1, 2003 through October 15, 2006.
- Agreed with QTC's recommendation to reclassify CPT code 88141 and refund the difference.

QTC's Settlement Offer

VA requested that QTC determine the monetary impact for the entire contract period of Kearney's endemic situation findings, and QTC complied. On February 8, 2007, QTC offered to repay VA \$3,103,821.54. This amount was comprised of the following, as shown in Table 3:

Table 3—QTC's Initial Settlement Offer

Description	Amount
Amount due to VA for the contract period from May 1, 2003 through September 15, 2006, as calculated by QTC	\$3,500,271.17
QTC identified undercharges to VA from September 16, 2006 through January 15, 2007	-396,449.63
Total	<u>\$3,103,821.54</u>

QTC initially agreed to repay VA the \$3,103,821.54. The COTR, OGC, and Contracting Officer reviewed and agreed with most of the results of QTC's offer. On February 21, 2007, VBA decided that the settlement should increase by \$56,000. This adjustment was due to QTC initially agreeing to repay only \$50,000 of the \$106,000 monetary amount for Kearney's Finding 3, Comprehensive or Component Edits. On March 7, 2007, QTC agreed to repay the entire \$106,000 for the Comprehensive or Component Edits. On March 13, 2007, QTC confirmed the total amount due to VA at \$3,159,821.55, a penny higher than the amount stated in Table 3, and including the \$56,000.

Between March 13 and May 3, 2007, VA contracting officials, program officials, and OGC began negotiating a modification to accept payment of the agreed upon overcharges and to modify the terms and conditions of the contract as proposed by OGC in the January 12, 2007 memorandum. These efforts were discontinued on May 3, 2007, after the OIG notified VA that we opened an investigation/audit after receiving a hotline complaint.

Results and Conclusions

A. OIG's Questioned Costs and Recommended Recovery

Our audit identified errors in both the calculations of Kearney and QTC, and we identified additional questioned costs, primarily related to re-pricing the contract to adjust the pricing of the Medicare-based CLINs (6AA and 6AB) to agree with 1998 Medicare rates, as stipulated in the contract. A summary of our questioned costs is delineated in Table 4. We recommend that QTC pay \$6,011,749.12 in questioned costs.

**Table 4—Summary of Questioned Costs
May 1, 2003 – April 30, 2007**

Description	Amount
Gross Amount of QTC's Settlement Offer as adjusted by OIG (from Table 5, page 12)	\$3,624,228.92
Questioned Costs associated with other CPT codes (from Table 7, page 15)	28,361.77
Re-pricing of Contract to 1998 Medicare levels as stipulated in the contract.	2,636,911.54
Total Questioned Costs	6,289,502.23
Less: Amount VA owes QTC	-277,753.11
Total Amount Owed to VA	<u>\$6,011,749.12</u>

B. Validation of Charges and Pricing

Using IDEA auditing software, we tested QTC's invoices to determine whether the prices charged were consistent with the contract price for the 23 non-Medicare-based CLINs for the 4-year audit period. The audit's pricing calculations included the 10 CLINs that allowed locality adjustments. Charges for these CLINs represent more than two thirds of the contract payments. Using the contract's pricing schedule, we calculated the price as appropriate for each locality in which services were provided. We concluded that the pricing shown on all invoices was consistent with the fee schedules in use for the 4-year audit period.

We also tested the prices charged for the two CLINs based on Medicare rates to determine whether the prices were calculated correctly even though they were based on current Medicare rates instead of 1998 Medicare rates. This included determining the contract price for 184 CPT codes year by year for each of the 2,005,147 records. The two CLINs represent less than one third of the amount paid

under the contract. We used the contract fee schedule for the non-Medicare-based CLINs and the current Medicare-based CPT pricing, updated annually, for the Medicare-based CLINs.⁶ As appropriate, we adjusted the fee schedule and CPT pricing by contractual adjustment factors (for the Medicare-based CLINs) and by locality adjustments. We then compared what the pricing should have been to actual pricing. We concluded that the contract pricing for the 184 CPT codes tested reflected the use of current published Medicare-based rates for non-Government facilities as the baseline price. We used non-Government facilities because the vast majority of QTC's examinations are provided in non-Government facilities. Our testing of all CLINs (non-Medicare and Medicare-based) covered approximately 95 percent of about \$267 million in contract costs.

The testing also included determining if current pricing was consistent with the agreement between VA and QTC regarding the use of proprietary codes. As previously stated, over 80 percent of Kearney's monetary findings involved QTC's use of proprietary CPT codes when billing VA for Medicare-based CLINs. Because VBA did not accept Kearney's Findings 7 and 8, about 92 percent of the accepted monetary findings represented QTC's use of proprietary codes. Audit results show that QTC is using the agreed upon CPT codes and the issues identified by the Kearney audit no longer occur. We concluded that QTC no longer uses proprietary CPT codes to bill VA. In addition, we did not identify any proprietary CPT codes in QTC's system that the Kearney audit did not identify.

After Kearney's audit, QTC hired the services of Moss Adams LLP, Certified Public Accountants/Business Consultants (Moss Adams) to review QTC's use of CPT codes. Although Moss Adams did not find significant exceptions, we followed up on the report's contents and identified some additional minor monetary issues, which are discussed in Section D.

C. OIG's Evaluation of QTC's Settlement Offer

Our audit of the issues identified by Kearney and addressed in QTC's settlement offer resulted in a net increase of \$186,654.27 for a recommended settlement amount of \$3,346,475.81.⁷ Table 5 summarizes OIG adjustments to the settlement offer.

⁶ Although the contract stipulated the use of 1998 Medicare rates for the Medicare-based CLINs, QTC has charged using current Medicare-based rates that are updated annually. This issue is further discussed in Section E.

⁷ This figure does not include overcharges for miscellaneous CPT code charges and for the misuse of current Medicare rates, which are discussed in Sections D and E.

We worked extensively with QTC management on the issues surrounding our proposed adjustments. During our on-site visit during the week of July 23, 2007, QTC agreed with most of them. After our on-site visit, we provided QTC with the revised monetary amounts as shown in Table 5, and to date, QTC has not objected to any of the revised amounts.

Table 5—Summary of OIG Adjustments to Settlement Offer

Kearney Finding No.	Original Amount Agreed to	OIG Adjustments	Recommended Settlement
1	\$764,839.16	\$14,999.99	\$779,839.15
2	2,539,283.35	-239.25	2,539,044.10
3	106,000.00	37,723.31	143,723.31
4	1,404.00	9,038.00	10,442.00
5	68,869.29	0	68,869.29
6	75,875.37	6,435.70	82,311.07
Subtotal	3,556,271.17	67,957.75	3,624,228.92
Less Undercharge Adjustment	-396,449.63	118,696.52	-277,753.11
Total	<u>\$3,159,821.54</u>	<u>\$186,654.27</u>	<u>\$3,346,475.81</u>

In the paragraphs below, we discuss OIG's adjustments to the settlement offer shown in Table 5.

1. Findings 1 and 2. QTC's settlement offer for these findings covered the period of May 1, 2003 through September 15, 2006. After September 15, 2006, QTC discontinued the use of the proprietary codes associated with these findings. To verify QTC's settlement offer for these findings, we reviewed the same sales data that QTC reviewed in determining the total monetary effect. During our on-site visit, QTC reviewed and agreed with our prospective adjustment to Finding 1 of \$14,999.99. The adjustment for Finding 2 is in favor of QTC, but involves an immaterial amount.

2. Finding 3. Comprehensive or Component edits, also known as NCCI edits (National Correct Coding Initiatives), are designed to prevent certain CPT codes from being billed together because one of the codes is a component of a more comprehensive code. As such, billing certain codes together would amount to a duplicate billing. Kearney's monetary finding of \$106,000 covered the 1-year period of their audit (June 1, 2005 through May 31, 2006) only. We extended the analysis to the audited contract period, going back to May 1, 2003 and forward

through April 30, 2007. We summarize the composition of the \$143,723 in adjustments in Table 6.

**Table 6—Composition of Finding 3
Recommended Adjustment**

Description	Amount
Kearney's monetary finding amount	\$106,000.00
Less amount removed for invalid portion of Kearney's finding	-57,979.00
Valid portion of Kearney's finding	48,021.00
Additional NCCI Amounts Identified by OIG	94,552.03
Additional Amounts for "Add-on" Code	1,150.28
Total	\$143,723.31

Kearney's finding included a monetary amount of \$57,979 for NCCI edit errors in the billing of CPT code 93325 (Doppler echocardiography color flow velocity mapping). Kearney's finding maintained that code 93325 could not be billed in conjunction with code 93922⁸ because the procedure covered by 93325 is also covered by 93922. We found Kearney's finding to be erroneous because the NCCI edit had expired, effective January 1, 1997. We discussed the issue with Kearney officials and determined that code 93325 is not an NCCI issue. Instead, the code is an "add-on" code that must be billed in conjunction with at least 1 of 15 other CPT codes. Accordingly, we adjusted the analysis to determine whether CPT code 93325 was billed in conjunction with the appropriate codes. We found six instances where the code was billed alone, and the monetary effect is \$1,150.28. The \$94,552 monetary amount shown in Table 6 represents additional NCCI error amounts that we identified for the remaining contract period not covered by Kearney's audit.

3. Finding 4. The contract allows QTC to bill VA for "no-shows", veterans who either do not show up for their scheduled examinations or fail to cancel them within 24 hours of the scheduled times. There are two components to the no-show findings—duplicates and overbillings. "Duplicates" represent QTC billings for valid no-shows twice, and "overbillings" represent erroneous no-show billings because the veteran actually showed up for his appointment. QTC's settlement offer of \$1,404 involved nine no-show errors through the period September 15, 2006. We identified 63 additional no-show errors. All of these errors occurred prior to September 15, 2006, and had not been identified by QTC's review.

⁸ The CPT code description is "Noninvasive physiologic studies of upper or lower extremity arteries, single level, bilateral."

4. Finding 6. QTC was inappropriately billing CPT code 88141 as a laboratory code (6AB) instead of a procedure code (6AA), as recognized by Medicare. This resulted in overbillings to VA, because in each contract year Medicare approved billing rates for the code as a procedure were lower than such codes billed as laboratory codes, as follows: (i) 2003 - \$26.91 procedure code price versus \$43.50 laboratory code price; (ii) 2004 - \$26.84 procedure code price versus \$54.14 laboratory code price; and (iii) 2005 and 2006 - \$26.30 procedure code price versus \$54.96 laboratory code price.

An additional factor in the recalculated pricing was that under the contract, QTC was allowed locality adjustments for procedure codes, but not for laboratory codes. In an effort to simplify their calculation by avoiding a detailed review of each record, QTC used an average price to approximate the locality adjustment to the pricing for each of the 3,932 records involved. With the use of IDEA auditing software, we calculated the correct price for each CPT code 88141 record that included locality information. This allowed us to find the exact amount the QTC should have charged under the contract terms, and calculate the difference from what was charged. We used QTC's methodology for those records that did not have locality information. Overall, our method arrived at a more accurate adjustment than QTC's method, and QTC agreed with our methodology.

5. Undercharge Adjustments. QTC's settlement offer included undercharges of \$396,449.63 that were applied as an offset to the \$3.6 million they overbilled VA. During the period of September 16, 2006 through January 15, 2007, QTC adjusted their VA billings to coincide with the pricing levels stated in Kearney's audit report. These undercharges resulted from QTC's billing adjustments to Kearney's findings that were not accepted by VBA. As previously stated, VBA determined that QTC's explanations for Findings 7 (overbilling for CPT code 99173—Screening for Visual Acuity) and 8 (overbilling for CPT code 80074—Hepatitis Panel) were valid and concluded no pricing adjustments were necessary for those findings. QTC's adjustments were intended to recoup the 4 months of undercharges for those codes, and other related issues.

QTC's initial undercharge calculation of \$396,449.63 was erroneous. During our site visit, QTC's Senior Vice President (SVP) informed us that she discovered her initial calculation to be erroneous and had recalculated the adjustments. We reviewed the revised calculated adjustment of \$277,753.11, determined that it was accurate, and included it in our revised settlement offer.

D. CPT Code Issues not Previously Identified by VA, QTC, or Kearney

Our audit included a review of nine additional CPT codes: 90801, 96117, 96118, and 92541 through 92546. The review resulted in a monetary impact for the nine codes, as shown in Table 7.

Table 7—Monetary Impact of CPT Code Overbillings

CPT Code	Description of Errors	Monetary Effect
90801	Unneeded psychiatry exam in conjunction with CPT Code 90801	\$633.84
96117 and 96118	Billing for average hours instead of actual hours for Neuropsychological testing on CPT codes 96117 and 96118	16,488.97
92541 – 92546	Billing for more times per procedure than allowed	11,238.96
Total		\$28,361.77

We discuss these findings in the paragraphs below.

1. CPT Code 90801. The code's description is for "Psychiatric Diagnostic Interview". From May 1, 2003 through April 30, 2007, QTC billed VA \$14,382.86 under this code. Because QTC uses the code in conjunction with the two Psychiatric examinations on the fee schedule (CLINs 0003AD and 0003AE), it appeared to be redundant, in that the psychiatrist performing the examination could order the specific neuropsychological testing to perform.

Because the code's description allowed the code's use for ordering diagnostic studies, we did not question its use solely in conjunction with psychiatric examinations. In consultation with VBA's Medical Director on the contract, we reviewed the use of CPT code 90801 for a judgmentally selected 15 cases. We are questioning the costs associated with one case (Quadis 1543596). In this case, a Psychiatrist conducted the Psychiatric Exam (CLIN 0003AD), the Psychiatric Interview (CPT Code 90801) and the Neuropsychological testing (CPT Code 96118). QTC reviewed the case at our request, and stated there should have been no need for the 0003AD billing. As such, we are questioning the \$633.84 cost to VA.

2. CPT Codes 96117 and 96118. These codes are for Neuropsychological testing, and are charged on an hourly basis. In 2006, CPT Code 96118 was one of three codes that replaced CPT Code 96117. We found that QTC routinely billed

VA 9 hours under these codes, even if the provider spent less time with the patient. QTC's rationale is that 9 hours is the average time required to complete the testing. For both CPT codes, we asked QTC to determine the actual time spent on the testing for each encounter. We question those charges where QTC billed for more hours than the providers spent conducting the testing. Table 8 shows the total hours billed for each code, the total questioned hours, and questioned costs.

Table 8—Questioned Costs for Neuropsychological Testing

	Contract Costs	Total Hours Billed	Questioned Hours	Questioned Costs
96117	\$44,677	386	78	\$9,435.33
96118	45,877	243	37.5	7,053.64
Total	\$90,554	629	115.5	<u>\$16,488.97</u>

QTC was able to provide actual provider hours related to the use of CPT code 96118, but was not always able to do so with CPT code 96117 because of the age of the records (2006 and earlier). In calculating the monetary effect of CPT code 96117, we subtracted one of the following from 9 hours: (i) actual hours, if less than 9 hours; (ii) 7 hours if no actual hours were provided based on 7 hours being the most frequently occurring hours for CPT code 96118; or (iii), if a range of hours was used—e.g. 8 to 10 hours—we used the lowest range of hours. QTC has concurred with this finding and our methodology.

On October 8, 2007 and as a result of our audit, QTC began requiring their providers to bill Medicare-based CPT code 96118 based on actual hours spent with the patient. We recommend that VA require the number of hours be reported on the invoice.

However, VBA's Project Medical Director on the contract identified other issues related to the use of CPT code 96118. From her review of the cases, she identified several cases where it was not apparent that the results of the neuropsychiatric testing were used or interpreted by the psychiatrist who ordered the testing. In one case, the Medical Director concluded that the VARO rated the case without an interpretation of the neuropsychiatric testing, that VA wasted money, and the veteran went through a lot of testing that didn't make any difference on the decision about his disability. She also had concerns that the case documentation indicated the VARO ordered the neuropsychiatric testing, which is inappropriate.

3. CPT Codes 92541 – 92546. These CPT codes are for procedures that evaluate the patient's balance and equilibrium. These codes should only be billed once per procedure, except for 92543 which can be billed a maximum of four times per procedure. During our billing review, we found that QTC often billed these codes more than once per procedure. We questioned those charges where QTC billed one of these codes multiple times, or, in the case of 92543, when QTC billed the code more than four times for one procedure. QTC agreed with our assessment, and calculated \$11,238.96 to be the amount owed VA. We verified QTC's calculation and agree with the dollar amounts.

E. Analysis of Improper Use of Current Medicare Rates and Proprietary Codes

Of the approximately \$6.0 million we identified and verified as overcharges under the current contract, \$2.6 million is related to the improper use of current Medicare rates as the baseline price for CLINs 6AA and 6AB, and approximately \$3.4 million is related to the use of non-standard and proprietary CPT codes. These charges also were related to CLINs 6AA and 6AB. We reviewed these issues in greater scrutiny to determine whether QTC's conduct rose to the level of fraud. After reviewing all the facts, the Assistant United States Attorney decided not to pursue a civil fraud case.

Charges under CLINs 6AA and 6AB represent approximately 31 percent (\$82.2 million) of the \$267 million that VA paid under the contract during the 4-year audit period. The \$6 million in total overcharges (\$2.6 million + \$3.4 million) represents about 2.2 percent of the total amount paid by VA.

1. Improper use of Current Medicare Rates for CLINs 6AA and 6AB

As discussed in the Introduction under Contract Pricing Structure, CLINs 6AA and 6AB were awarded at a firm-fixed price for the entire term of the contract. The prices were comprised of a baseline Medicare rate with a percentage mark-up. The baseline Medicare rates were frozen for the term of the contract at the 1998 Medicare reimbursement rates. For CLIN 6AA, VA accepted QTC's offer which was a percentage mark-up of the 1998 Medicare rate as adjusted by the formula contained in the contract. CLIN 6AB was priced at a similar but higher percentage mark-up of the 1998 Medicare rate. Unlike the prior contract between VA and QTC, there was no provision in the 2003 contract to increase or decrease the base Medicare rates commensurate with annual changes approved by the Centers for Medicare and Medicaid Services (CMS). Nonetheless, QTC billed VA for these codes based on current Medicare reimbursement rates and all invoices were approved by the COTR. We calculated that QTC overcharged VA \$2,636,911.54 by using current Medicare rates as the baseline for calculating the

price charged to VA. Although 100 percent of all charges submitted by QTC for these CLINs violated the terms of the contract, not all the improper charges resulted in a gain to QTC. This is due in part to small increases in Medicare rates between 1998 and 2006 for some CPT codes and decreases in rates in others. Because QTC changed the baseline Medicare rate to the current year annually for all CPT codes, regardless of whether the rate was higher or lower than the 1998 rates, our audit identified both overcharges and undercharges.⁹ The \$2,636,911.54 represents the net owed VA, which is the amount paid by VA off-set by the amount VA should have paid if invoiced at the 1998 Medicare rates. The amount due represents approximately 1 percent of the total contract value.

QTC's proposal did not contain specific CPT codes or calculated prices and QTC was not asked to provide any calculations prior to award. Rather, the proposal stated that the 1998 Medicare rate baseline calculation would be increased by a percentage for the base year and each option year. In comparison, QTC's proposal for the other 22 CLINs relating directly to services all included a specific price for the service.

The technical and price evaluations did not include a comparison between current and proposed prices for any of the CPT codes included in CLINs 6AA or 6AB. There is a chart in the November 22, 2002, Consensus Report showing that VA compared CPT rates for 10 CLIN 6AA CPT codes with the prices QTC was charging VA under the current contract. At most, this showed a comparison between the prices VA was charged in April 2002 under the 1998 contract and the price listed for each CPT code.¹⁰ The comparison bore no relationship to the reasonableness of the pricing structure in QTC's proposal and did not provide any insight as to whether QTC would be using 1998 or current Medicare rates as the baseline rate.

The prior contract between VA and QTC contained a provision that allowed QTC to increase the base price annually for both CLINs commensurate with increases or decreases in Medicare rates. The RFI, issued by VA on March 1, 2002, for the current contract, contained the same provision permitting the use of updated Medicare rates for the two CLINs. However, this provision was not included in the September 6, 2002 RFP. The fact that the provision was not in the RFP was not raised by QTC or any other potential offeror before proposals were submitted. Furthermore, QTC did not raise the issue during the technical or price evaluations,

⁹ Overcharges occurred when the current Medicare rate was more than the 1998 rate. Undercharges occurred when the current Medicare rate was less than the 1998 rate.

¹⁰ It is not clear whether the CPT price listed was the 2002 general rate for each code; whether the rate was calculated using the formula in the Pricing Schedule or Medicare's formula; or, whether the price included a locality adjustment.

contract negotiations, or after award. There is evidence in the contract files of any discussion between VA and QTC regarding the use of 1998 versus current Medicare rates. In fact, during the technical and price evaluations, QTC specifically stated that the percentage “adjustment for laboratory work will be applied against the Medicare 1998 Clinical Diagnostic Laboratory Fee Schedule – National Limit.” QTC did not state in their proposal or in any discussions with VA that the percentage adjustment would be against the current Medicare rates or even the 2002 Medicare rates (which were in effect at the time the contract was negotiated).

During our visit to QTC's headquarters in July 2007, QTC's SVP told us that QTC, as the incumbent contractor, was aware that Section G¹¹ was not included in the RFP and that QTC made a business decision not to raise the issue to VA. Therefore, it is clear that QTC knew that contract pricing for the two CLINs was to be based on the 1998 rates throughout the term of the contract. Nonetheless, QTC never complied with the terms of the new contract and continued to bill using current year Medicare rates as the basis for calculating the base prices for each CPT code.

Other evidence that supports a finding that QTC was aware at the time of award that the baseline prices were fixed at the 1998 Medicare rates for the term of the contract includes:

- QTC's proposed prices for the two CLINs increased significantly from the prior contract pricing structure. The percentage increase over the Medicare base price increased 37 percent for CLIN 6AA. The price for CLIN 6AB increased 32 percent from the prior contract. QTC benefited from the large increase in the percentage mark-up even if they were required to base prices on 1998 Medicare rates throughout the term of the contract. The revenue realized by QTC exceeded what would have been paid if the terms, conditions, and pricing structure of the prior contract had remained the same, allowing the use of current Medicare rates with the negotiated percentage mark-up from the prior contract. We compared Medicare rates from 1998 to 2003 for the top 22 CPT codes and found that the rate changes ranged from a minus 13 to a plus 104 percent. The rate increases from 2003 to 2007 ranged from a minus 69 to a plus 37 percent. Therefore, by increasing the firm-fixed-price by 37 and 32 percent for the two CLINs, QTC was guaranteed an amount that was more than QTC would have realized under the prior

¹¹ Section G refers to “Contract Administration Data” which was included in the prior contract and in the RFI for the current contract. Under Section G was sub-section G.1 “Invoice Requirements” which referenced pricing based on current Medicare rates.

contractual arrangement. For 160¹² of the 184 CPT codes included in our audit, if the pricing terms and conditions of the 1998 contract remained under the 2003 contract, QTC would have been paid \$53,617,388.66 for services provided under CLINs 6AA and 6AB. In comparison, even if the baseline Medicare rates were frozen at the 1998 rates, by increasing the percentage mark-up by 37 percent and 32 percent, QTC earnings were \$70,809,487.75, which is an increase in revenue of \$17,192,099.09.

- The issue of charging more than the contract price for the two CLINs was not identified during the Kearney audit or by VA prior to December 11, 2006, when QTC's SVP raised the issue. On November 17, 2006, the Contracting Officer sent a letter advising QTC's SVP that it had come to VA's attention that QTC was billing VA for improper codes and making other invoicing errors. Although the letter states that the contractual fee schedule is based on the 1998 Medicare Fee Schedule, the letter does not cite the improper use of current Medicare rates as an issue. In her December 11, 2006 response, QTC's SVP raised the issue by stating:

With regards to the statement that QTC should follow the contractual fee schedule and base its pricing on the 1998 Medicare Fee Schedule...

We did not identify any correspondence from VA to QTC that includes this statement or makes reference to this as an issue. Although QTC's SVP cites the provision in Section G of the prior contract allowing the baseline price to increase according to the Medicare schedule published at that time, she admits in the letter that the new contract does not have a Section G. However, she cites past practices and VA's acceptance of the invoices as the basis for QTC's non-compliance with the terms of the contract.

- QTC's SVP notes in her December 11, 2006, letter that the "current contract, V101 (93) P-2099, section B, Attachment No. 1, page 4 of 7, CLIN 6AA and 6AB refers to this same Section, G.1(2)(d)." She further states that while the "new contract does not have a Section G, nor does it contain the language [cited in Section G of the prior contract], [QTC] assumed it was an apparent oversight." These statements show that QTC was fully aware of the fact that the terms and conditions for these CLINs were different than the prior contract, and that QTC did not have a contractual right to increase the prices annually commensurate with Medicare rate updates. Because QTC did not raise the issue to VA before or during contract negotiations and QTC's

¹² We removed 24 CPT codes from this analysis because issues related to these codes were covered in the settlement agreement and other miscellaneous areas. The 160 codes represent 93.5 percent of the charges for CLINs 6AA and 6AB.

admission that it was a business decision not to do so, we give no credence to QTC's statement that they "assumed it was an oversight." Also, the only reference to Section G in the current contract is in the note delineating how the base Medicare rate will be calculated for CLIN 6AA and is referenced only for the purpose of identifying a website to obtain the 1998 Medicare rates. CLIN 6AB does not reference Section G.

The reasons QTC offered for continuing to use current Medicare rates are not accurate. In the December 11, 2006 letter to VA's Contracting Officer, QTC's SVP states:

VA was aware of and seemingly accepted QTC's interpretation because (1) QTC made no provision for annual increases in rates in its Section B pricing for CLIN 0006AA and 0006AB and (2) QTC has consistently billed at the current Medicare rates throughout both of our contracts as is consistent with Section G, and VA has paid those amounts.

There is no evidence in the file to support QTC's assertion that "VA was aware of and seemingly accepted QTC's interpretation." QTC never presented its interpretation to VA; rather, the company remained silent and used current Medicare rates as the base rate for billing. As discussed above, the same individual told us that QTC knew the provision was not included in the RFP and made a business decision not to raise the issue to VA.

Also, there is no evidence that VA officials who approved the invoices were aware of QTC's interpretation or whether the invoices for the CLINs were priced correctly or not. QTC provided VA with a list of CPT codes to be used and VA entered the information into a database. However, QTC did not provide, and VA did not create a price list to be used to compare the price charged with the contract price. Because of the volume of invoices submitted each month, approximately 8,000, VA did not verify the prices charged before certifying invoices for payment. Although they did sample invoices for quality control, for example—did VA get the services being paid for—we did not find that VA's review process included verification of the accuracy of the prices being charged under these CLINs. Also, because the percentage mark-up added to the Medicare rates increased dramatically under the new contract, a comparison of prices charged under the old contract and the new contract would not have been of any value to VA. Lastly, QTC's contention that VA was aware of QTC's intent to use current Medicare rates because QTC made no provision for yearly increases in the percentage mark-ups for the two CLINs is not credible for two reasons. The significant increase in the percentage mark-up for each CLIN was so high that further increases during the term of the contract would likely have been considered unreasonable. Second, in the prior contract, the percentage mark-ups (91 and 110

percent) did not change during the term of the contract. The statement that QTC has consistently “billed at the current Medicare rates throughout both contracts as is consistent with Section G” may be accurate; but, it is irrelevant because Section G was not included in the September 2002 RFP or the awarded contract.

The decision not to raise the issue during the award process may have benefited QTC over potential competitors. Had QTC raised the issue of the failure to include the provision allowing the base Medicare rates to increase annually, the RFP likely would have been modified to change the basis of pricing for the Medicare-based CLINs. A modified RFP citing updated Medicare reimbursement may have attracted other bidders vying for the award (QTC was the only bidder).

It is entirely plausible that QTC's competitors did not bid on the contract because they did not want to be saddled with the use of 1998 Medicare rates. Whereas potential QTC competitors were not necessarily aware that reimbursement based on current Medicare rates would ultimately be allowed by VBA, due to QTC's knowledge as the incumbent, they appeared to have gambled that updated Medicare rates would be allowed or VA would not realize that it was being overcharged.

We reviewed the evidence to determine whether there was an ambiguity in the contract with regard to the use of 1998 versus current Medicare rates as the baseline rate. QTC did not assert that the contract was ambiguous in its December 11, 2006, response or in any other discussions with VA or the OIG. We concluded that there was no ambiguity. The formulas presented in the Pricing Schedule for CLINs 6AA and 6AB are clearly based on the 1998 Medicare rates. There is no provision in the Pricing Schedule or anywhere else in the contract to allow for annual adjustments based on current Medicare rates. In the block in the pricing schedule for CLIN 6AA, there is a reference to Section G. However, the reference is to a website that has the 1998 Medicare rates, which does not create an ambiguity with respect to whether the 1998 rates were to be used.¹³

If there was an ambiguity, it was between the RFI and the RFP. The RFI included Section G that, among other things, allowed for the base Medicare rate to be adjusted annually. Because the provision was included in the 1998 contract, as the incumbent, QTC was in a better position than any other potential offeror to recognize that Section G was not included in the RFP and there was no provision allowing for annual adjustments to baseline Medicare rates.

If QTC considered the absence of Section G in the RFP to be a patent ambiguity, QTC was obligated to file a protest before submitting a proposal. *Matter of Pitney*

¹³ In comparison, there would have been an ambiguity if the reference to the non-existent Section G had been for the website for the 2002 Medicare rates.

Bowes, Inc. Comptroller General, B-294868, B-294868.2. The fact is that QTC knew prior to submitting its proposal and prior to signing the contract that the rates were frozen at the 1998 rates. QTC made a business decision not to raise the issue. Records show that VA also knew from statements made by QTC during the technical and price evaluations that the RFP contained baseline Medicare rates that were frozen at the 1998 rates because the provision allowing for an annual adjustments were not included. However, no one in VA made any attempt to amend the RFP prior to award. Rather, VA accepted without any further review, the significant increases in the percentage adjustments for CLINs 6AA and 6AB.

We recommend that QTC be held to the 1998 Medicare rates for CLINs 6AA and 6AB, as required by the contract. As such, we re-priced the contract to reflect the 1998 rates. To avoid duplication, we deleted the 24 Medicare-based CPT codes from the analysis that either Kearney or the OIG had identified as having monetary findings. This resulted in re-calculated pricing for 160 of the 184 CPT codes in our sample. For the 160 CPT codes, we determined what the pricing would have been for each CPT code based on the 1998 Medicare schedules, added in the contract percentage adjustment factors, and then added in the appropriate locality adjustments. This resulted in pricing adjustments to over 1.2 million records. We totaled the allowable contract pricing from this analysis and subtracted the total from the amounts billed for the 160 CPT codes. This analysis resulted in a monetary effect of \$2,636,911.54 for the 4-year audit period.

2. Improper use of Proprietary Codes

As previously discussed and shown in Table 5, the bulk of the amount owed for overcharges relates to QTC's use of non-standard CPT codes for foot x-rays (\$779,839.15), and proprietary codes 8000 for lab handling and 8001/8002 for venipuncture (\$2,539,044.10). We obtained documentation from QTC showing that this practice began with the 1998 contract and continued into the current contract.

It is clear that the terms and conditions of both the 1998 and 2003 contracts limited charges under CLINs 6AA and 6AB to Medicare rates and, as such, charges had to be based on specific CPT codes for procedures and laboratory tests. Both contracts required that the invoice identify the CPT code describing the services provided to support the charges. QTC also provided VBA with a list of all codes for their lines of business which VBA entered into a database of codes for the contracts. Although VBA was not aware of QTC's use of non-standard and proprietary codes until after the Kearney audit, the information was readily available to them from the invoice and the database of codes. QTC discontinued the use of proprietary codes after September 15, 2006.

Table 4 on page 10 shows a summary of all questioned costs. The questioned costs are primarily due to the improper use of current Medicare rates and proprietary codes. We recommend that the Contracting Officer issue a Bill for Collection to collect the \$6,011,749.12 in overcharges from QTC.

F. Adequacy of Internal Controls over Billings

Since Kearney's audit, QTC has hired a new staff member dedicated to ensuring the accuracy of QTC billings to VA, and QTC has implemented additional internal controls over billings. As such, the internal control environment is significantly stronger than in the past. From our internal control review, we initially concluded that QTC's controls were primarily focused on the quality and timeliness of the medical examinations, and the accuracy of billings from QTC's providers to them instead of the accuracy of billings to VA. We found that internal controls over the accuracy of billings to VA have significantly improved, but certain areas continue to need improvement.

1. Kearney's Audit

Kearney's audit included internal control walkthroughs of QTC's Unified Automated Disability Information System (Quadis) System, Quality Assurance Process, and Billing Assurance process. Kearney's initial conclusions were that internal controls surrounding the invoicing process were adequate. However, after conducting additional testing and identifying various billing errors on cases sampled, Kearney later modified their internal control opinion to conclude there were internal control weaknesses over billings.

2. Improvements to Internal Controls over Billings

Prior to November 2006, QTC's Date of Invoice (DOV) procedures were the primary internal control procedures over billing accuracy to VA. QTC has modified these procedures with the intent on improving them. The new process strengthens the DOV as an internal control by facilitating identification of no-shows and duplicates. All appointments are authenticated to other reports in the Quadis and to the Automated Medical Information Exchange (AMIE¹⁴) worksheets.

In addition to strengthening its DOV procedures since Kearney's audit, QTC established new internal control procedures called Invoice Auditing Procedures. Kearney assisted in developing these procedures; they were initially implemented

¹⁴ AMIE worksheets are originated by VBA and contain examination protocols.

by QTC on November 20, 2006, and updated on June 18, 2007. These procedures are conducted daily by QTC, and basically replicate the procedures used by Kearney that identified the billing errors pointed out by their audit. The procedures check for duplicate billings based on sequence, duplicate billings based on duplicate testing, and duplicate billing based on no-shows and consultants.

We tested QTC's implementation of the duplicate billing controls for five selected dates by reviewing the reports generated on those dates. The reports identify potential duplicate billings so that QTC can research them and adjust the billings, as needed. We have concluded that QTC's newly implemented internal controls have been effective in preventing duplicate billings, and erroneous billing for no-shows, as such overbillings have essentially not occurred since the new internal control procedures were implemented. For example, we performed substantive testing for no-shows from November 1, 2006 through April 30, 2007, the end of our audit period. We identified no overbillings for no-shows and only two duplicate no-show billings. QTC's internal controls had already detected and corrected the two duplicates.

However, QTC still needs to improve internal controls over NCCI edits. Our audit identified an additional 219 instances totaling \$30,513 where CPT code 70355 was billed in conjunction with CPT code 70310¹⁵ during the period November 2006 through April 2007. QTC's Invoice Auditing Procedures implemented in November 2006 and updated in June 2007 were also designed to monitor this issue to ensure designated CPT codes were not billed together, including CPT codes 70355 and 70310. We discussed this issue with QTC and found that QTC's newly established internal controls had identified 217 of the 219 instances of the overbillings, a significant improvement. However, as of October 29, 2007, QTC's adjustments for 33 of the overbilling instances were still in process for the overbillings which occurred prior to the end of April 2007. A fundamental internal control precept is that such errors should be detected and corrected in the normal course of business, and in a timely manner. QTC's SVP acknowledged that they were behind on the NCCI edit checks. QTC needs to identify such errors more quickly, or more importantly, add internal controls to their billing software to prevent such billing errors from occurring in the first place. We recommend that the Contracting Officer require QTC to update their NCCI edit review to the current period and report the results to VBA. Additionally, we recommend that QTC be required to improve internal controls over NCCI edits so that such errors can be identified and corrected prior to contract billing. QTC's SVP has informed us that they have acquired "IDEA" auditing software for use as an internal control tool. After introducing QTC to IDEA, we highly endorse QTC's use of it as an internal control aide. Kearney also used IDEA, and we believe that if IDEA is

¹⁵ These Radiology CPT codes are: 70310, partial examination, less than full mouth; 70355, Orthopantogram (panoramic x-ray of the jaw).

used properly and consistently, it can be used as an internal control to ensure NCCI billing errors and other errors are caught by QTC before being billed to VA.

G. Other Matters

Prior to our on-site visit to QTC's office, the COTR requested that we review two issues: (i) QTC's procedures to ensure their contracted professional provider licenses remain current and in good standing (i.e. re-credentialing procedures); and (ii) QTC controls to ensure physicians spend a least 1 hour when conducting PTSD examinations. We conducted limited reviews of these issues and our results are discussed in the paragraphs below. Other issues related to contract pricing, contract changes, and communications between the contracting and program offices that came to our attention during the audit are also discussed.

1. Provider Re-Credentialing

QTC has written policies and procedures regarding provider re-credentialing entitled "RE-CREDENTIAL OF PROVIDERS", last updated on April 16, 2007. The stated purpose of the policy is "To check the current status of professional licenses of providers (Active & S2 status) in QTC network for any disciplinary actions; to ensure that the professional license and malpractice insurance of QTC providers are updated and current."

QTC's policy requires a monthly check of each of their active and short-term contract (S1) providers to ensure the provider's license to practice is still active, without disciplinary actions, and that the provider maintains malpractice insurance. To accomplish this policy, each of QTC's five Professional Relations Specialists spends 25 to 30 hours monthly validating the credentials of up to 3,700 providers by searching 49 state web sites and making phone calls to state licensing authorities. If a provider appears on a disciplinary list, the details are investigated and submitted to the Professional Relations supervisor or Vice President of Provider Relations for further review and action, as appropriate. If provider licenses cannot be validated and updated or malpractice insurance cannot be obtained, the provider is placed in an inactive status on the date of expiration. If this happens, the provider is locked out of QTC's system—the Tracking Tools portion of the system will prevent scheduling appointments with the provider.

We conducted a limited review of QTC's policy by discussing it with them, and reviewing certain documentation that should be generated to support the policy (e.g., the exception/status report, re-credential letters to providers, follow-up letters, non-compliant lists, relevant correspondence, and statistical information). From this information, we concluded that QTC does implement their policy.

Because we did not conduct any substantive testing, we could not arrive at a conclusion concerning the effectiveness of QTC's implementation of the policy.

However, one of QTC's reports that we reviewed revealed a serious disciplinary problem with a provider that was identified by the VBA staff, not QTC. In our opinion, this is an indicator that QTC's procedure needs improvement. We discussed this issue with QTC's SVP, who acknowledged the issue should have been identified by QTC, but was missed due to human error. The SVP indicated the issue got elevated to QTC's Medical Director, who directed that QTC's Information Technology staff develop software to assist in automating the labor intensive re-credentialing policy. The SVP advised us that software currently is being tested. We recommend that VBA continues to conduct their own testing until they are satisfied that QTC's procedures have improved enough so that QTC is detecting all credentialing, disciplinary, and malpractice issues. Additionally, VBA should require QTC to report to VA on a regular basis any accomplishments in improving their re-credentialing procedures.

2. PTSD Examination Timeframes

VBA requested that we review this issue because they had received complaints from veterans that PTSD examinations sometimes were significantly shorter than the minimum 1-hour timeframe that VBA's COTR and Project Medical Director believed to be adequate (AMIE worksheet suggests more than 1 hour).

We obtained copies of letters that QTC has sent to their providers questioning the validity of PTSD examinations that take less than 1 hour. We also discussed the issue with QTC's SVP. She said the PTSD appointments for many patients can be less than 1 to 2 hours because most of the patients are young active duty service members without a lot of stressors. She added that the examination reports appear to be the result of thorough exams and the physicians believe the examinations to be valid. She provided an example of a physician who conducts a lot of PTSD exams on active duty service members, many of which last less than an hour. QTC has discussed this issue with the physician, who adamantly maintains that his examinations are thorough. The physician indicates that because the service members are mostly young and still on active duty, they don't have as many issues as older veterans. As such, competent exams can be conducted quickly. Currently, QTC requires the questionnaires associated with the examinations to be filled out by the physicians during the examination, whereas in the past, the veteran would fill them out before the appointment. It forces the physician to spend time talking with the veteran and getting to know him or her to conduct a more thorough evaluation.

The PTSD examination (CLIN 0003AE) is expensive. In discussions with VBA's COTR and Project Medical Director, they advised us that VBA only allowed the negotiated price to be so high because the belief was that the examination would be very time consuming, usually taking significantly over 1 to 2 hours to complete. This belief was based on information from the Veterans Health Administration and a study performed by the Institute of Medicine. Based on QTC's assessment of the situation for active duty service members with few stressors, we believe the cost for the PTSD examinations should be significantly reduced. Therefore, we recommend that VBA negotiate tiered pricing for CLIN 0003AE, reducing the cost for active duty service members with a predetermined number of stressors.

3. Contract Appears to be Overpriced

We cannot definitively conclude that the contract is overpriced because we did not examine cost data. However, several factors indicate that the contract may be overpriced. These factors include: (i) prior to award VBA had concerns about the pricing that were not resolved; (ii) Kearney's audit recommended re-negotiation of the fee schedule; and (iii) QTC's proposed pricing on a similar new award for six additional sites is significantly lower than on the current contract. We discuss these factors in the following paragraphs.

a. Unanswered Questions About Pricing Reasonableness. Prior to the award to QTC, VBA had some concerns about the contract's pricing. The "Consensus Report", dated November 22, 2002, stated: "Based on the re-evaluation after the negotiation, the most significant omissions of the Business Proposal is insufficient data to justify the proposed QTC prices." Specifically, the Evaluation Panel had significant questions about the proposed locality adjustments.

The Evaluation Panel members noted that:

QTC expanded the meaning of locality adjustment when developing the pricing structure for this proposal. They used it as an adjustment rate to come up with a fully loaded price, not merely as an adjustment rate to a locality as being used conventionally... QTC considered two main factors when developing the locality adjustment rates in order to arrive at a fully loaded pricing for this proposal, Relative Value fee schedules and QTC experience modification rates... QTC stated that Relative Value uses a quantifiable formula and virtually most well known fee schedules, such as Medicare fees, are developed according to this methodology... Under the QTC experience modification rates, QTC takes price-sensitivity and/or competitive pricing into

consideration and the fees do reflect current disability evaluation industry trends in local communities.

The Evaluation Panel was not comfortable with QTC's justification for the locality adjustments, and considered it as a weakness. The Consensus Report stated that the panelists were "Unclear as to where 'relative value fee schedules' are extracted based on what data", and Unclear as to what 'QTC experience modifications' are." Additionally, the Panel considered the fact that QTC did not provide a breakdown between the administrative costs and professional services costs in the proposed contract pricing as a pricing deficiency.

Although the Evaluation Panel had significant concerns about the locality adjustments, they were approved. The panel stated: "Did not give a good justification for their locality adjustments, but since they are exactly the same¹⁶ as what VA is paying now, and they don't increase over the next five years, it is acceptable." The final pricing reasonableness determination stated: "The prices now offered demonstrate only a 5.98% increase from the prices VA now pays for examinations, which is fair and reasonable." The prices for CLINs 6AA and 6AB were much higher than VA was paying under the prior contract.

We believe that locality adjustments should be limited only to the increased costs of doing business in specific localities. Without additional information, which was not available in the contract file, the relevancy of "relative value fee schedules" and "QTC experience modification rates" to QTC's locality adjustments is not clear. QTC's locality adjustments ranged from 0 to 17 percent for medical examinations and from 0 to 40 percent for Medicare-based CLIN 6AA.¹⁷ If QTC's reference to relative value fee schedule is synonymous with Medicare's use of relative value units, then QTC's use of relative value has no relevance to a locality adjustment. Under Medicare, relative value units are fixed components—regardless of locale—of Medicare rates per procedure. Medicare procedure rates are then subject to locality adjustments, but the adjustment is significantly lower than QTC's locality adjustments.

b. Kearney Audit. Kearney's audit suggested contract pricing was too high and recommend consideration be given to immediately re-negotiating the Fee Schedule. For example, Kearney concluded that the negotiated fee for dental exams did not include x-rays that are required to complete the exams, and similar inconsistencies existed for audiology and ophthalmology

¹⁶ The locality adjustments for the same locations on both contracts were identical.

¹⁷ There was no locality adjustment for CLIN 6AB.

examinations. Kearney's report stated: "Based on this al a carte versus all inclusive approach to Fee Schedule application, the value being derived from its application appears minimal." We agree with Kearney's assessment, especially for x-rays conducted in conjunction with medical examinations. We analyzed the sales data for the 4-year period ending April 30, 2007. We found that QTC provided over 483 thousand x-rays on the day of, or the next day following the 98,523 medical examinations provided during the period. This indicates that x-rays are routinely ordered during medical examinations. We also noted that comprehensive and general medical examinations did not include the price of laboratory blood testing, required for most general medical examinations. Although the contract indicates that the prices are "all inclusive," it is not clear from the contract what aspects of the examination are included and what aspects can be charged separately.

Kearney also strongly criticized the locality adjustments, stating that they appeared to be regional versus based on a specific location. For example the report cited the same locality adjustment of 25 percent for Seattle and Walla Walla, Washington, 270 miles apart. Kearney recommended "that further clarification on the application of locality adjustments be obtained. Specifically, the purpose of the locality should be understood and its applicability to all charges in the region should be questioned. It may be appropriate to incorporate different incentive arrangements with QTC."

c. Pricing for New Contract. Perhaps the strongest indicator that QTC's current contract may be overpriced is QTC's pricing on a similar VA RFP to provide disability examinations at two additional VAROs. The contract was awarded to QTC in March 2007. QTC's awarded prices for the identical services offered on the current contract are significantly lower than current contract pricing. Awarded prices for the 23 non-Medicare-based CLINs decreased an average of 16.2 percent. Prices for one of the two Medicare-based CLINs also decreased.

The proposed pricing for "No-Shows" (CLIN 0007) also significantly decreased. Additionally, the proposal differentiates between a complete and partial no-show. A complete no-show is defined as the veteran not showing up for the scheduled appointment, one of the definitions on the current contract. The proposed partial no-show is when a veteran cancels less than 24 hours prior to the examination but reschedules a new appointment. In these cases, the no-show is charged on the initial appointment, but at the significantly reduced price because the administrative preparation work is eventually used. Under the current contract, a partial no-show charge is the same as for a complete no-show.

Although the lower prices may represent some economy of scale savings,¹⁸ we believe it is an indicator that the current contract is overpriced. We believe any economy of scale savings would be limited only to administrative and overhead costs. Conversely, the costs QTC pays its providers for the examinations probably would be the same proportionally as they are on QTC's current contract. As such, the reduced pricing probably represents a reduced profit margin on the new contract compared to the profit margin on the current contract. The COTR informed us that QTC bid on the proposal believing that there would be increased competition. Therefore, they may have been willing to accept a reduced profit margin on the new contract, because they possibly enjoy an excessive profit margin on the current contract.

We recommend that the follow-on contract be negotiated using an all-inclusive approach; that any locality adjustments exclude all pricing factors except for the increased costs of providing services in the specific locality; and, that all aspects of the pricing be fully understood before a fair and reasonable pricing determination is made.

4. Potential Cardinal Changes. Prior to OIG's involvement in the audit, VBA on advice from OGC had intended to modify the contract. The modification would allow contract pricing for the Medicare-based CLINs to be based on current Medicare fee schedules instead of the 1998 Medicare fee schedule, as stipulated in the contract. OIG subsequently requested that VA not take any contractual actions until OIG completed the audit/investigation. If VA had modified the contract to contractually change contract pricing, such a change would have constituted approval of significantly increased contract prices to the point that the change may have represented a "cardinal change" in the contract. A cardinal change is a change comprising such a material modification of the underlying contract that it imposes risks on the surety that are fundamentally different from those present in the initial contract. Generally, a cardinal change can take one of two forms. The first one, far more common, is a material change in the scope of work. Also, a change that dramatically increases the cost of the underlying contract or would have affected competition will constitute a cardinal change. In our opinion, VBA's proposed modification would have been a cardinal change, requiring the procurement to be re-advertised and re-bid. We recommend that the Contracting Officer evaluate all proposed changes to ensure they do not constitute prohibited cardinal changes.

¹⁸ Economy of scale refers to lower unit pricing as the number of units produced increase.

5. Contract Clause 4.1. Contract Clause 4.1 states:

The contract line items (CLINs) listed are to be fully loaded; that is, they shall include all services and/or costs the Contractor shall incur in the performance of these CLINs. Such costs include, but are not limited to: labor, fringe benefits, equipment, Veteran's mileage expense reimbursement (VA allows see paragraph 5.1.3.3 for allowance), necessary reports, overhead, G&A, and profit.

We believe the above provision is inappropriate for the QTC contract, which is a firm-fixed-price commercial acquisition type of contract. Instead, the clause would be appropriate for a negotiated contract based on the contractor supplying cost or pricing data. We recommend that this clause be deleted from the follow-on contract's solicitation.

6. Listing of Medicare-based CPT Codes and Pricing. We believe that internal controls over Medicare-based CLIN pricing can be improved if such pricing is more closely monitored by VBA. If the follow-on contract allows Medicare-based CLIN pricing to be based on the current year's Medicare pricing, such pricing should be disclosed to, and approved by VBA every year. An appropriate means to accomplish this under a commercial acquisition contract would be an annually updated price list generated by the contractor and approved by VBA's COTR. Such a procedure would allow VBA to monitor contract pricing (Medicare and non-Medicare-based pricing) through the use of a robust data mining software program such as IDEA, thus, significantly improving internal controls over the accuracy of billings. We recommend that VBA monitor contract pricing by obtaining annual price lists and using data mining software to compare authorized pricing to invoiced pricing as invoices are submitted to VA.

7. Communications need Improvement between Contracting and Program Offices. Communications between the Office of Acquisition & Logistics (OA&L) and VBA need improvement. Prior to the award of the contract, it was clearly documented that QTC was basing their CPT-based pricing on 1998 Medicare rates. It is also clear that VBA's intent was to allow such pricing to be based on the current year's Medicare pricing. However, there is no evidence that VBA brought the issue to the Contracting Officer's attention and the solicitation was not amended to allow current year's Medicare pricing to be the basis of CPT-based pricing. During our review, we became aware of additional issues that caused a rift between the two offices, including the lack of any continuity or consistency in contracting officers. We recommend that the Under Secretary for Benefits and the Deputy Assistant Secretary for OA&L establish a protocol to ensure better communication between the offices and that all pertinent program and contract requirements are incorporated into subsequent contracts.

8. Statement of Work for Audit of Contract: As previously stated, we recommend that VBA develop an internal control process using a software program such as IDEA to test contract pricing as invoices are submitted to VA. We believe such a process would significantly improve internal controls over contract billings. Additionally, such a procedure could obviate the need for annual contract audits, such as the audit performed by Kearney.

In regard to the award to Kearney to conduct the audit, the RFP was issued under a General Services Administration Schedule, under full and open competition, and stipulated the need for key personnel who could quickly familiarize the audit staff with the unique aspects of the project including the schedule of fees and customary medical pricing. The RFP's Statement of Work (SOW) required a financial audit of invoices with the objectives of determining if:

1. The services performed were appropriate for the examination protocols and individual VARO requests;
2. There are appropriate financial internal controls in place to review charges prior to invoicing VA; and
3. Independent medical opinions performed were necessary per the regional offices examination requests and charged accordingly.

The RFP also stipulated that the contractor selected would be required to conduct annual audits of QTC's invoices. The RFP was silent with regard to the number of invoices the contractor would be required to review or the confidence level required. Absent such requirements, it is not possible to determine whether a firm-fixed price proposal is fair and reasonable.

Kearney was awarded the contract for a base year, at a cost of \$276,762, and option years. The first option year audit would have occurred in 2007 at a total cost of \$287,824, but the audit was cancelled because it was duplicative of the OIG's audit. Once Kearney was awarded the contract, they selected a sample of 233 invoices from a universe of 72,309 invoices covering appointments from June 1, 2005 through May 31, 2006. According to the Kearney audit report, the 233 selected invoices comprised a statistically valid sample at a 90 percent confidence level with an error rate of 5 percent or less. Kearney noted that for most of their findings the error rate exceeded 5 percent. Kearney viewed these situations as endemic and they estimated the monetary impact for the entire 1-year period by accounting for all invoices with the problem charges.

We have no criticisms of the audit that Kearney conducted. However, we point out that the first option year costs of \$287,824 to Kearney, or to any incumbent contractor, is expensive and possibly unreasonable. Because of lessons learned

and the development of a template during the base year, auditing firm costs on follow-on audits generally are less than their costs on the initial engagement. Therefore, an option year that is more expensive than the initial audit may not be reasonable, even if the contract was modified to include a requirement for a confidence level of 95 percent.¹⁹

Our recommended procedure to compare invoiced pricing to established price lists could satisfy Objective 2, because it involves the accuracy of billings, but the procedures would not address Objectives 1 or 3, above. Since the monetary findings in Kearney's audit related primarily to Objective 2, above, we recommend that VBA implement our recommended procedures to internally monitor the accuracy of billings instead of expensive annual audits.

¹⁹ Although not required under the terms and conditions of the contract, Kearney's base year audit was conducted using a confidence level of 90 percent.

Recommendations

1. We recommend that the Under Secretary for Benefits monitor contract pricing and payments by obtaining annual price lists and using data mining software to compare authorized pricing to invoiced pricing as invoices are submitted to VA.
2. We recommend that the Under Secretary for Benefits and the Deputy Assistant Secretary for the Office of Acquisition and Logistics establish a protocol to ensure all pertinent program and contract requirements are incorporated into subsequent contracts.
3. We recommend that the VA Contracting Officer Issue a Bill for Collection to QTC, as follows:

QTC's Settlement Offer with OIG Adjustments	\$3,624,228.92
OIG Adjustments for other CPT codes (Table 6)	28,361.77
Adjustment to freeze prices at 1998 levels	<u>2,636,911.54</u>
Subtotal	6,289,502.23
Adjustment for Undercharges for un-sustained findings	-277,753.11
Total	<u>\$6,011,749.12</u>

4. We recommend that the Contracting Officer require QTC to immediately update their NCCI coding self-audits to the current period and report to VBA the results.
5. We recommend that the Contracting Officer require QTC to implement internal controls to their system (i.e. software) to prevent overbillings for NCCI edit issues, instead of detecting such errors after the fact.
6. We recommend that the Contracting Officer require QTC to implement additional internal controls over the use of CPT code 96118 to entail: (i) that QTC reviews the results of each neuropsychiatric examination to ensure the results are clearly documented, interpreted, and explained by the psychiatrist who ordered the tests; and (ii) the testing be clearly ordered by the psychiatrist who performed the psychiatric examination, not the VARO.
7. We recommend that the Contracting Officer request VBA to continue conducting their own re-credentialing testing until they are satisfied that QTC's procedures have improved enough so that QTC is detecting all credentialing, disciplinary, and mal-insurance issues. Additionally, VBA should require QTC to

report to VA on a regular basis any accomplishments in improving their re-credentialing procedures.

8. We recommend that the Contracting Officer re-negotiate pricing for PTSD examinations to establish tiered pricing for CLIN 0003AE, lowering the price for PTSD examinations for active duty service members with few stressors.

9. We recommend that the Contracting Officer negotiate the follow-on contract using an all-inclusive approach to include the price of routine diagnostic tests and procedures in the price for medical and dental exams. Any locality adjustments should exclude all pricing factors except for the increased costs of providing services in specific localities, and all aspects of the pricing should be fully understood before a fair and reasonable pricing determination is made.

10. We recommend that the Contracting Officer ensure that proposed contract modifications do not constitute cardinal changes to the contract.

11. We recommend that the Contracting Officer Delete Contract Clause 4.1 from the RFP for the follow-on contract.

Management Comments

Memorandum

**Department of
Veterans Affairs**

Date: **MAR 25 2008**

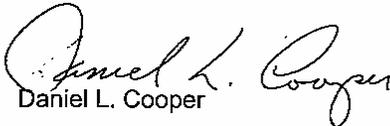
From: Under Secretary for Benefits (20)
Assistant Secretary for Management (004)

Subj: OIG Draft Report – Audit of QTC Medical Services, Inc.'s, Settlement Offer for
Overcharges under Contract V101(93)P-2099

To: Acting Director, Office of Contract Review (55)

1. This responds to your request for a response to the recommendations in the subject report. Comments from the Veterans Benefits Administration and the Office of Management are attached. We anticipate implementation of all recommendations by September 30, 2008.

2. Questions may be referred to Brad Mayes, Director of Compensation and Pension Service, at 202-461-9700 or Jan Frye, Deputy Assistant Secretary for Acquisition and Logistics, at 202-461-6920.


Daniel L. Cooper


Robert J. Henke

Attachment

Veterans Benefits Administration and Office of Management
Response to OIG Recommendations in Draft Report:
Audit of QTC Medical Services, Inc.'s Settlement Offer
For Overcharges under Contract V101(93)P-2099

OIG Recommendations:

1. We recommend that the Under Secretary for Benefits monitor contract pricing and payments by obtaining annual price lists and using data mining software to compare authorized pricing to invoiced pricing as invoices are submitted to VA.

RESPONSE: The Under Secretary for Benefits and the Assistant Secretary for Management concur. In April 2007, VBA prepared a statement of work to hire a CPA firm to conduct semi-annual audits (data mining of the invoices). However, based upon guidance provided by the OIG, VBA took no further action on the requirement until this OIG audit report was completed. VBA does not have the expertise or the resources required to conduct bi-weekly data mining as the invoices are submitted for payment (currently over 9,000 per month). VBA believes that conducting independent, semi-annual audits will identify invoicing errors and ensure that actions are taken to correct past errors. VBA agrees to obtain annual pricing lists to compare authorized pricing to invoiced pricing. VBA will move forward to solicit CPA services to provide the expertise required. We expect this action will be completed by September 30, 2008.

2. We recommend that the Under Secretary for Benefits and the Deputy Assistant Secretary for the Office of Acquisition and Logistics establish a protocol to ensure all pertinent program and contract requirements are incorporated into subsequent contracts.

RESPONSE: The Under Secretary for Benefits and the Assistant Secretary for Management concur and will work collaboratively using Integrated Process Teams to develop all future program requirements and contracts.

3. We recommend that the VA Contracting Officer Issue a Bill for Collection to QTC, as follows:

QTC's Settlement Offer with OIG Adjustments	\$3,624,228.92
OIG Adjustments for other CPT codes (Table 6)	28,361.77
Adjustment to freeze prices at 1998 levels	<u>2,636,911.54</u>
Subtotal	6,289,502.23
Adjustment for Undercharges for un-sustained findings	-277,753.11
Total	<u>\$6,011,749.12</u>

RESPONSE: The Under Secretary for Benefits and the Assistant Secretary for Management non-concur with the dollar amount of the OIG's findings. The VA General Counsel, in an opinion dated January 30, 2008, SUBJECT: Audit of QTC Medical

Services, Inc. Settlement Offer for Overcharges under Contract V101(93)P-2099, has opined that the contract language is ambiguous. Thus, QTC is not liable for \$2.64 million of the \$6.01 million in overcharges as alleged by the OIG. On March 25, 2008, VA issued QTC a bill of collection for \$3.37 million.

4. We recommend that the Contracting Officer require QTC to immediately update their NCCI coding self-audits to the current period and report to VBA the results.

RESPONSE: The Under Secretary for Benefits and the Assistant Secretary for Management concur and will work collaboratively to require QTC to immediately update their National Correct coding Initiative coding self-audits to the current period and report the results.

5. We recommend that the Contracting Officer require QTC to implement internal controls to their system (i.e. software) to prevent overbillings for NCCI edit issues, instead of detecting such errors after the fact.

RESPONSE: The Under Secretary for Benefits and the Assistant Secretary for Management concur and will work collaboratively to require QTC to implement internal controls to their system to prevent overbillings before, rather than after the fact.

6. We recommend that the Contracting Officer require QTC to implement additional internal controls over the use of CPT code 96118 to entail: (i) that QTC reviews the results of each neuropsychiatric examination to ensure the results are clearly documented, interpreted, and explained by the psychiatrist who ordered the tests; and (ii) the testing be clearly ordered by the psychiatrist who performed the psychiatric examination, not the VARO.

RESPONSE: The Under Secretary for Benefits and the Assistant Secretary for Management concur. The contract will be modified to ensure that QTC reviews the results of each neuropsychiatric examination to ensure results are clearly documented, interpreted and explained by the psychiatrist who ordered the tests. Further, the contract will be modified to require that the psychiatrist who performed the examination order the testing, not the VARO.

7. We recommend that the Contracting Officer request VBA to continue conducting their own re-credentialing testing until they are satisfied that QTC's procedures have improved enough so that QTC is detecting all credentialing, disciplinary, and mal-insurance issues. Additionally, VBA should require QTC to report to VA on a regular basis any accomplishments in improving their re-credentialing procedures.

RESPONSE: The Under Secretary for Benefits and the Assistant Secretary for Management concur. VBA will continue to conduct its own re-credentialing testing to ensure that QTC is detecting all credentialing, disciplinary, and mal-insurance issues, and will monitor improvements in QTC's re-credentialing procedures.

8. We recommend that the Contracting Officer re-negotiate pricing for PTSD examinations to establish tiered pricing for CLIN 0003AE, lowering the price for PTSD examinations for active duty service members with few stressors.

RESPONSE: The Under Secretary for Benefits and the Assistant Secretary for Management concur. Pricing for PTSD examinations will be renegotiated downward. The number of stressors is not relevant to the complexity of the neuropsychiatric examinations needed.

9. We recommend that the Contracting Officer negotiate the follow-on contract using an all-inclusive approach to include the price of routine diagnostic tests and procedures in the price for medical and dental exams. Any locality adjustments should exclude all pricing factors except for the increased costs of providing services in specific localities, and all aspects of the pricing should be fully understood before a fair and reasonable pricing determination is made.

RESPONSE: The Under Secretary for Benefits and the Assistant Secretary for Management concur. Follow-on contracts will use an all-inclusive approach, assuring all aspects of the pricing model are fully understood in making a fair and reasonable pricing determination.

10. We recommend that the Contracting Officer ensure that proposed contract modifications do not constitute cardinal changes to the contract.

RESPONSE: The Assistant Secretary for Management concurs. However, in the General Counsel opinion cited in paragraph 3 above, OGC opines that reformation of this contract as recommend by the OIG would not result in a cardinal change. All modifications to this contract will receive legal review and concurrence prior to execution by the Contracting Officer.

11. We recommend that the Contracting Officer Delete Contract Clause 4.1 from the RFP for the follow-on contract.

RESPONSE: The Assistant Secretary for Management concurs, subject to the follow-on contract being a FAR Part 12 acquisition.

Monetary Benefits In Accordance With IG Act Amendments

Report Title: Audit of QTC Medical Services, Inc.'s Settlement Offer for Overcharges under Contract V101(93)P-2099, Report Number 07-02280-104.

RECOMMENDATION	Category/Explanation of Dollar Impact	Questioned Costs
3. Issue a Bill of Collection	Recovery of overcharges relating to contract V101(93)P-2099	\$6,011,749.12
	Total	<u>\$6,011,749.12</u>

OIG Contact and Staff Acknowledgments

OIG Contact	Maureen Regan
-------------	---------------

Acknowledgments	John Ames
	George Jordan
	Michael Cheman

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Veterans Benefits Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel

Non-VA Distribution

House Committee on Veterans' Affairs
House Committee on Appropriations, Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Committee on Appropriations, Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget

This report is available at <http://www.va.gov/oig/publications/reports-list.asp>.