

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



Veterans Health Administration

*Review of
Alleged Inappropriate
Referrals at the Southern
Nevada Healthcare
System to a Non-VA
Medical Provider*

September 30, 2015
15-01590-523

ACRONYMS

ACR	American College of Radiology
ACRO	American College of Radiation Oncology
CAPM	Clinical Access Program Manager
NROP	National Radiation Oncology Program
NVC	Non-VA Care
OIG	Office of Inspector General
PC3	Patient-Centered Community Care
VASNHS	VA's Southern Nevada Healthcare System
VHA	Veterans Health Administration
VA	Department of Veterans Affairs

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Report Highlights: Review of Alleged Inappropriate Referrals at VHA's SNHS to a Non-VA Medical Provider

Why We Did This Review

We performed this review to determine the merits of an allegation made to the Office of Inspector General (OIG) in November 2014. The complainant alleged that a VA Southern Nevada Healthcare System (VASNHS) employee limited the choice of providers for patients needing to obtain non-VA care (NVC) for radiation oncology treatments and directed patients to one NVC provider because of a friendship with a physician associated with the provider's business. It was further alleged the VASNHS Chief of Staff directed staff not to refer patients to the NVC provider and the NVC provider had a previous contract that VA canceled due to poor performance.

What We Found

We did not substantiate the allegations. We determined that VASNHS personnel allowed radiation oncology patients to choose their treatment providers and no personal relationship existed that resulted in inappropriate patient referrals. Additionally, we did not substantiate the VASNHS Chief of Staff directed staff not to refer patients to the NVC provider and that VA terminated a radiation oncology contract due to poor performance. However, while reviewing these allegations we found TriWest Healthcare Alliance Corporation (TriWest), a Patient-Centered Community Care (PC3) contractor, referred 15 of 58 oncology patients to network practices that did not meet VA clinical accreditation standards established under the terms of the PC3 contract. As a result, Veterans Health

Administration (VHA) lacks assurance that these patients received radiation oncology treatments that met VHA's standards of care.

What We Recommended

We recommended the Under Secretary for Health ensure that TriWest refers radiation oncology patients only to practices/facilities properly accredited under the terms of the contract, determine whether the PC3 contract needs to be amended, and to ensure patients receive radiation oncology treatments that meet VHA's standards of care.

Agency Comments

The Under Secretary for Health concurred with our findings and recommendations and provided an appropriate action plan. We will follow up on the implementation of the corrective actions.

A handwritten signature in black ink that reads "Gary K. Abe".

GARY K. ABE
Acting Assistant Inspector General
for Audits and Evaluations

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RESULTS AND RECOMMENDATIONS

Allegation **Employee at the VA Southern Nevada Healthcare System Inappropriately Referred Patients to a Non-VA Radiation Oncology Provider**

On November 26, 2014, the Office of Inspector General received a complaint that the Department of Veterans Affairs (VA) Southern Nevada Healthcare System (VASNHS) Clinical Access Program Manager (CAPM), named by the complainant as the “director of VA fee basis,” limited the choice of non-VA care (NVC) to primarily one provider for patients needing radiation oncology treatments. The complainant asserted that the CAPM directed VA radiation oncology patients to one NVC provider because the CAPM was a “longtime friend” of a physician associated with the provider’s business. The complainant further alleged the VASNHS’ Chief of Staff directed staff not to refer patients to the NVC provider named in the complaint, and the NVC provider had a previous contract that VA canceled “due to poor performance.”

What We Did

After interviewing the complainant, we conducted a site visit to the VASNHS to assess the merits of the allegation. While there, we interviewed the CAPM, the Chief of NVC, and an NVC nurse case manager. We also interviewed the Chief of Staff, Chief of Medicine, the Acting Chief of Hematology and Oncology, and all three of the facility’s oncologists.

We reviewed data to include all 451 radiation oncology patients authorized by the VASNHS NVC office to receive radiation oncology treatment during calendar years 2013 and 2014. We randomly selected 76 of the 451 patients and reviewed their medical records found on VA’s Computerized Patient Record System. Further, we reviewed some of the CAPM’s email transmissions pertaining to radiation oncology referrals and authorizations.

What We Found

We did not substantiate that the CAPM or any other VASNHS personnel inappropriately referred patients to one NVC radiation oncology provider. Instead, we found correspondence that showed the CAPM consistently advised VASNHS physicians that patients should choose their NVC radiation oncologists. In addition, after reviewing the Computerized Patient Records System treatment consults for randomly selected radiation oncology patients, we found VASNHS staff routinely afforded patients a choice of NVC radiation oncology providers.

Alleged Friendship Did Not Influence Referrals

We did not substantiate that a personal friendship existed between the CAPM and a physician at the NVC radiation oncology practice named by the complainant, or that the alleged relationship influenced referrals of radiation oncology patients to the NVC provider. Additionally, our review of the

CAPM's email correspondence did not provide any evidence the CAPM attempted to influence patient referrals, or attempted to contact anyone at the NVC provider's office.

*Facilities
Chosen for
Convenience of
Location*

We did determine about 79 percent of sampled oncology patients authorized for NVC chose the provider named in the allegation. Because of this high percentage, we interviewed VASNHS staff to understand the reasons so many patients chose this provider. Staff provided a number of reasons to include the most prominent, which was that the NVC provider had four locations in the Las Vegas area and most patients chose a facility close to where they lived.

We verified this by comparing the addresses of the sampled patients and their selected NVC providers. We found that 71 percent of patients chose providers whose locations were within about 8 miles of their home addresses, which was the average distance from the patients' homes to one of the four office locations of the NVC provider named in the allegation. Additionally, the named provider had a radiation oncology contract with VASNHS from April 2007 through July 2010, creating familiarity within the veteran population in the Las Vegas area.

*Chief of Staff
Did Not Direct
Staff To Avoid
Referrals to
NVC Provider
or Terminate
Contract*

We did not substantiate the VASNHS Chief of Staff directed staff not to refer patients to the NVC provider. None of the three oncologists interviewed supported the allegation. Additionally, the Chief of Staff reported that he did not provide direction to his staff to avoid referring oncology patients to the named NVC provider.

We also did not substantiate that VASNHS terminated a radiation oncology contract that was effective from April 1, 2007, to March 31, 2010, due to poor performance. We reviewed the contract and other documents in the contract file. Our review found that the contracting officer determined the need to extend the contract for 4 months, to July 31, 2010, "while the new long-term solicitation is being solicited and awarded."

This long-term solicitation was suspended when VA began planning the implementation of the Patient-Centered Community Care (PC3) program.¹ Additionally, we interviewed personnel at the VASNHS, including the contract's contracting officer representative at the time when the contract ended. None of these officials reported any knowledge of contractor performance problems. Furthermore, our review of the contract file did not reveal any evidence of poor performance by the contractor.

¹ In September 2013, VA established the PC3 Program, when it awarded Health Net Federal Services, LLC and TriWest Healthcare Alliance Corporation (TriWest) contracts totaling approximately \$5 billion and \$4.4 billion, respectively. PC3 contracts are expected to provide veterans timely access to quality care, including oncology services, when VA medical facilities cannot meet their needs. The TriWest network of providers services VASNHS and the greater Las Vegas area.

Other Matters

When we questioned VASNHS staff how they provided oncology services from August 2010 to when VA implemented PC3 in September 2013, they said they referred oncology consults to NVC. PC3 radiation oncology providers in TriWest's network were first available to VASNHS on January 2, 2014. However, VASNHS did not use the TriWest providers until February 18, 2015, after the VASNHS Associate Director, Chief of Staff, and Nurse Executive issued a joint memo directing staff to use PC3 contract providers for radiation oncology services. VA policy requires VA medical facilities to refer patients to the PC3 contractors when the services are not available at the VA medical facility.

We asked the VASNHS Chief of Staff why the facility did not use the PC3 contract earlier. He stated he had concerns about some TriWest providers not having appropriate clinical accreditations. We interviewed the Director for Veterans Health Administration's (VHA) National Radiation Oncology Program (NROP) who stated that NROP recognizes the American College of Radiology (ACR) accreditation program as the standard for on-site VHA radiation oncology. The Director of NROP stated that there are certain exceptions for NVC radiation oncology practices/facilities that have accreditation from the American College of Radiation Oncology (ACRO). Accreditation by either organization helps ensure that community practices/facilities meet the radiation oncology standards required of all VHA facilities.

While NROP recognizes both ACR and ACRO accreditations for NVC practices/facilities, the PC3 contract only allows TriWest to refer patients to ACR-accredited practices/facilities, unless certain exceptions apply. However, TriWest had one ACR and one ACRO accredited radiation oncology practice/facility in its contract network in the greater Las Vegas area. Neither ACR nor ACRO have accredited the remaining two radiation oncology practices/facilities in TriWest's network.

Since February 2015, when VASNHS began to use the PC3 contract to provide radiation oncology services, TriWest referred 23 of 58 patients to its 1 ACR accredited network practice/facility and referred the remaining 15 patients to practices/facilities who were accredited by neither ACR nor ACRO. VHA lacks assurance that these 15 patients received radiation oncology treatments that met VHA's standards of care. To ensure veterans receive the same standard of care required in VA medical facilities, VA must ensure TriWest sends patients to NVC practices/facilities that meet the clinical accreditation standards established under the terms of the PC3 contract.

Recommendations

1. We recommended the Under Secretary for Health ensure that TriWest Healthcare Alliance Corporation meets the terms of the Patient-Centered

Community Care contract by referring radiation oncology patients to only American College of Radiology-accredited network practices/facilities.

2. We recommended the Under Secretary for Health determine whether the Patient-Centered Community Care contract with TriWest Healthcare Alliance Corporation needs to be amended to allow referrals to other than American College of Radiology-accredited network practices/facilities.
3. We recommended the Under Secretary for Health require the review of medical results for the 15 patients referred to practices/facilities not accredited by the American College of Radiology or American College of Radiation Oncology to ensure they received treatment that met Veterans Health Administration standards of care.

Government Standards

We conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

Agency Comments

The Under Secretary for Health concurred with our findings and recommendations and stated that VHA would implement Recommendations 1 and 2 by June 2016, and Recommendation 3 by November 2015. The Under Secretary for Health's entire verbatim response is located in Appendix A.

OIG Response

The Under Secretary for Health's planned corrective actions are acceptable. We will monitor VHA's progress and follow up on the implementation of our recommendations until all proposed actions are completed.

Appendix A Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: September 25, 2015
From: Under Secretary for Health (10)
Subj: OIG Draft Report, Review of Allegation of Inappropriate Referrals to a Non-VA Medical Provider at the VA Southern Nevada Healthcare System (VAIQ 7635788)
To: Assistant Inspector General for Audits and Evaluations (52)

1. I have reviewed the draft report and concur with the report's recommendations. Attached is the Veterans Health Administration's corrective action plan for recommendations 1 through 3.
2. Thank you for the opportunity to review the draft report. If you have any questions, please contact Karen Rasmussen, M.D., Director, Management Review Service (10AR) at VHA10ARMRS2@va.gov

(original signed by:)

David J. Shulkin, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report, Department of Veterans Affairs: Review of Allegation of Inappropriate Referrals to a Non-VA Medical Provider at the VA Southern Nevada Healthcare System

Date of Draft Report: August 31, 2015

Recommendations/ Actions	Status	Completion Date
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OIG recommends that the Under Secretary for Health

Recommendation 1. Ensure that TriWest meets the terms of their Patient-Centered Community Care contract by referring radiation oncology patients to only American College of Radiology-accredited network practices/facilities.

VHA Comments: Concur.

The Veterans Health Administration (VHA's) Chief Business Office for Purchased Care (CBOPC) will ensure TriWest meets the terms of the contract by referring radiation oncology patients to the American College of Radiation or American College of Radiation Oncology (ACRO)-accredited practices and develop a plan to monitor contractor accreditation.

On July 1, 2015, the VHA Assistant Deputy Under Secretary for Health for Operations Management recognized that due to the need for prompt radiation oncology referrals, requiring urgent care should not be processed through Patient-Centered Community Care. Rather, radiation oncology referrals should be processed through sharing agreements and local contracts. According to this guidance, VA facilities without current contracts are to use urgent/emergent non-VA community care funding. VHA CBOPC will pursue a contract modification to clarify that radiation oncology practices accredited by the ACRO must document that a physician radiation oncologist was included in the ACRO on-site survey team.

To complete this action plan, VHA will submit:

1. Accreditation Compliance Audit Plan
2. Proposal to modify contract

Status:
In process

Target Completion Date:
June 30, 2016

Recommendation 2. Determine whether the Patient-Centered Community Care contract with TriWest Healthcare Alliance Corporation needs to be amended to allow referrals to other than American College of Radiology-accredited network practices/facilities.

VHA Comments: Concur.

Current contract provisions for the Patient-Centered Community Care contracts, which address additional accreditation of facilities, are narrower than those provided by the VHA's National Radiation Oncology Program Office contract templates for sharing agreements and local contracts for off-site radiation oncology services.

By completing those contract modifications described for recommendation 1, VHA's Chief Business Office for Purchased Care (CBOPC) will also have adequately addressed recommendation 2, which is to determine whether the subject contract should be amended.

To complete this action plan, VHA will submit:

1. Proposal to modify contract

Status:
In process

Target Completion Date:
June 30, 2016

Recommendation 3. Require the review of medical results for the 15 patients referred to practices/facilities not accredited by American College of Radiology or American College of Radiation Oncology to ensure they received treatment that met VHA standards of care.

VHA Comments: Concur.

VHA strongly believes that evidenced based cancer related treatment and outcomes for Veterans is highly dependent on the delivery of quality assured radiation oncology care. Based upon the information provided, medical records for the 15 patients referred to practices not accredited by American College of Radiology or American College of Radiation Oncology (ACRO) will be reviewed, in an expedited manner. This review will not be able, however, to ensure these Veterans received treatment that met VHA standards of care.

Radiation therapy delivered according to VHA standards must meet the following three criteria:

1. Radiation oncology evaluation was complete, identifying the correct cancer diagnosis and staging.
2. The appropriate therapy, to include additional treatment modalities was prescribed, planned and delivered within appropriate time constraints.
3. The radiation was accurately delivered.

While a review of the medical records can evaluate the first two criteria, in the absence of accreditation, it is not possible to ensure that medical physics operations of the involved practice(s) followed appropriate standards for quality assurance. Additionally, the physical parameters of radiation delivery are not verifiable. There is no way short of a third party evaluation by an independent physicist to know the radiation dose or dose distribution received by these Veterans. It is for these reasons that VHA requires treatment within accredited practices.

To complete this action plan, VHA will submit:

1. An evaluation of each of the 15 Veterans referenced above

Status:
In process

Target Completion Date:
November 30, 2015

Veterans Health Administration
September 2015

Appendix B **OIG Contact and Staff Acknowledgments**

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Matthew Rutter, Director Todd Groothuis Tom Phillips Melinda Toom

Appendix C Report Distribution

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U.S. Senate: Dean Heller, Harry Reid
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Dina Titus

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