Administrative Closure

Alleged Fraudulent Computerized CPRS Documentation

Saginaw VA Medical Center, Saginaw, Michigan

MCI # 2011-03033-HI-0175

On May 24, 2011, the VA OIG Hotline Division received a referral from the Saginaw VAMC (facility) alleging that a physician (the provider) was documenting full physical examinations for patients when he had not conducted any examinations.

On March 8, 2011, a patient complained to the facility's patient advocate alleging incomplete and potentially fraudulent medical record documentation by a facility provider. On March 10, the patient also contacted the facility's Privacy Officer. Facility managers conducted an internal fact-finding investigation and determined that the provider's documentation of physical examinations of multiple patients may not have occurred. It was also discovered that the provider had recorded fraudulent patient information in the Computerized Patient Record System (CPRS).

In March 2011, the provider was removed from clinical care delivery and placed on Administrative Leave. On March 29, 2011, an Issue Brief was sent to the VISN 11 Director regarding allegations of potential fraudulent documentation of patient care.

On April 14, 2011, Facility managers convened an AIB to investigate the allegations. It was determined, following several patient interviews, that physical examinations documented in the patient's medical records did not occur.

The provider resigned his position with the facility on the morning he was scheduled to provide testimony in this matter.

The AIB found that the provider's performance and lack of improvements had been documented in Board Actions and Annual Proficiency Reports as far back as June 2000. For example, in June 2000, the Reappointment/Reprivileging Board Actions stated that "the Board took a dim view on the provider's request" for the following reasons:

- After two years as a practicing internist, the provider has not yet obtained Board certification or ACLC certification, consistent with VA and Medical Center policies.
- Quality Assurance (QA) documentation showed [redacted] (b)(5);5 U.S.C. §705

- (b)(3):38 U.S.C. 5705
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- The Board took an especially dim view of the fact that it appears that the provider is voluntarily reducing his requested privileges to include only one Category III privilege.

The Board unanimously recommended that the provider's privileges and Medical Staff membership be renewed for only six months, and that the provider be offered a performance improvement plan, and be offered counseling to improve his interpersonal relationship/communication skills with patients and staff.

Facility managers contacted the Office of Inspector General (OIG) Criminal Investigation Division after completion of an AIB. After reviewing the allegations, OIG Criminal Investigation Division declined the case. The case was then forwarded to the Office of Healthcare Inspection (OHI) for follow-up.

On October 25, 2011, Facility managers provided OHI managers with a detailed action plan. The plan included the following initial elements.

- Telephone contact to all national and state legislative offices
- Message sent out to all facility employees
- Contacted Veterans Service Officers
- Updated facility's home page on Internet and Intranet to include news release and Frequently Asked Questions (FAQs)
- Local media press release
- Initiate mailing out letters to affected patients (completed October 27, 2011)
- Establish a toll-free number
- Notified Consolidated Patient Account Center Program (CPAC) for possible reimbursements

On October 27, 2011, facility managers sent letters to 527 patients (or families of deceased patients) that were seen by the provider from April 18, 2010 – April 18, 2011. Six of the 527 records were undeliverable, and these veteran's records were flagged to update the address during the next visit.

Facility managers established a toll-free hotline number, staffed by two registered nurses, to answer patients' and families' questions and facilitate scheduling physical examinations upon request. This toll-free hotline number was effective until December 2, 2011. The facility

received 139 patient inquiries: 84 patients requested a new appointment, 19 declined new appointments, and 36 patients preferred to just keep their future scheduled appointment.

According to Facility managers, there were no significant findings identified with the veterans' health status during the additional physical examinations.

In 2008, VHA's Chief Business Office began implementing the Consolidated Patient Account Center (CPAC) program to improve efficiency and accountability in revenue operations. This program ensures that VA medical centers have the ability to bill patient's health insurance carriers.

CPAC identified 99 of the provider's patients that may have potential first party reimbursements which included deceased patients.

On November 23, 2011, Facility managers received notification from the Office of General Counsel to proceed with first and third party reimbursements back one year from the date of April 18, 2011. CPAC staff will review co-pays, cancel charges, and initiate refunds to the identified patients and/or families. Facility managers sampled 5 percent of records to determine if documentation supported the Coding Departments' assigned codes. Documentation supported the codes 100 percent. Results were shared with CPAC to determine if third party reimbursements were warranted. By January 20, 2012, a total dollar amount of $369.50 was refunded to veterans affected by this issue.

During the month of February, 2012, facility managers received a subpoena request from the State of Michigan regarding the provider. The request asked for all documentation reviewed by the Department of Veterans Affairs on this provider. On or around February 21, 2012, information requested was forwarded immediately to the State of Michigan. To-date the State of Michigan's final decision on this case is pending.

According to Facility managers, the provider's Michigan licenses are still active, and there has been no inquiries for this provider, either internal (within VA) or external (private sector facilities).

This case is closed at this time by the Office of Healthcare Inspections.

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