Department of Veterans Affairs
Office of Inspector General

Review of Resident Supervision Documentation and Billing Practices in Veterans Health Administration Facilities

VHA has taken actions that have improved resident supervision. VHA can further strengthen its oversight by ensuring that all resident-provided care is supervised, documented, and billed appropriately.

Report No. 05-01223-56 **January 8, 2007**

VA Office of Inspector General
Washington, DC 20420

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Contents

Executive Summary

The Office of Inspector General reviewed policies and procedures for documenting resident[1] supervision and billing practices for resident-provided care at 10 Veterans Health Administration (VHA) medical facilities. Our objectives were to determine whether: (1) local policies had been implemented that were consistent with VHA policies, (2) documentation in the medical records met requirements, and (3) billable resident-provided care was properly supervised and appropriately submitted for billing.

We found that all 10 facilities had developed local policies that were consistent with the national requirements. In addition, we found that all facilities had created separate procedures for monitoring resident supervision, as required by the handbook. However, facilities did not apply consistent methodologies in their monitoring activities. Because of local variability, VHA may not be able to accurately monitor system-wide resident supervision performance. VHA has demonstrated improvement in several aspects of resident supervision, as evidenced by the national performance measure results, since the time period from which we drew our sample. We found high compliance in inpatient medicine admission assessments. We found adequate compliance in inpatient bed-side procedures and outpatient clinic encounters. However, we identified improvement opportunities in inpatient surgery admission assessments, inpatient continuing care notes, inpatient consultation notes, and surgical pre-procedure evaluations.

We determined that the majority of missed billing opportunities, totaling $1.3 million in the 1st quarter of fiscal year 2005, were due to insufficient documentation of resident supervision, although other problems were also identified. Using the average collection rate for the 10 facilities of 28.4 percent for the same time period, we estimate that the 10 facilities could have increased collections by $367,598.

We recommended that the Acting Under Secretary for Health take actions to ensure that:

(1) Consistent sampling procedures are developed and implemented, when appropriate, to ensure adequate oversight of resident supervision activities for system-wide performance comparisons.

(2) Documented evidence of resident supervision of inpatient admission assessments in surgery; inpatient continuing care and consultation progress notes; and pre-operative procedure notes comply with the documentation standards defined in the handbook.

(3) Billable resident-provided care is properly supervised and appropriately submitted for billing.

The Acting Under Secretary submitted acceptable implementation plans; we will follow up until all actions are complete.

[1] A resident is a physician in an accredited graduate medical education program.

Introduction

Purpose

The Department of Veterans Affairs, Office of Inspector General (OIG) reviewed Veterans Health Administration (VHA) medical facilities' compliance with VHA policy on resident supervision and related billing requirements, as delineated in Handbook 1400.1[2] (the handbook). The objectives were to determine whether: (1) local policies, procedures, and guidelines had been developed and implemented and were consistent with the handbook; (2) medical record documentation reflected the involvement of the attending (supervising) physicians; and (3) billable medical care involving residents occurred in a properly supervised environment, and bills were submitted when appropriate.

Background

VA is the nation's largest provider of graduate medical education and has maintained affiliations with medical schools since 1946. In 2005, 120 VA medical facilities were affiliated with 107 of the nation's medical schools. Over 30,000 residents (a physician in an accredited graduate medical education program) receive a portion of their training at a VA facility each year. Nationally, VA supports 8,800 physician resident positions, and in fiscal year (FY) 2004, appropriations in support of physician education totaled $772 million. Because VA has the authority to bill health insurance carriers for the cost of medical care provided to selected veterans, VHA established resident supervision documentation standards that would also satisfy billing requirements.

In 2002, the VA OIG identified insufficient resident supervision at four VA medical facilities.[3] In 6 of the 29 outpatient clinics inspected, attending physicians were not present to supervise the resident physicians in training. In addition, from 1997 through early 2002, VA paid at least $21 million in malpractice suits related to substandard resident supervision.

In July 2003, the Government Accountability Office (GAO) issued a report concluding that VA did not have sufficient monitoring procedures to assure that resident physicians received adequate supervision.[4] In response, VA required facilities to develop and implement local monitoring procedures on resident supervision.

In 2004, the Acting Under Secretary for Health issued a memorandum advising attending physicians to fully comply with resident supervision requirements. VHA subsequently

[2] VHA Handbook 1400.1, *Resident Supervision*, July 27, 2005.
[3] VA OIG report, *Audit of Veterans Health Administration's Part-Time Physician Time and Attendance* (Report No. 02-01339-85, April 23, 2003).
[4] GAO report, *VA Health Care: Adequacy of Resident Supervision Is Not Assured, but Plans Could Improve Oversight* (Report No. GAO-03-625, July 2, 2003).

issued an updated version of the handbook that mandated facilities to develop local monitoring procedures and required the physical presence of attending physicians in clinic areas. In addition, the handbook described four types of documentation that would satisfy resident supervision and billing requirements by clinical settings, as reflected in the table below:

Clinical setting/activity	***Acceptable Resident Supervision Documentation***			
	Attending physician's independent progress note	Attending physician's addendum to the resident's note	Attending physician's counter-signature of the resident note	Resident's note reflected attending involvement
Inpatient admission assessments	YES	YES	NO	NO
Inpatient continuing care evaluations	YES	YES	YES	YES
Inpatient consultations	YES	YES	YES	YES
Inpatient bedside procedures	YES	YES	YES	YES
Outpatient clinic encounters	YES	YES	YES[5]	YES
Surgical pre-operative evaluations	YES	YES	NO	NO

Also in 2004, VA OIG testified before the House Committee on Veterans Affairs that inadequate documentation contributed significantly to lost opportunities to bill for services. The OIG determined that during the first 2 quarters of FY 2004, about 6,232 outpatient encounters totaling over $1.4 million were not billable because of inadequate documentation. About 71 percent of these encounters involved resident physicians.[6]

In late 2004, VHA's System-wide Ongoing Assessment and Review Strategy (SOARS) program reviewed local policies for compliance with the handbook. For the 68 facilities reviewed by the end of FY 2005, SOARS reviewers reported that most facilities had appropriate policies, data collection monitors, and physical supervision practices, as required by the national policy. SOARS did not review medical records.

In July 2005, VHA issued a revised version of the handbook that enhanced the documentation requirements for new outpatient encounters, intensive care unit settings, and inter-ward or service transfers.

[5] In the 2005 handbook, countersignature is not acceptable for outpatients new to the facility.
[6] U.S. House of Representatives, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, *Fourth Hearing on VA's Third Party Collections*, Washington, D.C., July 21, 2004.

Scope and Methodology

The review covered the 1st quarter of FY 2005 activities at 10 VHA facilities. (See the list below.) We selected facilities with high numbers of residents and locations over a representative geographic distribution system-wide. We conducted our work from March 2005 through June 2006.

Little Rock, AR	New York, NY
San Antonio, TX	Tampa, FL
San Diego, CA	San Francisco, CA
West Haven, CT	Portland, OR
Minneapolis, MN	Milwaukee, WI

We visited 4 of the 10 facilities and interviewed attending and resident physicians, coding and billing staff, compliance officers, and facility managers. We also inspected 20 outpatient clinics at these facilities. For the remaining six facilities, we reviewed medical records remotely and held telephone discussions with key staff.

To determine if resident supervision practices complied with the national policy and provided maximum billing opportunities for care provided by residents, we randomly sampled 69 insured and 69 non-insured encounters involving residents for a total of 138 cases for each of the following patient care settings:[7]

- Inpatient care – medical and surgical discharges.
- Surgical care – pre-operative assessments and operative reports of non-emergent inpatient and outpatient operating room procedures.
- Outpatient care – outpatient primary care and specialty clinic visits.

For the purpose of this review, we used the handbook issued in May 2004 to assess compliance with the documentation requirements. We examined over 2,000 progress notes and reviewed relevant quality management reports and facility performance measure results.

We validated our data during our briefings with facility managers at each site who all concurred with our findings. Final data analyses and validations occurred from March through June 2006.

The review was performed jointly by the OIG's Office of Audit and Office of Healthcare Inspections. The review was conducted in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

[7] See Appendix A, beginning on page 10, for sample methodology and billing results.

Results and Conclusions

Issue 1: Policy Development and Implementation

The handbook provides national policy on documentation requirements for resident-provided care and requires facilities to develop local policies and monitoring procedures on resident supervision. We found that all 10 facilities had developed local policies consistent with the national requirements. In addition, we found that all facilities had created separate policies outlining procedures for monitoring resident supervision in all six clinical settings,[8] as required by the handbook. The handbook was not prescriptive in how cases were selected for monitoring. Consequently, we found that facilities did not apply consistent methodologies in their monitoring activities. For example, the number and type of cases reviewed and the frequency of monitoring varied significantly. This variability may not adequately demonstrate system-wide performance for national comparisons.

Program managers told us that more prescriptive guidelines would not be realistic because facility residency programs differed in size and complexity. However, in FY 2005, VHA introduced a national performance measure that included a specific methodology for monitoring timeliness of attending involvement with resident-provided admissions, independent of program size and complexity. Therefore, we believe VHA could enhance its oversight in this area through increased consistency, to the extent possible and reasonable.

Conclusion

Local policies were consistent with the national guidelines. Facilities appropriately developed local monitoring procedures to measure attending involvement in resident-provided care for the six care settings identified in the national policy. However, because sampling methodologies and procedures varied significantly, VHA would be unable to accurately monitor resident supervision performance system-wide.

Recommended Improvement Action 1. We recommended that the Acting Under Secretary for Health develop and implement consistent sampling methodologies and procedures, whenever appropriate, to ensure adequate oversight of resident supervision for system-wide performance comparisons.

[8] Per the handbook, local policies must include procedures for monitoring resident-provided care in the following six settings: (1) inpatient, (2) outpatient, (3) procedural, (4) emergency, (5) consultative, and (6) surgical.

Issue 2: Adequacy of Documentation

The handbook established acceptable documentation standards for attending physician supervision of resident-provided care. As reflected in the table and descriptions below, we found overall adequate compliance (greater than 80 percent) in the following clinical settings and activities: (1) inpatient medicine admission assessments, (2) inpatient bedside procedures, and (3) outpatient clinic encounters. However, we identified documentation improvement opportunities in the inpatient surgery admissions assessments, continuing care and consultation notes, and surgical pre-procedure evaluations.[9]

Clinical settings/activities	No. of compliant records	Percent compliance*
Inpatient care		
Admission	117	91
Continuing care	722	**64**
Consultations	282	**70**
Bedside procedures	85	89
Outpatient clinic encounters	111	81
Surgical pre-procedure note	84	**63**

* Compliance at less than 80 percent shown in bold.

Inpatient Care Setting

We reviewed the medical records of 138 veterans discharged at the 10 facilities during the 1st quarter of FY 2005. Although overall compliance with timely documentation of inpatient admission assessment requirements was high (91 percent), we found that two-thirds of the non-compliant cases were surgery admissions. The handbook requires attending physicians to document, in the form of either an independent progress note or an addendum to the resident note, evidence of resident supervision by the end of the calendar day following admission. (The related VHA performance measure scores for resident associated admissions in surgery are reflected in the table on the next page.) Low compliance with timely documentation of surgery admissions for about half of the facilities in our sample indicated that further corrective actions were needed.

[9] See Appendix B, on page 13, for facility results.

VHA Performance Measure: Timely Attending Note for Resident Admissions in Surgery		
Facility	**1st Quarter FY 2005 Percent Compliance**	**1st Quarter FY 2006 Percent Compliance**
Little Rock	100	87
Milwaukee	**48**	**65**
Minneapolis	**64**	**73**
New York City	**45**	82
Portland	**53**	**60**
San Antonio	**62**	92
San Diego	90	**53**
San Francisco	90	86
Tampa	**17**	**70**
West Haven	ND*	82
National	**65**	**81**

Target score = 85 percent; scores less than that shown in bold.
****ND = No data reported.***

We also reviewed 1,127 continuing care progress notes, 405 consultation reports, and 95 bed-side procedure notes associated with the same 138 veterans to determine compliance with any of the four types of acceptable documentation standards.

We found that only 64 percent of the continuing care notes and 70 percent of the consultation reports complied with these requirements. Facility compliance rates ranged from 38–100 percent. All facilities had developed progress note templates intended to improve documentation compliance. However, the quality of the templates and the stage of implementation varied by location. Facility managers expected compliance to improve once templates were fully implemented.

While reviewing documentation for inpatient continuing care, we found several progress notes authored by medical students and countersigned by residents, instead of the attending physicians. Because electronic progress notes did not allow more than one countersignature, documented supervision by the attending physicians was not evident. Had residents recorded addendums to the students' notes, the attending physicians could have provided countersignatures that would have satisfied the supervisory requirements. Of the 10 facilities, only 1 required residents to record addendums to the students' notes. The handbook does not address documentation of supervision of medical students. Clear guidance is needed, and facility managers informed us that the Office of Academic Affiliations would be issuing updated guidance related to this issue. Missed billing opportunities related to medical student documentation are reflected in Issue 3.

Our review of documentation requirements for bedside procedures revealed adequate overall compliance. Of the 95 progress notes, 89 percent reflected appropriate supervision. Facilities compliance rates ranged from 65–100 percent.

Outpatient Care Setting

We reviewed 137 resident-provided outpatient encounters in primary care and subspecialty clinics to determine compliance with any of the four types of acceptable documentation standards. While individual facility rates ranged from 29–100 percent, the overall compliance rate was 81 percent.

In addition, we conducted unannounced visits to 20 randomly selected resident-provided clinics where residents provided care to determine if attending physicians were present in the clinic areas, as required by the handbook. Attending physicians were present in all clinics inspected.

Surgical Care Setting

We reviewed 133 pre-operative progress notes of veterans undergoing elective surgical procedures. The handbook requires documented evidence that the attending surgeon has evaluated the patient and either written an independent pre-operative note or recorded an addendum to the resident's progress note. We found that only 63 percent of the notes met this requirement.

Review of the performance measure results system-wide indicates that steady improvements have been made in surgical attending notes, with the 3rd quarter of FY 2006 results at 86 percent, which exceeded the target of 85 percent. We commend VHA for the efforts that have resulted in continuous improvements since the 1st quarter of FY 2005. We believe that continued efforts are necessary and will result in additional improvements.

Conclusion

VHA achieved overall high or adequate compliance with the resident supervision documentation standards in the following areas: (1) inpatient admission assessments in medicine, (2) bed-side procedures, and (3) outpatient clinic encounters. We identified supervision documentation improvement opportunities related to inpatient admission assessments in surgery, inpatient continuing care and consultation notes, and surgical pre-operative evaluations.

Recommended Improvement Action 2. We recommended that the Acting Under Secretary for Health ensure that:

(a) Attending notes for resident admissions in surgery are timely and include either an independent progress note by the attending physician or an addendum to the resident's note, as prescribed by the handbook.

(b) Documented evidence of resident supervision comply with the following requirements of the handbook:

- Inpatient continuing care and consultations progress notes include appropriate evidence of attending supervision.
- Surgical pre-operative notes reflect the attending surgeon's evaluation of the patient and either an independent progress note or an addendum to the resident's note.

Issue 3: Missed Billing Opportunities

The 10 facilities reviewed could have increased collections by $367,598 had clinicians adequately reflected attending involvement in the medical records and had coding and billing staff appropriately complied with billing requirements. During the 1st quarter of FY 2005, 53 cases of resident-provided care were not billed to insurance carriers. Missed billings were primarily caused by insufficient documentation of resident supervision. As a result, all 10 facilities had missed billing opportunities totaling $63,825. Based on the average unbilled amount, we estimate that missed billing opportunities totaled $1.3 million in the 1st quarter of FY 2005.[10] Using the Medical Care Collection Fund (MCCF) average collection rate for the 10 facilities of 28.4 percent for the same time period, we estimate that the 10 facilities could have increased collections by $367,598.

The 53 cases with missed billing opportunities had 306 billable episodes of care, as described and reflected in the table on the next page, of which 73 percent (223/306)[11] were related to resident supervision.

We found that the medical records for 55 percent (168/306) of billable episodes did not contain adequate documentation of resident supervision. We found 134 episodes of resident-provided care did not contain adequate documentation of the attending physician's involvement, totaling $16,734 in missed billing opportunities. The remaining 34 episodes of care were provided by medical students, with documentation of supervision by a resident physician. However, there was no evidence of supervision by the attending physicians, which is required for billing. This resulted in $4,294 in missed billing opportunities.

In some instances, coding staff mistakenly concluded that documentation did not indicate adequate resident supervision. As a result, these episodes were not coded and, consequently, not billed. This was primarily due to lack of coding experience. For example, staff at one facility only coded an episode of care if an addendum by an attending physician was present. In one case, a separate note was written by the attending physician, which was sufficient for billing. Staff at another facility did not interpret an attending physician's co-signature to a resident physician's note as acceptable for billing. We found 55 missed billing opportunities totaling $13,263.

[10] See Appendix A.
[11] The numerator excludes the number of episodes caused by coder/biller error.

Coding and billing staff made additional types of errors. For example, claims were submitted to the insurance carrier but denied for payment because the patient's identification number was incorrectly input by billing staff. At another facility, bills were mistakenly cancelled. As a result, there were 83 missed billing opportunities totaling $29,534 (see table below).

	Inpatient		Outpatient		Surgery		Totals	
Causes	**N***	**Dollars**	**N**	**Dollars**	**N**	**Dollars**	**N**	**Dollars**
Insufficient documentation	130	$16,158	4	$576	-	-	134	$16,734
Medical student documentation	34	4,294	-	-	-	-	34	4,294
Not coded – related to resident supervision issues	53	7,021	1	70	1	$6,172	55	13,263
Coder/biller error	74	12,529	4	1,189	5	15,816	83	29,534
Totals	291	$40,002	9	$1,835	6	$21,988	306	$63,825

*N= Number of billable encounters/episodes of care.

Conclusion

Improved documentation of resident supervision and procedures for billing insurance carriers would enhance revenue collections. Based on the average unbilled amount, we project that in the 1st quarter of FY 2005, the 10 facilities missed billing opportunities for 768 admissions, 638 outpatient visits, and 97 surgeries, totaling $1.3 million. Using the MCCF average collection rate for the 10 facilities of 28.4 percent for the same period, the 10 facilities could have increased collections by $367,598 ($1,294,361 x .284). The results of each facility's review were reported to the facility's managers, who concurred with the findings.

Recommended Improvement Action 3. We recommended that the Acting Under Secretary for Health ensures that adequately documented resident-provided care is appropriately billed.

Acting Under Secretary for Health Comments

The Acting Under Secretary for Health concurred with the recommendations and provided implementation plans with target completion dates. The full text of the comments is shown in Appendix C.

Inspector General Comments

The Acting Under Secretary for Health's comments and implementation plans are responsive to the recommendations. We will continue to follow up until all actions are complete.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

SAMPLE METHODOLOGY AND BILLING RESULTS

The overall objective was to assess VHA medical facilities' compliance with national VHA policy on resident supervision and related billing requirements during the 1st quarter of FY 2005. To accomplish our objective, the Austin Automation Center provided us with a listing of three separate universes of patient care (inpatient, outpatient, and surgical) for 10 facilities. From each universe, we extracted and reviewed a random sample of 138 cases (69 insured and 69 non-insured). The sample was based on attribute sampling at a 95 percent confidence level with a 5 percent error rate.

Inpatient Care Setting

Universe

The universe consisted of 10,300 discharges with length of stays of more than 2 days. We randomly sampled 69 of 1,394 insured cases and 69 of 8,906 non-insured cases as shown below.

Facility	Insured Cases	Non-Insured Cases	Total Inpatient Sample Size
1. Little Rock, AR	10	10	20
2. Milwaukee, WI	6	5	11
3. Minneapolis, MN	9	9	18
4. New York City, NY	7	6	13
5. Portland, OR	6	6	12
6. San Antonio, TX	8	7	15
7. San Diego, CA	5	6	11
8. San Francisco, CA	5	6	11
9. Tampa, FL	10	10	20
10. West Haven, CT	3	4	7
Totals	**69**	**69**	**138**

Our review showed that 38 (55 percent) of the 69 insured inpatient cases involving resident physicians, totaling $40,002, should have been billed but were not. Based on our sample results, we projected that the universe of 1,394 insured inpatient cases contained 768 cases that were not billed to insurance carriers. This projection has a confidence interval of +/- 11.443 percent, resulting in a lower limit of 608 cases and an upper limit of 927 cases. Based on the average unbilled amount of $1,053 per case ($40,002/38), we estimate that the 768 cases totaled $808,704 in unbilled care.

Based on the MCCF average collection rate for the 10 facilities of 28.4 percent for the 1st quarter of FY 2005, we estimate that the 10 facilities could have increased collections by $229,672 ($808,704 x .284).

Outpatient Care Setting

Universe

The universe consisted of 25,845 encounters. We randomly sampled 69 of 4,889 insured cases and 69 of 20,956 non-insured cases as shown below.

Facility	Insured Cases	Non-Insured Cases	Total Outpatient Sample Size
1. Little Rock, AR	6	7	13
2. Milwaukee, WI	5	4	9
3. Minneapolis, MN	9	9	18
4. New York City, NY	11	11	22
5. Portland, OR	3	4	7
6. San Antonio, TX	5	4	9
7. San Diego, CA	7	7	14
8. San Francisco, CA	5	5	10
9. Tampa, FL	9	10	19
10. West Haven, CT	9	8	17
Totals	**69**	**69**	**138**

Our review showed that 9 (13 percent) of the 69 insured outpatient cases involving resident physicians, totaling $1,835, should have been billed but were not. Based on our sample results, we projected that the universe of 4,889 insured outpatient cases contained 638 cases that were not billed to insurance carriers. This projection has a confidence interval +/- 7.891 percent, resulting in a lower limit of 252 cases and an upper limit of 1,023 cases. Based on the average unbilled amount of $204 per case ($1,835/9), we estimated that the 638 cases totaled $130,152 in unbilled care.

Based on the MCCF average collection rate for the 10 facilities of 28.4 percent for 1st quarter FY 2005, we estimated that the 10 facilities could have increased collections by $36,963 ($130,152 x .284).

Surgical Care Setting

Universe

The universe consisted of 8,275 encounters. We randomly sampled 69 of 1,115 insured cases and 69 of 7,160 non-insured cases as shown on the next page.

Facility	Insured Cases	Non-Insured Cases	Total Surgery Sample Size
1. Little Rock, AR	10	10	20
2. Milwaukee, WI	5	5	10
3. Minneapolis, MN	9	10	19
4. New York City, NY	9	9	18
5. Portland, OR	5	6	11
6. San Antonio, TX	6	5	11
7. San Diego, CA	7	8	15
8. San Francisco, CA	6	5	11
9. Tampa, FL	7	7	14
10. West Haven, CT	5	4	9
Totals	**69**	**69**	**138**

Our review showed that 6 (9 percent) of the 69 insured surgery cases involving resident physicians, totaling $21,988, should have been billed but were not. Based on our sample results, we projected that the universe of 1,115 insured outpatient cases contained 97 cases that were not billed to insurance carriers. This projection has a confidence interval +/- 6.44 percent, resulting in a lower limit of 25 cases and an upper limit of 169 cases. Based on the average unbilled amount of $3,665 per case ($21,988/6), we estimate that the 97 cases totaled $355,505 in unbilled care.

Based on the MCCF average collection rate for the 10 facilities of 28.4 percent for the 1st quarter of FY 2005, we estimate that the 10 facilities could have increased collections by $100,963 ($355,505 x .284).

Appendix B

FACILITY RESULTS – DOCUMENTATION

Facility	Documentation Review	Inpatient				Outpatient	Surgery
		Admission	Cont. Care	Consultation	Procedure		
Little Rock	Documentation complied with policy	17	105	41	11	10	13
	Percent met requirements	**89%**	**53%**	**40%**	**65%**	**77%**	**65%**
Milwaukee	Documentation complied with policy	11	48	16	11	8	4
	Percent met requirements	**100%**	**57%**	**48%**	**100%**	**89%**	**50%**
Minneapolis	Documentation complied with policy	16	64	22	6	17	17
	Percent met requirements	**100%**	**50%**	**63%**	**75%**	**94%**	**89%**
New York	Documentation complied with policy	13	82	33	7	15	11
	Percent met requirements	**100%**	**82%**	**83%**	**88%**	**68%**	**69%**
Portland	Documentation complied with policy	11	77	55	10	2	5
	Percent met requirements	**92%**	**58%**	**87%**	**83%**	**29%**	**45%**
San Antonio	Documentation complied with policy	15	94	23	17	8	7
	Percent met requirements	**100%**	**84%**	**88%**	**100%**	**89%**	**64%**
San Diego	Documentation complied with policy	6	40	5	2	11	5
	Percent met requirements	**60%**	**67%**	**56%**	**100%**	**79%**	**33%**
San Francisco	Documentation complied with policy	10	26	9	7	8	10
	Percent met requirements	**91%**	**38%**	**75%**	**100%**	**80%**	**91%**
Tampa	Documentation complied with policy	12	108	43	7	15	7
	Percent met requirements	**80%**	**65%**	**86%**	**100%**	**83%**	**50%**
West Haven	Documentation complied with policy	6	78	35	7	17	5
	Percent met requirements	**86%**	**99%**	**100%**	**100%**	**100%**	**63%**
Totals	All sample cases					138	138
	No. of episodes of care	138	1,235	417	99	138	138
	No. of episodes of care with residents	129	1,127	405	95	137	133
	Documentation complied with policy	117	722	282	85	111	84
	Percent met requirements	**91%**	**64%**	**70%**	**89%**	**81%**	**63%**

Appendix C

Acting Under Secretary for Health's Comments

Department of Veterans Affairs **Memorandum**

Date: November 8, 2006

From: Acting Under Secretary for Health (10)

Subject: OIG Draft Report: **Review of Resident Supervision Documentation and Billing Practices in Veterans Health Administration Facilities** (Project No. 2005-01223-HI-0160/EDMS 362400)

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed your assessment of resident supervision documentation and billing practices in Veterans Health Administration (VHA) medical facilities and concur with your findings and recommendations. I particularly appreciate OIG's acknowledgment that our actions within the last several years have resulted in notable improvement in resident supervision, a conclusion that reflects our own encouraging oversight findings. Although I agree with your estimate of increased collections based on data that were available to you at the time of your review, I am also confident that the same assessment made today would probably identify a significant reduction in missed billing opportunities, in view of evidenced improvement in supervisory documentation. The attached action plan details VHA's plans to address each of your recommendations.

2. During the last 5 years, VHA has greatly increased the expectations regarding supervision of resident physicians. Beginning with the 2004 version of VHA Handbook 1400.1, *Resident Supervision*, requirements for supervising practitioners were expanded to include presence in the clinic, emergency department, and the operating room. Standards for the documentation of resident supervision were clarified and strengthened, and policy established by the Office of Academic Affiliations mandated establishment of local monitoring processes and procedures for monitoring specific clinical settings. As you report, VHA also designed and implemented a national performance measure in 2004 that focused on resident supervision. As an inpatient measure, supervising attending

admission notes for medicine, psychiatry, and surgery were monitored for timeliness. Current results from the measure show impressive improvement in the last 2 years. For example, surgical service has moved from a compliance rate of 65 percent in the first quarter of FY 2005 to an 86 percent rate of compliance in the third quarter of FY 2006. Medicine and Psychiatry held steady during the past fiscal year with compliance rates of 96 percent and 97 percent, respectively. I anticipate that fourth quarter data will support this improvement trend. Beginning in late 2005, VHA also added performance measure monitoring in the neurology and rehabilitation medicine bed services, with results showing excellent compliance thus far.

3. As your report stresses, most resident supervision monitoring processes are generally locally driven and overseen by facility and Veterans Integrated Service Network (VISN) leadership. Although all components of care must be monitored, each facility may choose which aspect of care to monitor, which clinics to monitor and with what frequency, and how to decide to discontinue one monitor and begin another. Because each of our facilities has a unique mission and a unique mix of patient care services, this decentralized oversight approach was deliberately chosen to maximize patient safety and quality of care.

4. Nevertheless, I agree with you that our efforts might benefit from more consistent sampling methodologies and procedures in specific areas where a more systematic process can be reasonably applied to facilitate national performance comparisons. In that regard, VHA will add an additional component to the Annual Report on Residency Training Programs (ARRTP) and will recommend, on an annual basis, a particular setting and sample size to be monitored for cross-facility comparisons. The ARRPT is a yearly roll-up of a subset of resident supervision information. The data are generated through a web-based interface with all facilities, whose clinical managers input details of their resident monitoring processes, including types of monitors, record sampling techniques, frequency of sampling, etc. Facilities must also report on their local monitoring process for each clinical site or activity and provide compliance percentage levels. The Office of Academic Affiliations (OAA) reviews and analyzes these data and prepares an annual summary report for VHA and VISN leadership. OAA is currently assessing which clinical areas can be recommended for such standardized monitoring and is expected to identify some options by February 2007. We will provide additional information to you about our decisions in status updates to this report.

5. VHA has also intensified efforts to assure that billable resident care is appropriately submitted for billing. On July 26, 2006, VHA released Directive 2006-045, *Monitoring Use of the "-GR" Billing Modifier*, that includes three additional monitors related to resident supervision. These new monitors, when fully implemented within the next several months, should facilitate billing third-party payers for services provided in whole or in part by residents by flagging episodes of unbilled care. This new directive, used in conjunction with VHA Billing Directive 2005-054, *Revised Billing Guidance for Services Provided By Supervising Practitioners and Residents* (November 21, 2005), provides ample direction in ensuring that all properly supervised resident-related care is coded and billed appropriately. Ongoing training has been provided to coding and billing staff to maximize compliance with the directives. As OIG reports, missed billing opportunities they identified at the ten sites were primarily caused by insufficient documentation of resident supervision. Based on the current high levels of documentation compliance, we expect to see a corresponding increase in billing submissions.

6. In summary, I believe that VHA has made significant progress over the past 5 years in improving many components of our resident supervision program. I recognize, of course, that this is an ongoing process involving coordinated action and oversight monitoring at all organizational levels. We are committed to maintaining established improvement trends. If additional information is required, please contact Margaret M. Seleski, Director, Management Review Service (10B5), at 565-7638.

(original signed by:)
Michael J. Kussman, MD, MS, MACP

Attachments

VHA Action Plan

OIG Draft Report
Review of Resident Supervision Documentation and Billing Practices in Veterans Health Administration Facilities (Project No. 2005-01223-HI-0160)

Recommendations/ Actions	Status	Completion Date

We recommend that the Acting Under Secretary for Health takes actions to ensure that:

1. Consistent sampling procedures are developed and implemented, when appropriate, to ensure adequate oversight of resident supervision activities for system-wide performance comparisons.
Concur

Although VHA supports a decentralized, locally driven monitoring process to meet the unique needs of our facilities, VHA also recognizes that system-wide performance comparisons, using standardized monitoring procedures, are also important oversight tools. VHA currently ensures a roll-up of a subset of resident supervision information on an annual basis through the Annual Report on Residency Training Programs (ARRTP). Through this web-based interface, all facilities that train physician residents must submit a wide range of data on their supervision monitoring processes. The Office of Academic Affiliations (OAA) will include an additional component to the ARRTP and will recommend a particular setting and sample size to be monitored by each facility each year to enable cross-facility comparisons.

Proposed systematic monitoring options are now being considered by OAA, with setting and sample size decisions anticipated by February 2007. Instructions will be disseminated to field facilities by the end of May 2007, and facilities should begin collecting data in July 2007, at the beginning of the new academic year.

	In Process	July 2007 and Ongoing

2. Documented evidence of resident supervision of inpatient admission assessments in surgery; inpatient continuing care and consultation progress notes; and pre-operative procedure notes comply with the documentation standards defined in the handbook.
Concur

The OIG report was based on a review that was conducted in the first quarter of FY 2005, at the initiation of the resident supervision performance measure. At that time, inpatient surgery compliance with the resident supervision performance measure was only 65 percent. The most recent findings (third quarter, FY 2006) report a surgical compliance rate of 86 percent, a remarkable gain. VHA believes that if surgery were monitored again, the results of the review would show much improvement and substantial compliance with respect to the surgical attending admission and pre-operative note requirements.

Continuing care notes and consultation reports require that the resident name the supervising practitioner in the text of the note, the attending co-signs the note, or writes an independent note or addendum. Standardization of templates that require the naming of the attending physician is of paramount importance in each facility in order to ensure compliance with documentation requirements. By the end of November 2006, OAA will provide guidance to the facilities to evaluate all templates used by physician residents to ensure that the entry of the supervising practitioner is a mandatory field that cannot be bypassed.

VHA acknowledges that policy clarification on the use of medical student documentation in the medical record is also needed. Interim information on the topic has been posted on the OAA website in the Frequently Asked Questions section. OAA will supplement this information with official guidance to be released by May 2007.

In Process May 2007 and Ongoing

3. Billable resident-provided care is properly supervised and appropriately submitted for billing.
Concur

The report concludes that the missed billings at the ten visited sites were based primarily on insufficient documentation of resident supervision. As already reported, significant improvements in supervisory documentation compliance have been validated since the time of OIG's review, and it is

anticipated that levels of missed billing opportunities have been subsequently lowered.

Nevertheless, VHA has expanded efforts to assure maximum billing submissions. For example, on July 26, 2006, a new VHA Directive, *Monitoring Use of the "-GR" Billing Modifier*, was released. This directive instructs the field in three additional monitors related to resident supervision:

1. Monitoring for the discontinuation of usage of GC and GE modifiers
2. Monitoring that the GR modifier, when used, is used correctly
3. Monitoring for all episodes of resident-related care, for which the GR modifier is not used to bill for care

VHA believes that these new monitors, when fully implemented by the end of December 2006, will serve to accurately and efficiently call attention to unbilled resident-related care and to ensure that VHA has systems in place to ensure that all properly supervised resident-related care is coded and billed appropriately.

In Process December 2006 and Ongoing

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Julie Watrous, Director Office of Healthcare Inspections, Los Angeles Region (213) 253-5134
Acknowledgments	Daisy Arugay Elizabeth Bullock Robin Frazier Joseph Janasz Gilbert Melendez Dao Pham Carla Reid John Tryboski William Withrow

Appendix E

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