

STATEMENT OF WORK (SOW)
COMPLIANCE AND BUSINESS INTEGRITY (CBI) AUDITS
AND CLAIMS ANALYSIS SERVICES FOR
VETERANS INTEGRATED SERVICE NETWORK (VISN) 16 MEDICAL FACILITIES
(May 8, 2018)

SECTION I - CBI AUDITS

SECTION II - CLAIMS ANALYSIS

SECTION I - CBI AUDITS

- 1) The contractor shall provide all labor, tools, materials, equipment, facilities, transportation and supervision necessary to perform off-site electronic Compliance and Business Integrity (CBI) Audits for VISN 16 Department of Veterans Affairs Medical Centers, in accordance with the terms and conditions of the contract and all attachments thereto. CBI Audits shall be completed using authorized VA forms and tools in accordance with VA guidelines. The potential exists for indicator process changes to be made at the direction of the VA Compliance and Business Integrity Office (CBIO), annually or otherwise. Should VA make modifications to the requirements of the CBI Audits, the contractor shall make such modifications at no additional cost to the VA within the records to be audited, facilities may determine that adjustments in types of records audited are needed, based on current indicators. Work will be performed for the following medical center facilities and their affiliate facilities only:

Alexandria, LA - 100B/100NB
Biloxi, MS - 50B/50NB
Fayetteville, AR - 100B/100NB
Houston, TX 100B - 100B/100NB
Jackson, MS - 100B/100NB
Little Rock, AR - 100B/100NB
New Orleans, LA - 100B/100NB
Shreveport, LA - 100B/100NB

- 2) Minimum Experience Requirements:
 - a) Auditors must have a minimum of five years' experience completing VA CBI audits.
 - b) Auditors must have a minimum of five years' experience completing provider audits.
 - c) Auditors must have a minimum of five years' experience performing one on one training for VA providers
 - d) Auditors must have a minimum of five years' experience completing E/M audits, surgical audits and extensive experience with ICD-10 audits.

- e) Auditors must have a minimum of five years' experience completing VA DRG audits and inpatient pro fee audits.
 - f) Auditors must have a minimum of five years' experience completing, Non-VA care audits.
 - g) Auditors must have a minimum of five years' experience training VA coders and providing support for coding issues and questions
 - h) Auditors must have a minimum of ten years' experience as a coder, certified through AHIMA or AAPC
- 3) Summary reports shall be completed in addition to individual report forms and forwarded to the Compliance Officer and HIM's chief at the respective VAMC.
- 4) VA required forms shall be used in completion of the audits and forwarded electronically to each VAMC Compliance Officer and HIM's Chief by close of business on the 20th calendar day following the end of the month audited.
- 5) Additional services shall include:
- a) Five (5) Provider audits per month, samples to be pulled by the contractor prior to coding, rotating by provider.
 - b) Fifty (50) Fee Basis audits per quarter as requested by the Compliance Officer, to be performed and charged only when requested by the medical center(s) Compliance Officer.
 - c) Actively assist the HIM's chief or authorized coordinator with regard to coding issues.
 - d) Annual visit to requesting VAMCs at contractor's expense.
 - e) Additional visits to medical center(s) as deemed necessary by the Compliance Officer per the Schedule of costs.
- 6) Indicator Specifications
- I. Indicator Identifier #1
 - a) Indicator Name: Medical Record Coding Accuracy for Billed Claims
 - b) Indicator Statement: Percent accurate codes assigned for billed inpatient DRG and outpatient professional services.
 - c) Indicator Numerator Statement: Total # of correct codes assigned
 - d) Indicator Denominator Statement: Total # of codes assessed 1
 - e) Indicator Focus: Domain: Quality, Non-clinical
 - II. Indicator Topic Relevance
 - a) Rationale: In governmental oversight reviews by the IG and GAO, medical record coding accuracy was found to be less than industry standard. Numerous VA facilities have been on 100% review after third party payers identified coding inconsistencies.
 - b) Summary of findings of literature review: American Health Information Management Standards of Ethical Coding defines how codes should be assigned. The Department of

Health and Human Services Office of Inspector General Work Plan includes review of accuracy of coding of evaluation and management services and diagnosis related groups. Common Procedural Terminology (CPT) Guidelines Correct Coding Initiative VHA Handbook for Coding Guidelines.

- c) Strategic Importance: Promotes quality and operational integrity and contributes to increased MCCF collections through efficient and ethical business practices.

7) Definition of Terms

Ambulatory Care: All types of health services provided on an outpatient basis, in contrast to services provided in the home or to persons who are hospitalized. The term ambulatory care usually implies that the patient has come to a location other than his home to receive care or services and has departed the same day. Ambulatory care services are often referred to as outpatient services.

Ancillary Services: Those services other than room, board, medical, and nursing services, such as laboratory, radiology, pharmacy, and therapy services that are provided to patients in the course of care. An ancillary service does not include the exercise of independent medical judgment in the overall diagnosing, evaluating and/or treating the patient's conditions. An ancillary service is usually the result of an encounter.

Billable: Encounter Treatment provided to veteran covered by a third-party health plan (excluding TRICARE) for a non-service connected condition.

Coding: The process of assigning a number (alpha, numeric, or a combination of both) from a recognized and approved coding classification system that properly identifies and defines medical services, procedures and diagnoses.

Consolidated Patient Account Center (CPAC): A revenue operations center that performs billing and collections activities for more than one VA Medical Center.

Correct Coding Initiative: Definitions by Medicare of procedures that cannot be reported together because: 1) they are considered bundled because it is the standard of care, violates the separate procedure CPT rule, or payment is specifically prohibited; or 2) the procedures are mutually exclusive, the codes contain a definition of with and without an additional service or codes are in the same family.

CPT: Current Procedural Terminology, 4th Edition, published by the American Medical Association (AMA). A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians, or performed under the supervision of a physician. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services, and will thereby provide an effective means for reliable nationwide communication among physicians, patients, and third parties.

Diagnosis: The identity of a medical condition, cause or disease.

DRG: A method of dividing hospital patients into clinically coherent Diagnostic Related Groups based on the consumption of resources. Patients are assigned to the groups based on their principal diagnosis (the reason for admission, determined after study), secondary diagnosis, procedures performed and the

patient's age, sex, and discharge status. These groups form the basis of one payment methodology for inpatient care.

E-Code: Code describing the external cause of an injury. E-codes cover an extensive range of mishaps, such as auto accidents, train wrecks, and even poisoning.

E&M Codes: A subsection of CPT codes entitled Evaluation & Management codes introduced in 1992 to classify physician services.

HCPCS: Centers for Medicare and Medicaid Services (CMS) Common Procedural Coding System (HCPCS) is a coding system that was developed by CMS for the purpose of standardizing the coding systems used to process Medicare claims on a national basis. The HCPCS coding system is used to bill primarily for supplies, materials and injections. It is also used to bill for certain procedures and services that are not defined in CPT. HCPCS is a three-level coding system which incorporates CPT, national and local level codes. HCPCS level 1 is CPT codes. HCPCS level 2 is national level modifier codes which are uniform in description throughout the United States. HCPCS level 3 modifiers are maintained by the local Medicare intermediary and will vary from state-to-state. HCPCS Level 3 codes are used to report supplies, materials, injections, and procedures not defined in CPT.

ICD-CM: International Classification of Diseases, Clinical Modification (ICD-CM) is a nomenclature developed by the World Health Organization and modified for use within the United States to classify morbidity and mortality information for statistical purposes, and for the indexing of hospital records by disease, diagnosis and operations.

ICD-10-CM: ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). It codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases. The code set allows more than 14,400 different codes and permits the tracking of many new diagnoses. The codes can be expanded to over 16,000 codes by using optional sub-classifications.

Inpatient: A patient who has been admitted to a hospital or other health facility for the purpose of receiving diagnostic treatment or other medical services. VHA inpatients are classified on the Gains and Loss sheet and through the Patient Treatment File (PTF).

Insufficient documentation: Existing documentation is insufficient to base code assignment, i.e., "Patient doing well".

Medical Necessity: Medical necessity is defined as tests and services that are determined to be reasonable and necessary: Documentation supporting diagnosis codes assigned for procedures performed must be legibly maintained in the medical record. Physicians must provide the specific symptom, sign, or diagnosis at the time the service is ordered. Each facility should have a process in place to identify appropriateness of services to be rendered.

Modifier: A modifier provides the means by which the reporting provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. For this review, only the following modifiers will be considered when monitoring errors:

- 21 Prolonged E&M
- 22 Unusual procedure services
- 24 Unrelated E&M by Same Physician during Postoperative period
- 25 Separate E&M by Same Physician during Postoperative period
- 47 Anesthesia by Surgeon
- 50 Bilateral procedure
- 52 Reduced services
- 53 Discontinued procedure
- 54 Surgical care only
- 55 Post op management only
- 56 Preoperative management only
- 57 Decision for surgery
- 58 Staged or related procedure or service by Same Physician during postoperative period
- 59 Distinct procedural service
- 62 Two Surgeons
- 66 Surgical Team
- 76 Repeat procedure by same physician
- 77 Repeat procedure by another physician
- 78 Return to operating room for a related procedure during postoperative period
- 79 Unrelated procedure or service by Same Physician during Postoperative period
- 80 Assistant Surgeon
- 81 Minimum Assistant Surgeon
- 82 Assistant Surgeon (when qualified resident not available)
- GR This service has been performed by a resident with the appropriate level of supervision and documentation of a teaching/attending physician

Mutually Exclusive Code Pairs: These CPT codes represent services or procedures that, based on either the CPT definition or standard medical practice, would not or could not reasonably be performed at the same session by the same provider on the same patient. Mutually exclusive procedures are those procedures that cannot be reasonably performed during the same session.

No documentation for encounter: No progress note exists to support the encounter.

Non-Billable encounter: Treatment provided to a Veteran beneficiary for which a third-party payer cannot be billed.

Non-Physician Practitioner: A health care professional who is not a physician. Examples of non-physician Practitioners are nurse practitioners, physician assistants, and certified registered nurse anesthetists.

PCE: Patient Care Encounter is VISTA software, which enables transmission of an ambulatory encounter, inpatient professional fees, or ancillary service data to the National Patient Care Database. A patient must be assigned to a clinic through either scheduling or through the Automated Information Collection System (AICS) manual data entry option. PCE direct data entry, PIMS checkout, AICS, Laboratory and Radiology are the only nationally released applications currently entering data into PCE.

Provider: A business entity which furnishes health care to a consumer. For VHA purposes, a VA medical center, to include its identified divisions and satellite clinics is considered to be the business entity furnishing health care at the organizational level.

Separate Procedures: CPT codes are occasionally provided as part of a more comprehensive procedure. When this occurs, these codes should be submitted with their related and more comprehensive codes, designating a "separate procedure". This indicates that the procedure, while possible to perform separately, is generally included in the more comprehensive procedure code and should not be billed separately.

Significant procedure: An inpatient procedure that affects the DRG assignment.

Unbundling: The practice of a provider billing for multiple components of a service that were previously included in a single fee or defined in one CPT code. The practice of unbundling CPT codes results in excessive undue payments from third party insurance carriers and is a prohibited practice. For example, if the cost of dressings and instruments are included in a fee for a minor procedure, unbundling would cause a fee for the procedure as well as additional charges for the dressings and instruments.

Undercoding (Downcoding): The process of selecting a code for a service this is less intense, extensive, or has a lower charge than the service actually provided.

Upcoding: The process of selecting a code for a service that is more intense, extensive, or has a higher charge than the service actually provided.

Vesting Provider: Only certain clinicians are authorized to Vest patients in the VHA. The list of vesting clinicians include physicians (including the supervising physicians of medical residents), physician assistants, clinical nurse specialists and nurse practitioners. In general, these clinicians are recognized as providers that perform primary care in outpatient settings. The "person class" field in the VHA database identifies the VHA professional, and the precise list of clinicians.

Note: that the Vesting provider does not need to be identified as the "primary provider" on the encounter but must be one of the providers identified as part of the encounter.

- Indicator Inclusion Criteria: Indicator will monitor inpatient and outpatient professional fee.
- Indicator Exclusion Criteria: Laboratory, radiology, and telephone services will not be included in the data universe for this indicator.

- Risk Adjustment Requirements: *NI A*
- Specification of Final Strategic Target and Target Rationale:
- Calculation/Scoring:

Contractor shall complete the Outpatient Coding Monitor Worksheet, DRG Monitor Worksheet, and VAMC Coding Audit Summary Sheet. The reasons for determination of an incorrect code are included below. These reasons will be tabulated on the worksheets provided with the indicator.

8) Outpatient and inpatient fee encounters:

- a) Is the E&M code correct? (Yes or No or *NI A*) Reasons for incorrect code:
 - 1) Insufficient documentation
 - 2) Undercoded
 - 3) Upcoded
 - 4) Missing (not coded)
 - 5) Provider cannot use that level of E&M code
 - 6) Provider cannot use E&M codes
 - 7) E&M code bundled into another CPT code
 - 8) Wrong E&M type assigned (new/established/consult/preventative medicine)
 - 9) No documentation for encounter
- b) Is the primary procedure code correct? (Yes or No or *NI A*) Reasons for incorrect code:
 - 1) Insufficient documentation
 - 2) Missing (not coded)
 - 3) Incorrect code selected
 - 4) No documentation for encounter
- c) Are secondary CPT/HCPCS codes correct? (yes or No or *N/A*) Reasons for incorrect code:
 - 1) Insufficient Documentation
 - 2) Missing (not coded)
 - 3) Unbundled codes
 - 4) Incorrect code selected
 - 5) No documentation for encounter
- d) Are modifiers assigned correctly? (Yes or No or *NI A*). Reasons for incorrect code: (Use the list provided under definitions)
 - 1) Modifier should not be used
 - 2) Missing (not coded)
 - 3) Incorrect modifier assigned
 - 4) Modifier assigned to the wrong code
 - 5) No documentation for encounter
- e) Is the primary diagnosis coded correct? (Yes or No or *NI A*) Reason Codes:
 - 1) Insufficient documentation
 - 2) Missing (not coded)
 - 3) Lack of specificity (4th or 5th digit incorrect)
 - 4) Incorrect code selected
 - 5) No documentation for encounter

Note: Occasion of service locations, i.e. lab, radiology and EKG, will not have a primary diagnosis. (Only applies to outpatient encounters)

f) Were the secondary diagnoses coded correctly (only review up to 4)? (Yes or No or *N/A*) Reason Codes:

- 1) Insufficient documentation
- 2) Missing (not coded)
- 3) Lack of specificity (4th or 5th digit incorrect)
- 4) Incorrect code selected
- 5) No documentation for encounter

9) Procedures

The number of billable inpatient discharges will be the basis for the DRG reviews. Worksheets shall be used for coding and documentation monitoring.

- a) Review the documentation for each encounter and compare the documentation to the coded data reported in Patient Care Encounter file (PCE)
- b) If the Coding Monitor Worksheet (DRG/OPT) is being used, this form will automatically calculate the totals and accuracy rates in each column if data is entered electronically on the form. These totals will then transfer to the Coding Audit Summary Sheet. If the Summary Sheet is the worksheet being utilized, this too, will calculate the percentages.
- c) The following explanation of terms and definitions are provided to help clarify documentation results. These definitions apply to both outpatient and inpatient reviews:
 - 1) The E&M (# 1) and the other CPT (#2) are mutually exclusive. If an E&M was entered inappropriately, or should have been entered and wasn't, the error is listed in #1. All 908xx series codes will be considered "non-E&M services" even when an E&M service is included, as in code 90805.
 - 2) Sequencing will not be considered a factor in secondary CPT (#3) or secondary diagnoses (#6).
 - 3) E codes cannot be coded as a primary diagnosis.
 - 4) V codes in the secondary position will be excluded.
 - 5) Violations of the Correct Coding Initiative (bundling) will be counted as errors in the secondary CPT code review when bundled codes are listed separately.

10) Coding Monitor Worksheets (DRG/OPT): These forms are to be used by all facilities and VISNs.

11) Medical Center Audit Summary Sheet: This form is required for use and should not be altered.

12) Documentation Audit Form: This form is provided as a tool designed to improve the completeness of documentation that supports the results of your monitoring process. The use of this form is highly encouraged but is at the discretion of the VISN. Other electronic tools that VISN may currently use may be substituted if similar information is captured.

13) Algorithm

Accuracy will be scored measured as a percentage: Number of codes correctly assigned/Total number of codes assigned. The minimum business standard for accuracy output is 95 percent.

14) Data Collection

a) Audit Worksheet

The Data Collection Tool contains formulas to automatically calculate the results of the monitor. The tool contains five tabs; one for outpatient coders, one for inpatient coders, a summary tab that will calculate the medical center coder results, a provider coding tab and a provider summary tab. NOTE: All calculations will occur provided the formulas are not altered.

b) Outpatient Coder Audit Worksheet

The worksheet contains labeled columns for each section: Patient Name, last 4; date of service; coded by and then the coding categories of E/M, Principal CPT codes, secondary CPT codes, Primary Diagnosis code, secondary dx codes and modifiers. The worksheet also contains a "Legend" that describes reasons why the selected code may be incorrect such as: insufficient documentation, down coded, up coded, missing/not coded; provider cannot use that level of E/M code, E/M code bundled into CPT code, etc. These "reasons" are assigned "letters" A thru O and the "reason" for the error is entered under the "Error Code" column. There is also a "comment" section so that any notes or even references that may pertain to that particular encounter can be entered into this column. If there is a need to go back and review the monitor, the comment section should help recall why the codes for each encounter were chosen. Each category is broken out and the accuracy rate for that particular category, such as Primary Diagnosis coding, will be calculated at the bottom of the worksheet provided the formulas are not altered. The bottom of the worksheet contains the totals derived from the data entered when completing the monitor. Everything is together so it easily identifies where the coder is having issues and where they are not.

c) DRG Audit Worksheet

The second tab of the Data Collection Tool is the "DRG" worksheet. It has a "legend" as well and contains the following columns: Patient Name; last 4 of SSN, coded by, admission & discharge dates, DRG, Correct; POA correct; error code and comment section. Once again, the totals are calculated at the bottom of the worksheet provided no changes are made to the formulas that have already been set.

d) Coding Audit Summary

The third tab is the Coding Audit Summary that will automatically calculate & summarize the data entered on the Outpatient Coding and DRG worksheets. An overall facility accuracy rate will also be provided. This accuracy rate includes elements entered on both the outpatient and DRG coder audit worksheets. NOTE: The POA accuracy rate and provider accuracy rate are not calculated as part of the overall medical center accuracy percentage.

e) Outpatient Provider Audit Worksheet

The fourth tab is the Outpatient Provider Audit Worksheet which is set up exactly like the Outpatient Coder Audit Worksheet with the exception of the modifier category,

which is omitted for providers. It contains labeled columns for each section: Patient Name, last 4; date of service; coded by and then the coding categories of E/M, Principal CPT codes, secondary CPT codes, Primary Diagnosis code, and secondary dx codes. The worksheet also contains a "Legend" that describes reasons why the selected code may be incorrect such as: insufficient documentation, down coded, up coded, missing/not coded; provider cannot use that level of E/M code, E/M code bundled into CPT code, etc. These "reasons" are assigned "letters" A thru O and the "reason" for the error is entered under the "Error Code" column. There is also a "comment" section so that any notes or even references that may pertain to that particular encounter can be entered into this column. If there is a need to go back and review the monitor, the comment section should help recall why the codes for each encounter were chosen.

Each category is broken out and the accuracy rate for that particular category, such as Primary Diagnosis coding, will be calculated at the bottom of the worksheet provided the formulas are not altered. The bottom of the worksheet contains the totals derived from the data entered when completing the monitor. Everything is together so it easily identifies where the provider is having issues and where they are not.

f) Provider Audit Summary

The fifth and last tab is the Provider Audit Summary that will automatically calculate & summarize the data entered on the Outpatient Provider worksheet. An overall facility accuracy rate for providers will also be provided.

g) Sampling methodology

Statistical sampling methodology shall provide sufficient data upon which management decisions can be based.

h) Sampling timeframe

The sample will be extracted on the first business day of each month for the prior month.

i) Data Requirements for successful collection

Appropriate access to medical records supporting billable and non-billable claims.

j) The Data Collection Tool & Instructions will be provided after award.

15) Service:

- a) Provide all necessary labor, material, equipment, supplies and supervision to perform off-site electronic Compliance and Business Integrity (CBI) Audits for each VAMC, in accordance with the terms and conditions of the contract. CBI Audits shall be completed using VA forms and in accordance with VA guidelines. The potential exists for indicator process changes to be made at the direction of the VA Compliance and Business Integrity Office (CBIO), annually or otherwise. Should VA make modifications to the requirements of the CBI Audits, the contractor shall make such modifications at no additional cost to the VA.
- b) The contractor shall provide at least one (1) employee with no less than ten years of experience in a hospital or insurance setting as a medical record analyst or auditor that has provided them with sufficient knowledge and experience to accurately review and validate ambulatory, outpatient and inpatient encounters coding including, ICD-CM, CPT with modifiers, Evaluation and Management coding. Certified Professional Coders,

Certified Coding Specialist, Registered Health Information Technicians or Registered Health Information Administrators are preferred. The scope of services shall include performing an audit of both billable and non-billable encounters. Findings shall be documented. The contractor shall prepare the Compliance and Business Integrity Indicator for Coding Accuracy.

- c) Work performed shall be accomplished electronically. Audits shall be performed and accomplished by the 20th of each month. Audits shall not be performed on federal holidays. Any training performed by the contractor shall be performed on-site from 7:00 A.M.-4:30 P.M. Local Time, Monday through Friday.
- d) The Compliance Officer shall ensure that contractor's staff has all required access into the VISTA system.
- e) Tasks to be performed include auditing outpatient and inpatient charts for correct coding. Performing monthly Compliance and Business Integrity Indicators related to Coding Accuracy, providing reports by provider and providing training.
- f) Contract staff shall maintain patient confidentiality and data base security at all times.
- g) The Contractor shall ensure all personnel that will be working on this contract have completed background investigations on existing and new employees. These will be at the contractor's expense.
- h) The Contractor shall provide written documentation that all personnel that will be working on this contract have completed a HIPAA-compliant Privacy Policy Training course and Compliance and Business Integrity Awareness course annually and shall provide written documentation of completion to the VISN 16 Compliance Officer.

NOTE: The parties agree that the contractor, its employees, agents and subcontracts shall not be considered VA employees for any purpose.

16) Billing Requirements:

- a) Billing for auditing services will be made once a month, in arrears, per encounter audited. Billings are to be supported by an itemized breakdown indicating the name of the agency employee and number of encounters audited. All invoices from the contractor shall be submitted electronically in accordance with Section B.2 of the contract.
- b) Billing for on-site training shall be made once a month, in arrears, per the agreement.

17) Contractor Monitoring:

The Contracting Officer's Representative (COR) shall be responsible for verifying contract compliance and verification of work accomplished invoiced by contractor.

18) Personnel Policy:

The Contractor shall be responsible for protecting the personnel furnishing services under this contract. To carry out this responsibility, the contractor shall provide the following for these personnel:

- a) Workers Compensation
- b) Health Examinations/Immunizations
- c) Income Tax Withholding

d) Social Security Payments

19) Dress:

Contractor personnel shall wear casual business attire. Contract agency shall provide nametags including name of individual, title and agency name.

20) Schedule of Work:

Contractor shall provide services Monday through Friday, 8:00AM - 4:30PM Local Time, excluding weekends and Federal holidays, (which includes New Year's Day, President's Day, Martin Luther King's Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veteran's Day, Thanksgiving, Day, Christmas Day and any other day specifically declared by the President of the United States to be a national holiday.) if work is to be performed on-site. Contractor shall immediately provide replacement personnel in the event that contract employee is unable to perform duties due to illness, vacation, or reassignment to other positions.

21) Competencies:

In compliance with TJC requirements, the contractor shall be required to ensure the competency of the employees. Assessment shall be made of all employees assigned to work on this contract. These assessments shall be provided to the COR (Contracting Officer's Representative) within the first 30 days of the contract.

22) Appeals:

- a) Facility CBIO, HIM's chief or designee may appeal audit findings when inter-rater disagreement of composite and/or component results would alter overall coding accuracy.
- b) Appeals shall be provided to the contractor electronically, via encrypted message, within ten business days (excluding Federal holidays) of published audit results.
- c) The facility shall neither revise coding assignments nor modify the content of the initial audit report data during the appeal process.
- d) The contractor shall resubmit the audit report and data, citing changes and sustained findings, no later than five business days (excluding Federal holidays) upon receipt of appeals.

SECTION II – CLAIMS ANALYSIS**1) Intent**

Review of the accuracy, appropriateness and compliance of coding of billable and non-billable health care - encounters by the ten facilities in VISN 16.

2) Purpose

The purpose is to evaluate the accuracy and consistency of coding of billable and non-billable encounters at all ten facilities in VISN 16 and to measure the overall quality of coding accuracy by individual coders and vesting providers. Invoices shall be approved by the VISN Contracting Officer's Representative (COR).

3) Background

The VA has developed and utilizes an integrated billing package that interfaces with accounts receivable software. Claims are prepared for billable facility and professional services performed within VA Systems or purchased by VA. The integrated billing software includes a charge master with inpatient and outpatient charges. Following an episode of care, Health Information coders assign appropriate ICD-CM, CPT-4, and HCPCS codes. Inpatient facility charges are specific to the patient's DRG and include ancillary and room and board charges. Inpatient professional and outpatient facility and professional charges are based on CPT codes. The charge master includes the professional fee and outpatient facility fee unit charges for each code. Normally facility fees are billed on a UB-04 and professional fees on a CMS 1500, unless other arrangements have been made with an individual insurance carrier. Billers select the appropriate HIMS assigned codes to be entered on the UB-04 and/or CMS 1500 forms; the software assigns the charge according to the codes. The bill is transmitted electronically or a hard copy is mailed to the reimbursable insurance carrier. Coding of billable and non-billable encounters is performed by VAMC staff and by contracted coding personnel at each of the VISN 16 VAMCs. Billing is performed for each of the eight facilities within VISN 16 by the VA Mid-South Consolidated Patient Account Center (MSCPAC) located in Smyrna, TN.

4) Scope

- a) The intent of this section is to furnish validation of the compliance, appropriateness and accuracy of the coding of claims sent from VISN 16 facilities to the MSCPAC for billing commercial insurance carriers.
- b) VISN 16 CODING REVIEW
 - 1) The VISN 16 Coding review shall be conducted subsequent to 30 days written notice by the VISN Compliance and Business Integrity Officer (CBIO) to determine overall accuracy of coders, to include all specialties in VISN 16. An optional second Coding review shall be accomplished if requested by the VISN Compliance and Business Integrity Officer (CBIO) with 30 days written notice.
 - 2) All coders shall have a sample of 5 inpatient, and 30 outpatient claims audited to determine the bell curve accuracy of coding quality; approximately 3000 records.
 - 3) The random sample shall be provided by the vendor for both scheduled audits.

- 4) A representative sampling of claims must be audited. When auditing, the contractor shall review all claims prepared for an individual patient for the selected date of service. The contractor shall review each claim for compliance, appropriateness and accuracy. The following guidance shall be followed when reviewing claims: Review of claims must follow Veterans Health Administration (VHA) guidelines. Errors shall not be reported for issues that are not applicable to the VHA. Information and guidelines on billing and collections within the VHA may be found at <http://vaww.va.gov/revenue/>. VA bills health insurance carriers for treatment of non-service connected conditions provided to veterans. Treatment of service-connected conditions should not be billed. The presence of service-connected conditions may be found in the medical record documentation. The VA is not authorized to bill Medicare or Medicaid, however Medicare supplemental policies are required to pay based upon the electronic Medicare Remittance Advice. Recommendations not compatible with VHA guidelines must be identified and discussed with the VISN Compliance and Business Integrity Officer (CBIO) and VISN Business Implementation Manager (BIM) prior to inclusion in the final results.
 - 5) The contractor shall review findings with the CBIO, HIM'S chief, SIM during or following the audit, and prior to preparing the final written report. Upon request, the contractor shall provide VA with the specific resource used to substantiate a reported error. Additional training shall be provided to the sites with marginal audit results. Areas of disagreement shall be referred to the CBIO/HIM's chief for resolution prior to the completion of the written report. Areas that cannot be resolved at the facility level shall be referred to the VISN 16 CBIO/BIM for resolution.
 - 6) VA shall provide the contractor with online access to the applicable claim forms, medical record, NUANCE Charge master and patient registration information. The Offeror shall develop the review sheets required for the following data elements: CBI Data Elements - Outpatient Coding Monitor: The Outpatient Provider Audit Worksheet is designed exactly like the Outpatient Coder Audit Worksheet except the "coded by" column refers to the provider instead of the coder. A quick and easy way to select providers for monitoring is by generating the E/M Reason for Change Report available in Nuance ACM. Another idea is to start out by choosing a different specialty to audit each month until all the specialties within the facility have been monitored.
- 5) E/M Reason for Change Report:

The E/M Reason for Change Report is utilized to monitor changes in E/M coding and services; this provides valuable education to both the coder and provider. The report may be used to track the reason why coders are changing E/M levels of service and trend documentation and coding practices of providers, giving a clear-cut picture of documentation patterns of providers. Patterns will identify the areas where providers need education on E/M level coding.

Available in Nuance ACM:

- a) Open Specialized Reports.
- b) Select E/M Reason for Change.
- c) Generate by Last Date Coded Date Range (this is the default).
- d) Enter date range.
- e) May generate by All Providers or choose specific provider(s).
- f) Right click in the report display area and select View Reasons for Change Report Records.

6) Provider List:

The Provider List is a listing of encounters by provider. One provider or multiple providers may be selected.

Available in Nuance ACM:

- Select PCE Compliance Module.
- Select Audit PCE Records.
- Right-click in the gray area.
- Select visit date range.
- Select Provider Screening.
- Select Provider Radio button.
- Click on Ellipsis button.
- Enter Provider name(s).
- Highlight Provider name and double-click to put name in the Provider Import List Box.
- Select OK.
- Select additional Filter Criteria as applicable.

Right click in grey area to select screening options. This is a shot of how it is defaulted

From: 12/ 7/2015 To: 2/ 8/2016

Flag	Provider	Visit Date/Time	Check Out Status	Patient Name	Patient Age	Patient Date Of Birth	Terminal Digit/SSN	Primary Eligibility Code	Current Means Test	Location	Division	Insurance
OK	CPSPHYSICIAN.DNE	12/10/2015 12:10	CHECKED OUT	CPSPATIENT EIGHT F C 61		02/01/1955	08-666660008	NSC	REQUIRED	GASTROENTEROLOGY/474-TROY		#HUMANNA
OK	CPSPHYSICIAN.DNE	12/30/2015 12:00	INPATIENT APPOINTM	ACMPATIENT EIGHT (*Se 65		12/06/1950	89-Sensitive Patient	NSC	REQUIRED	GASTROENTEROLOGY/474-TROY		#BLUE CROSS
NLK	CPSPHYSICIAN.DNE	01/04/2016 10:00	CHECKED OUT	EPSPATIENT BABY 1011 2		10/01/2013	11-666661011	CHAMPVA		MIKES MENTAL CLINIC, 474-TROY		No patient ins
OK	CPSPHYSICIAN.DNE	01/07/2016 01:00	INPATIENT APPOINTM	ACMPATIENT EIGHT (*Se 65		12/06/1950	89-Sensitive Patient	NSC	REQUIRED	CHECKING \$	500-ALBANY	#BLUE CROSS
LNK	CPSPHYSICIAN.DNE	01/07/2016 12:00	CHECKED OUT	VIP-CANADIAN DEVE 828 66		01/01/1950	82-666668282	SC LESS THAN 50%		GASTROENTEROLOGY/474-TROY		No patient ins
NLK	CPSPHYSICIAN.DNE	01/12/2016 13:12	INPATIENT APPOINTM	ACMPATIENT EIGHT (*Se 65		12/06/1950	89-Sensitive Patient	NSC	REQUIRED	GASTROENTEROLOGY/500-ALBANY OPC		#BLUE CROSS
SUS	CPSPHYSICIAN.DNE	01/13/2016 08:00	INPATIENT APPOINTM	CPSPATIENT TWO F 00 63		09/03/1952	02-666660002			GASTROENTEROLOGY/474-TROY		#BLUE CROSS
NLK	CPSPHYSICIAN.DNE	01/14/2016 12:00	CHECKED OUT	CPSPATIENT FOUR M C 61		10/25/1954	04-666660004	NSC	REQUIRED	GASTROENTEROLOGY/474-TROY		Reimbursable
NLK	CPSPHYSICIAN.DNE	01/14/2016 13:00	CHECKED OUT	CPSPATIENT FOUR M C 61		10/25/1954	04-666660004	NSC	REQUIRED	EMERGENCY 6	500-ALBANY OPC	Reimbursable
NLK	CPSPHYSICIAN.DNE	01/15/2016 00:01	CHECKED OUT	ACMPATIENT BRIDGET 3 39		01/01/1977	33-321143333	SHARING AGREEMENT		CARDIOLOGY1	500-ALBANY	BLUE CROSS
LNK	CPSPHYSICIAN.DNE	01/15/2016 12:00	CHECKED OUT	ZZTESTPATIENT FIFTYE 71		01/01/1945	80-666668080			GASTROENTEROLOGY/474-TROY		#TRICARE

Audit Records

- No ICD/CPT Code Filters/All Records
- ✓ Patient Screening
- Provider Screening
- Location Screening
- Stop Code Screening
- Audit Actions
- Chart Audit Results
- View Visit Notes
- View SC Disabilities/SA Eligibilities/CV Status

VistA Patient Selection
Enter Patient Name, SSN, or last 4 of SSN and press enter to begin search. View details within information box.

Search and Selection
Enter At Least Three Characters <Press Enter>

CPRS

- CPRSDONOTUSER,ONE
- CPRSPATIENT,EIGHT F
- CPRSPATIENT,ELEVEN M
- CPRSPATIENT,FIVE S
- CPRSPATIENT,FOUR M
- CPRSPATIENT,KT
- CPRSPATIENT,NINE
- CPRSPATIENT,ONE M
- CPRSPATIENT,SEVEN M**
- CPRSPATIENT,SIX M
- CPRSPATIENT,TEN M
- CPRSPATIENT,THREE M
- CPRSPATIENT,TWENTY-ONE T
- CPRSPATIENT,TWENTYTHREE'S G
- CPRSPATIENT,TWO F

Information

Name: CPRSPATIENT,SEVEN M

SSN: 666660007

DOB: 11/02/1923

Gender: MALE

++

XX

Clear All OK Cancel

highlight to select and "++" or double click to populate in selection area

Ability Code	Current Means Test	Location	Division	Insurance	Date Last Verified	Vested
						Vested
						Vested
						Vested
						Vested
						Vested
						Vested
						Vested
						sted
						sted
						Vested
						Vested
						Not Vested
						Not Vested
						Vested
						Vested

7) Clinic/Location List:

The Clinic/Location List provides a list of encounters by clinic/location (Available in Nuance ACM).

- Select PCE Compliance Module.
- Select Audit PCE Records.
- Right-click in the gray area.
- Select visit date range.
- Select Location Screening.
- Select Location Radio button.
- Click on Ellipsis button.
- Enter Location name(s).
- Highlight Location name and double-click to put name in the Location Import List Box.
- Select OK.
- Select additional Filter Criteria as applicable.

8) DRG Frequency Report:

The DRG Frequency Report is a way to find inpatient providers to monitor and will show activity per DRG. If the most frequent DRG is in the Cardiac area, then monitoring those providers is probably a good idea to ensure the documentation is as complete and timely as possible. The coding staff assigns the codes for inpatient but if there is a high admission frequency, chances are there are many follow up appointments in the outpatient area as well. By utilizing the DRG Frequency report providers and coders can be selected for monitoring that month and/or quarter (Available in Nuance Clintegrity 360):

- Select Coding/Abstracting tab.
- Reports.

- (c) DRG Reports.
- (d) Enter discharge date range.
- (e) DRG Frequency Report.
- (f) Preview.

9) Documentation Accuracy:

When auditing providers, documentation must be complete, accurate and timely as it needs to tell the story of what transpired between the patient and provider. Are all needed elements such as the chief complaint or the history of the present illness documented in the note? Does the documentation have the specificity required at the coding level? Documentation plays a vital role in continuity of care so the visit notes must be as complete, accurate and timely as possible.

10) Clinic Assignment Accuracy:

One area that may get overlooked when monitoring providers is the accuracy of where the clinic note is listed/or tied to. Is an orthopedic clinic note actually tied to a cardiology clinic? Or maybe the Primary Care clinic is being monitored and the note is actually a telephone visit? Make sure this area is reviewed when performing the monitor *E&M* codes, Primary CPT code, Secondary CPT code, Primary Diagnosis code, Secondary Diagnosis codes, and Modifiers:

- a) Insufficient documentation
- b) Undercoded
- c) Upcoded
- d) Missing (documented) not coded
- e) Provider can't use level of E/M code
- f) E/M code bundled into another CPT code
- g) Wrong E/M Type assigned
- h) No documentation for encounter
- i) Incorrect code selected
- j) Unbundled codes
- k) Lack of specificity (4th' 5th digit incorrect)
- l) Incorrect modifier assigned
- m) Modifier assigned to wrong code
- n) Modifier should not be used

11) CBI Data Elements - Coding Monitor:

Contract coders need to be included in the coding monitor as the HIM department is responsible for work performed under contract for their department. The contract may have a coding supervisor assigned to the account and that supervisor may send accuracy and productivity reports on those contract coders, but the HIM department is still responsible for monitoring the productivity and accuracy of contract coders working for their department. Both accuracy and productivity need to be monitored. One is really not more important than the other, productivity and accuracy coexist together.

12) Accuracy – VHA Handbook 1907.03:

The accuracy requirements from VHA Handbook 1907.03 state the following: The American Health Information Management Association (AHIMA) recommends maintaining a 95 percent accuracy rate as a minimum goal, while the Medical Records Briefing recommends setting ranges for accuracy of 90-95 percent (see paragraph 4) the suggested quality indicators for measuring accuracy include:

- a) Accurate coding of all diagnoses and procedures;
- b) Existence of documentation to substantiate codes assigned; and
- c) Correct sequencing according to coding guidelines.

Also, the minimum expected coding accuracy standard for all types of work for experienced professional coders at the target-grade level is 95 percent. Appropriate lower standards may be set for coders in developmental positions.

13) Productivity – VHA Handbook 1907.03

Scope of Work	Minimum Standard per Day NOTE: This is based on a 7.5 hour workday and does not include leave, educational hours or non-coding activities. Appropriate lower standards may be set for coders in developmental positions.
Inpatient Discharges with Professional Fees	9
Inpatient Discharges without Professional Fees	13
Surgery Cases including Billable Pathology and Anesthesia Services	25
Outpatient, Outpatient Testing, and Inpatient Professional Encounters	70

14) Outpatient Coder Productivity Report (Available in Nuance ACM):

- (a) Select PCE Compliance Module
- (b) Run by Last Date Coded date range (default)
- (c) Enter date range: Previous business day
- (d) Select Status filters: Referred to UR, Coded by CCM, Suspended/Pending (Optional), Referred To Billing, Reviewed/Not Billable, Bypass CCM Coding, Bill Process Complete, RR Recoded/Refer To Billing, Legal Refer to Billing
- (e) Coder Filter: Select all Coders or an individual coder
- (f) Right-click in the report display area and select Retrieve CCM Cases
- (g) Sort by CCM Coder
- (h) Save to Excel (option)

15) Inpatient Coder Productivity Report (Available in Nuance VIP Director):

- (a) Standard Reports
- (b) Report Builder
- (c) Select date range type – Last Date Coded
- (d) Enter desired date range

- (e) Select All Coders or an individual coder
- (f) Select All Statuses (default)
- (g) Select All Case Actions (default)
- (h) Right-click in the report display area and select Get Records
- (i) The report can be saved to Excel, printed or charted
- (j) Drag VIP Coder Column into gray area to review the # of cases completed by each coder

16) Retrospective Review Process:

- a) The billing supervisor, or designee, must be notified when a code has been changed based on a retrospective review and that encounter has been previously billed. If the review is conducted on encounters that have already been billed and there are code changes via that review, the billing department must be notified so that appropriate action can be taken.
- b) The encounter is assigned back to the coder by applying the status "Code for Retrospective Review" within ACM.
- c) When the coder generates their work list, the status of "Code for Retrospective Review" must be included so the encounter will appear on the work list. When the coder files the encounter to PCE and there have been no edits, the software will automatically assign the status of "RR Recoded/Refer to Billing". If the coder selected to bypass edits on the encounter, then the coder must manually assign the status of "RR Recoded/Refer to Billing" before filing the encounter to PCE.
- d) The "RR Recoded/Refer to Billing" status indicates to Billing that this encounter had a code change after the encounter was billed. Billing will determine the appropriate action to take; i.e., submit a new claim. (For more detail, please refer to the Retrospective Review Process Fact Sheet located on the HIM Website.)
- e) DRG monitor:
 - 1) Admit date
 - 2) Discharge date
 - 3) DRG correct
 - 4) Principal Diagnosis not supported by documentation
 - 5) Complications and Comorbidities (cc) not coded (absent/incorrect) according to new MS DRG coding rules
 - 6) Incorrect code selected for principal diagnosis
 - 7) Significant procedure(s) not correct
- f) Summaries: Results of the claims audit shall be provided in written form and must include, but are not limited to:
 - 1) Review Methodology with collection tool; Findings
 - 2) Recommendations for improvement-format to be provided
 - 3) Attachment with a listing of claims reviewed with detailed findings and recommendations for the claims
 - 4) Education via teleconference or in person for sites with less than marginal results

17) Contractor Requirements:

- a) The contractor shall provide all labor, materials, transportation, and supervision necessary to perform audit.

- b) The actual reviewer shall have at least three years of experience reviewing claims in a large tertiary care hospital and outpatient health care organizations, as well as two years of education and training. Experience shall include both institutional (UB-04) and professional (CMS 1500) claims. In addition, the reviewers who will be verifying ICD-CM and CPT-4 codes shall have one of the following current credentials: Registered Health Information Technician (RHIT), Registered Health Information Administrator (RHIA), Certified Coding Specialist (CCS), or Certified Professional Coder (CPC). The proposal shall include the resumes of the actual reviewers, two (2) current client references specific to each individual reviewer, and proof of credentials.
- c) All reviews shall utilize electronic auditing of the computerized medical record system (CPRS) and, NUANCE Code Me/Bill Me software, whenever possible. Claims shall be reviewed from an electronic copy. If the information is not contained in CPRS, i.e., a scanned document, the contractor shall request a copy from the VISN 16 COR before, considering the audit of the claim incomplete.
- d) Contractor shall be responsible for providing for their staff computers, reference material, and software/encoder tools for conducting reviews and developing training materials. Contractor shall be proficient in the use of the laptops, reference materials, and software/encoder tools.
- e) Contractor shall develop a collection tool for data reviews, and submit it as requested.
- f) Contractor shall be responsible for reviewing facility 's procedures prior to commencement of review.
- g) Contractor shall document in writing all records reviewed and provide such documentation to contact each facility COR at the conclusion of the review.
- h) Contractor shall review findings with the CBIO and HIM'S chief and other designated medical center personnel to review proposed changes to final written report for mutually agreed upon changes.

18) Confidentiality And Nondisclosure:

- a) All deliverables, associated working papers, and other material deemed relevant by VA generated by the Contractor in the performance of this task order are the property of the United States Government.
- b) All individually identifiable health records shall be treated with the strictest confidentiality. Access to records shall be limited to essential personnel only. Records shall be secured when not in use. The contractor shall comply with the Privacy Act, 38 USC 5701, and 38 USC 7332.
- c) Reviewer will be required to sign a confidentiality statement upon accessing any facility's electronic records or visiting any facility in coordination with each COR.

19) Terms:

- a) This Statement of Work could be updated throughout the term of the contract due to possible changes in policy regarding semi-annual coding requirements. The Contracting Officer will issue any changes to the specifications in writing.
- b) Due to the complexity of the services required herein, the offeror will have to perform 100% of the work.
- c) Contractor shall use the following programs: CPRS, VISTA and NUANCE Products. Auditor will maintain up-to-date ICD-10-CM and CPT, HCPC reference books. Vendor must be able to access VA VISTA through high speed internet connection.

- d) All computers shall be password protected and protected from unauthorized access. Access passwords are set and maintained by the employee only.

20) Compliance and Business Integrity (CBI) Training For Contractor Employees:

The VHA requires that those vendors performing services directly or indirectly affecting the VHA Revenue Cycle complete annual CBI compliance training. This training shall be accomplished using one of the following three options.

- a) Individual contractor employees having access to VA computer systems can complete the training on-line at: <http://vawww.visnl6.med.va.gov/index.htm>
- b) Contractors may use the Course Content Outline for New Employee Orientation: CBI Program and VHA CBI Helpline Poster.
- c) Contractor's own compliance training course will suffice provided that it is supplemented by the information that is contained in the Course Content Outline for New Employee Orientation.

For new or existing contracts up for renewal, the vendor shall provide copies of the CBI Training Certificate or the training certificate generated by the VA's on-line training program to the COR within ten (10) calendar days of contract award or exercise of option year.

21) Privacy and HIPPA Policy Training:

- a) All contractor and subcontractor employees performing work under this contract and having access to patient records and other privacy act information are required to complete the VHA's mandatory "VHA Privacy Policy" training course. The course is available on-line at the Veteran's Health Administration's (VHA) Employee Education System (EES) website: <https://www.ees-learning.net/librix/>. The basic course is designed to be finished in 50-60 minutes. If you choose to read information behind the MORE buttons, self-test questions, and scenarios, it may take you about 30 more minutes to finish. When the course is successfully completed, a training certificate will be issued on-line.
- b) Privacy and HIP AA Policy Training completion certificates or proof of training for contractor furnished training for all applicable contractor and subcontractor employees shall be forwarded as one submittal package to the COTR within ten (10) calendar days of contract award or exercise of option year.

22) Cyber Security Training:

- a) All contractor and subcontractor employees performing work under this contract and having access to VA computer systems are required to complete the VA's mandatory "VA Cyber Security Awareness" training course. The course is available on-line at the Veteran's Health Administration's (VHA) Employee Education System (EES) website: <https://www.ees-learning.net/librix/>. The course is designed to take approximately one (1) hour. When the course is successfully completed, a training certificate shall be issued on-line.
- b) Cyber Security Training completion certificates for all applicable contractor and subcontractor employees shall be forwarded as one submittal package to the COR within ten (10) calendar days of contract award or exercise of option year.

23) Computer Access And Security:

- a) VA may provide Contractor and subcontractor, if any, with access to Department of Veterans Affairs (VA) automated patient records and general files maintained on VA computer systems. Contractor, Contractor's employees, and Contractor's subcontractors (if any) shall maintain, access, release, and otherwise manage the information contained in the automated patient record and general file system in accordance with all federal laws governing that information, including federal laws applicable to federal agency records. Contractor shall take reasonable safeguards, both physical and electronic, to safeguard the information and prevent unauthorized disclosures. Contractor, Contractor's employees, and Contractor's subcontractors (if any) shall follow all VA policies governing access to, release of, and management of the information maintained in the automated system. Contractor shall take steps to ensure that its employees and subcontractors (if any) are bound by this requirement and subject to adverse action, up to and including termination of the relationship with Contractor, for failure to follow these requirements and that its employees and subcontractors, if any, meet the same requirements as VA employees for access to information contained in the automated record system. Contractor shall utilize computers that are consistent with VA requirements and upgrade its computers if instructed to do so by VA in order to ensure compatibility with the VA system. If using the One-VA Virtual Private Network (VPN) connection, the contractor must supply the internet connection.
- b) In performing this agreement, Contractor shall be considered a part of VA for purposes of 5 U.S.C. §552a, 38 U.S.C. §§5701 and 7332. Contractor's employees and agents shall have access to patient medical records and general files to the extent necessary to perform this on tract. Notwithstanding any other provision of this agreement, Contractor and/or its employees shall not disclose information contained in general files and patient records and or other individually identified patient information, including information and records generated by the Contractor in performance of this agreement, except pursuant to explicit instructions from the VA. For the purposes of this paragraph, instruction to disclose shall be provided by these officials only: Contracting Officer, Contracting Officer Representative, the Release of Information supervisor, or VA attorneys.
- c) Records created by Contractor in the course of performing this agreement are the property of the VA and shall not be accessed, released, transferred, or destroyed except in accordance with applicable federal law, regulations, and policy. Access to data shall be limited to the minimum necessary for performance of the contract. Contractor shall take steps to ensure that access is limited to those employees who need access to the data to perform the contract. Contractor shall not copy information contained in the system, either by printing to paper or by copying to another digital format, without the express permission of one of the officials listed in paragraph (2), above, except as is necessary to make single copies in the ordinary course of providing patient care. Contractor shall not commingle the data from the system with information from other sources. Contractor shall report any unauthorized disclosure of VA information to the officials listed in paragraph (2).
- d) If this agreement is terminated for any reason, Contractor shall provide the VA with all individually-identified VA patient treatment records or other information in its possession, as well as any copies made pursuant to paragraph (3), above within seven (7) days of the termination notice.
- e) Certain information available from the database and other records created by the Contractor under this Agreement are medical quality assurance records protected by 38 U.S.C. §5705; it's implementing regulations at 38 U.S.C. §§ 17.500-511; VHA Directive 98-016, 4.b.(l)(d), 4.6(2)(c)

and 4.6(4). These records shall be disclosed only as authorized by 38 U.S.C. §5705 and the VA regulations. Disclosure of these records in violation of §5705 is a criminal offense under 38 U.S.C. §5705(e).

- f) Contractor shall follow all VA policies regarding the retention of records. In the alternative, Contractor may deliver the records to VA for retention.
- g) Any changes in the law or regulations governing the information covered by this agreement during the term of this agreement shall be deemed to be incorporated into this agreement. Contractor shall educate its employees and subcontractors, if any, of the requirements of this section and shall advise its employees and subcontractors, if any, of any changes as they occur. On Contractor's request, VA will provide trainers who can educate Contractor's employees and subcontractors, if any, of their obligations under this section.
- h) Contractor shall make its internal policies and practices regarding the safeguarding of medical and/or electronic information available to federal agencies with enforcement authority over the maintenance of those records upon request.

24) Mandatory Annual Security Training:

The contractor and employees are required to complete annual privacy, compliance and business integrity, HIP AA and security training. The training can be accomplished via video or online training. Access to either will be provided by the VA Information Security Office.

25) Special Contract Requirements:

- a) Services:
 - 1) The services specified in the Sections entitled Schedule of Services and Costs and Special Contract Requirements shall be changed by written modification to this contract. The modification shall be prepared by the VA Contracting Officer.
 - 2) Other necessary personnel for the operation of the services contracted for by the VA shall be provided by the contractor at levels mutually agreed upon which are compatible with quality medical care programming. Other personnel assigned to provide services under the contract shall be subject to the same qualification requirements.
 - 3) The services to be performed by the contractor shall be performed in accordance with VA policies and procedures and the regulations of the VA facility.
 - 4) The services and documentation to be performed by the Contractor shall be performed in accordance with VA policies and procedures and the regulations of the VA facility, Code of Ethics, Medical Center Memorandums, and TJC. Contracted provider shall comply with JC and Department of Veterans Affairs (OVA) requirements pertaining to documentation; the V AMC Quality Assurance Requirements; the Network Performance VISN Plan; and Mission of the VA.
- b) Qualifications:
 - 1) The Contractor shall be responsible, through written policies and procedures regarding staff credentials, to ensure that Contractor employees providing work on this contract are fully trained and completely competent to perform the required work.
 - 2) The Contractor shall be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Public Law 104-191 also addresses pertinent issues related to security and confidentiality of individually identifiable health information and records that include protected health information. It is the responsibility of the Contractor to assure that patient records are protected against any anticipated threats or hazards to

- their security or integrity which could result in substantial harm, embarrassment, inconvenience, or unfairness to any individual for whom information is maintained.
- 3) The Contractor shall make available, upon request, copies of certificates, training, licensure or other information as requested by the Contracting Officer or the Contracting Officer's Representative (COR) as evidence of the qualifications and/or experience of personnel providing services under this contract.
 - 4) The Contractor shall be financially responsible and able to show evidence of their responsibility, ability, experience, equipment, facilities, and personnel directly employed or supervised by them to render prompt and satisfactory service in the volume required for all items under this contract. By execution of this contract, the Contractor is certifying that all requirements of Federal, State, or local laws, codes, and/or regulations regarding the operation of this type of service will be met.
 - 5) Any subcontractor utilized by the Contractor for the provision of services required under this contract shall meet the same qualifications specified herein for the Contractor. The Contractor shall obtain approval from the Contracting Officer for any subcontractor to be utilized for the provision of services required under this contract.
- c) VA Protected Information Or Sensitive Data:
- 1) The contractor shall protect, secure, and safeguard to the maximum extent practicable all patient identifiable information and VA protected information. The confidentiality and integrity of this information must be maintained.
 - 2) VA protected information shall not be transmitted by remote access unless VA-approved protection mechanisms are used. Only approved encryption solutions using validated modules may be used when protecting data during transmission. Public Key Infrastructure (PKI) is the only VA approved solution for Microsoft Outlook Email.
 - 3) Additional security controls are required to guard VA protected information stored on computers outside VA facilities. All VA protected information stored on the computer, file or electronic storage media must be encrypted using VA-approved protection mechanisms (see item 4.b.). Equipment shall be housed and protected to reduce the risks from environmental threats and hazards, and the opportunities for unauthorized access, use, or removal.
 - 4) Portable computers that have VA protected information on their storage device(s) or have software that provides access to VA private networks must be secured under lock and key when not in immediate vicinity of responsible individual. This includes external hard drives and other storage devices. These devices shall be encrypted per VA.
 - 5) Data and system backups that include VA information have the same confidentiality classification as the originals. Therefore, these materials shall be protected with the same or equally effective physical security as that provided to the source computer, its media, and information contained therein.
 - 6) If the contractor has a need to transmit patient identifiable, sensitive, confidential, or other VA private data via the internet/electronic mail, the data must be encrypted. For those contractors that have access to Microsoft Outlook or Microsoft Outlook Express, the Fayetteville VAMC shall provide assistance in obtaining a Public Key Infrastructure Key (PKI) Partner Certificate for encryption purposes. If Outlook is not available, the contractor shall not transmit any of the afore-mentioned data over the internet to any VA facility. Without Outlook and without PKI encryption, the only accepted means of transmitting sensitive data to the VA facility is (1) via regular mail to a properly identified recipient; (2) to a secure fax machine within the facility with a properly identified recipient; or (3) hand delivered to the proper recipient.
- d) Work Hours:

- 1) The services covered by this contract shall be furnished by the contractor as defined herein. The contractor shall not be required, except in case of emergency as determined by the Chief of Staff or designee, to furnish such services during off-duty hours or national holidays as described below.

The following terms have the following meanings:

A) Work hours: Monday through Friday, 8:00 a.m. - 4:30 p. m, Local Time.

B) National Holidays: The 10 holidays observed by the Federal Government are:

- New Year's Day
- Martin Luther King's Birthday
- Presidents Day
- Memorial Day
- Independence Day
- Labor Day
- Columbus Day
- Veterans Day
- Thanksgiving
- Christmas
- Any other day specifically declared by the President of the United States to be a National Holiday.

C) Off-Duty hours: Friday, 4:30p.m. through Monday, 8:00 a.m, Local Time.

e) Personnel Policy:

- 1) The contractor shall be responsible for protecting the personnel furnishing services under this contract. To carry out this responsibility, the contractor shall provide the following for these personnel:
 - workers compensation
 - professional liability insurance
 - health examinations
 - income tax withholding, and
 - social security payments
- 2) The parties agree that the contractor, its employees, agents and subcontractors shall not be considered VA employees for any purpose.

f) Record Keeping:

The VA Medical Center COR and the Contractor shall establish and maintain a record keeping system to verify contract performance.

g) Key Personnel And Temporary Emergency Substitutions:

The Contractors shall assign to this contract only those persons whose resumes, personnel data forms, or personnel qualification statements were submitted and approved as required. No substitution of personnel shall be made except as follows:

- 1) During the first ninety (90) days of performance, the Contractor shall make NO substitutions of key personnel unless the substitution is necessitated by illness, death, or termination of employment. The Contractor shall notify the Contracting Officer, in writing, within 15 calendar days after the occurrence of any of these events and provide the information required by paragraph (c) below. After the initial 90-day period of the contract, the Contractor shall submit the information required by paragraph (c) to the Contracting Officer at least 15 days prior to making any permanent substitutions.
- 2) The Contractor shall provide a detailed explanation of the circumstances necessitating the proposed substitutions, complete resumes for the proposed substitutes, and any additional information requested by the Contracting Officer. Proposed substitutes shall have

- comparable qualifications to those of the persons being replaced. The Contracting Officer will notify the Contractor within 15 calendar days after receipt of all required information of the decision on the proposed substitutes. The contract will be modified to reflect any approved changes of key personnel.
- 3) For temporary substitutions where the key person will not be reporting to work for three (3) consecutive work days or more, the Contractor will provide a qualified replacement for the key person. This substitute shall have comparable qualifications to the key person. Any period exceeding two weeks will require the procedure as stated above.
- h) Approval Of Contractor Personnel:
The VA reserves the right to refuse approval under this contract or require dismissal from contract work of any Contractor or subcontractor personnel who, by reason of unsatisfactory performance or for any other valid reason, is considered by the Contracting Officer to be objectionable.
- i) Tort Claims:
Contractor personnel are not covered by the Federal Tort Claims Act. When contractor personnel have been identified as a primary provider in a tort claim, the contractor personnel are responsible for notifying the contractor's legal counsel and/or insurance carrier. Any settlement or judgment arising from a contractor personnel's action or non-action is the responsibility of the contractor and/or insurance carrier.
- j) Insurance:
The contractor will attain and hold an in-force General Liability Insurance in an amount not less than one million dollars (\$1,000,000.00) during the contractual period. Copies of insurance coverage shall be sent to the Contracting Officer. Policy renewal statements shall be sent to the Contracting Officer throughout the term of the contract. The contract may be terminated for Default due to a lack of insurance.
- k) Contract Monitoring Procedures:
- 1) Record-Keeping Monitoring System: A record will be established by the Contracting Officer's Representative (COR) for individual services for verification of actual procedures performed by the Contractor. The COR to monitor contract compliance is the **Facility Compliance Officer**, or designee, and is the VAMC official responsible for verification of actual procedures performed by the Contractor. Failure of contractor to follow procedure may result in nonpayment or delay of payment.
 - 2) As requested by the COR, the contractor shall meet (conference calls are acceptable) with the COR to discuss contract performance, process improvement ideas, and the status of any contract issues.
 - 3) The COR will furnish a statement in writing to the Contracting Officer at the close out of the contract to include summary of contractor actions and a statement that all requirements of the contract were fulfilled as agreed.
 - 4) A summary evaluation of contractor performance, based upon the compliance or noncompliance of contract requirements as evidenced under the monitoring procedures shall be forwarded by the monitoring official to the Contracting Officer annually, no later than 15 days after the completion of each 12 month period of performance.
- l) Contract Compliance:
- 1) Any incident of contractor non-compliance as evidenced by the monitoring procedures shall be reported immediately by the COR to the Contracting Officer.
 - 2) The COR for this contract will monitor specific performance of the contract requirements.
- m) Joint Commission (JC) And Other Special Requirements:

- 1) The Contractor will be responsible to ensure that Contractor employees providing work on this contract are fully trained and completely competent to perform the required work.
 - 2) The VA will monitor the Contractor employees' work to ensure contract compliance.
 - 3) Notwithstanding other contract requirements, upon request of the Contracting Officer, the Contractor will refuse permission to provide services under this contract any Contractor employee who does not meet competency requirements for the work being performed.
 - 4) Where the contract does not require JC accreditation or other regulatory body requirements, the Contractor must perform the required work in accordance with JC standards. A copy of these standards may be obtained from the Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181.
 - 5) Where the contract does not require JC accreditation or other regulatory requirements regarding worker competency, the Contractor shall perform the required work in accordance with JC standards. The contractor is required to develop and maintain the following documents for each Contractor employee working on the contract: credentials and qualifications for the job; a current competence assessment checklist (an assessment of knowledge, skills, abilities and behaviors required to perform a job correctly and skillfully; includes knowledge and skills required to provide care for certain patient populations, as appropriate.); a current performance evaluation supporting ability of the Contractor employee to successfully perform the work required in this solicitation; and listing of relevant continuing education for the last two years. The Contractor shall provide current copies of these records at the time of contract award and annually on the anniversary date of contract award to the VA COR, or upon request, for each Contractor employee working on the contract.
- n) HHS OIG Exclusion List:
The contractor shall ensure that individuals do not appear on the current Office of Inspector General's Exclusionary List from participation in Medicare, Medicaid and other Federal Health Care Programs <http://epls.gov> or <http://exclusions.oig.hhs.gov>.
- o) Invoices And Payment For Services:
- 1) Payment for services rendered by the Contractor under the terms of this contract shall be made monthly upon receipt of a properly executed invoice. Invoice to be submitted within ten (10) workdays following the end of a month in which the Contractor rendered services. VA shall verify services performed and certify invoice for payment within thirty (30) days following date of receipt. Any identified discrepancy(s) in billings shall be cause for extending provisions of this paragraph until-such time as the discrepancy or other identified problem with the billing invoice has been resolved.
 - 2) The Contractor shall accept payment for services rendered under this contract as payment in full and will not bill the veteran or their third-party insurer for any services covered under this contract.
- p) Contract Administration:
The Contracting Officer is the only person authorized to approve changes or modify any of the requirements under this contract. The Contractor shall communicate with the COR on all matters pertaining to contract administration. However, only the Contracting Officer is authorized to make commitments or issue changes affecting price, quantity, or quality of performance of this contract. In the event the Contractor effects any such change at the direction of any person other than the Contracting Officer, the change shall be considered to have been made without authority and no adjustment shall be made in the contract price to cover any increase in costs incurred as a result thereof.

q) Confidentiality of Patient Records:

- 1) The Contractor is a VA contractor and shall assist in the provision of health care to patients seeking such care from or through VA. As such, the Contractor shall be considered as being part of the Department health care activity. Contractor is considered to be a VA contractor for purposes of the Privacy Act, Title 5 U.S.C. 552a. Further, for the purpose of VA records access and patient confidentiality, Contractor shall be considered to be a VA contractor for the following provisions: Title 38 U.S.C. 5701, 5705, and 7362. Therefore, Contractor shall have access, as would other appropriate components of VA, to patient medical records including patient treatment records pertaining to drug and alcohol abuse, HIV, and sickle cell anemia, to the extent necessary to perform its contractual responsibilities. However, like other components of the Department, and notwithstanding any other provisions of the contract, the Contractor shall be restricted from making disclosures of VA records, or information contained in such records, to which it shall have access, except to the extent that explicit disclosure authority from VA has been received. The Contractor shall be subject to the same penalties and liabilities for unauthorized disclosures of such records as VA.
- 2) The records referred to above shall be and remain the property of VA and shall not be removed or transferred from VA except in accordance with U.S.C. 551a (Privacy Act), 38 U.S.C. 5701 (Confidentiality of claimant's records), 5 U.S.C. 552 (FOIA), 38 U.S.C. 5705 (Confidentiality of Medical Quality Assurance Records), 38 U.S.C. 7332 (Confidentiality of certain medical records), and federal laws, rules and regulations. Subject to applicable federal confidentiality of privacy laws, the Contractor, or their designated representatives, and designated representatives of federal regulator agencies having jurisdiction over Contractor, shall have access to VA's records, at VA's place of business on request during normal business hours, to inspect and review and make copies of such records.

r) Contingency Plan:

The contractor shall prepare a contingency plan to provide reports specified under the contract in the event that the computer system is not functioning. This plan shall be provided to and approved by the COR upon request.

s) Automated Information Security:

Computer access and security shall be applicable to all contractor and subcontractor personnel engaged in the provision of any services under this contract

- 1) Contractor personnel shall each have a designated security level.
- 2) To authenticate positively the identity of individual Contractor personnel user, all requests for system access shall be completed by the Service Application Coordinator. The Service Chief shall sign the access form after reviewing for appropriateness, after which the ITS Service Staff will coordinate the assigning of access and verify codes to individual Contractor personnel.
- 3) Contractor personnel shall be trained in and be given a copy of the current Automated Information System (AIS) Security Policy by the Service ADPAC. This training is required prior to accessing any sensitive information and annually thereafter.
- 4) Personnel Clearances and Privacy Act considerations: All contractor personnel shall be required to observe the requirements imposed on sensitive data by law, federal regulations, VHA statutes and policy, VHS&RA policy, and the associated requirements to ensure appropriate screening of all personnel. Because of the inherent sensitivity of data at the facility concerned, the level of security clearance required of the Contractor shall reflect the same level of security clearance carried by their Health Care Facility personnel for the function under contract. The Contractor shall ensure that his/her personnel and all involved subcontractor personnel meet the above restrictions and that confidential and proprietary

information shall be divulged only to those officers and officials of DVA authorized to receive such information.

- 5) The VHA system(s) or records to which the Contractor personnel shall have access in order to maintain patient medical records and associated hardware is/are assigned by the Service Chief and shall be subject to ITS control and AIS security. Contractor personnel who obtain access to hardware or media which shall manipulate or store substance abuse, sickle cell anemia, *HIV* or AIDS treatment records or medical quality assurance records protected by 38 USC 4132 or 3305, as defined by the DVA shall not have access to the records unless absolutely necessary to perform their contractual duties. If access is obtained, no more individuals than are absolutely necessary to perform the contracted duties shall see these records. Any individual who has access to this data will disclose it to no one, including other Contractor personnel shall not be involved in the performance of the particular contractual duty for which access was obtained. Violation of these statutory provisions, as stated in VHA regulations, by the Contractor or contractor personnel, may involve imposition of criminal penalties.

t) Contractor Personnel Security Requirements:

The contractor shall comply with all applicable Federal and Department of Veterans Affairs security laws, regulations and policies. All contractor employees who require access to the Department of Veterans Affairs' computer systems shall be the subject of a background investigation and must receive a favorable adjudication from the VA Office of Security and Law Enforcement prior to contract performance. The contractor shall provide all required information needed for a security check. Currently this includes, but is not limited to, the following: name, home address, social security number, date of birth, place of birth, home phone number, cell phone number, and email address of the employee(s) requiring access. This requirement is applicable to all subcontractor personnel requiring the same access. Contractor employees requiring access to the VA computer systems shall also be fingerprinted as part of the background investigation process. Individuals requiring fingerprinting must present to the VA Medical Center, Fayetteville, Arkansas or their nearest police station. Contract performance shall not commence prior to confirmation from the Security and Investigation Center (SIC) that the investigative documents have been submitted. The SIC shall notify the VA Contracting Officer, VA Sponsor, and the contractor upon receipt of the appropriate investigative documents. Notification from the SIC is necessary for performance to begin but is not sufficient. The Contracting Officer shall provide approval to begin performance. If the investigation is not completed prior to any contract services being performed, the contractor shall be responsible for the actions of those individuals they provide to perform work for VA. If contract services are to be performed in any location other than a controlled office facility, the contractor shall be responsible to ensure that the remote work site and patient information therein is accessible only to the contracted employee. The contractor shall visually inspect the work site prior to its use. The contracted employee shall assume responsibility for securing the work site and complying with all privacy regulations in handling, securing, and destroying patient information. All contracted employees shall complete security/privacy training (VA Cyber Security Awareness and VHA Privacy Policy Training) and provide documentation of training completion to the contractor each fiscal year.

1) Position Sensitivity:

The position sensitivity will be designated as either Low Risk/Non-sensitive or Moderate Risk/Non-critical Sensitive.

2) Background Investigation:

The level of background investigation commensurate with the required level of access will be either National Agency Check with Written Inquiries or Minimum Background Investigation.

- 3) Contractor Responsibilities -
 - A) The contractor shall bear the expense of obtaining background investigations. If the investigation is conducted by the Office of Personnel Management (OPM), the contractor shall reimburse VA within 30 days.
 - B) The contractor shall prescreen all personnel requiring access to the computer systems to ensure they maintain valid documentation to work in the U.S. and are able to read, write, speak and understand the English language.
 - C) The contractor shall submit or have their employees submit the following required forms to the VA Office of Security and Law Enforcement within 30 days of notification:
 - (i) Standard Form 85, Questionnaire for Non-Sensitive Positions;
 - (ii) FD 258, U.S. Department of Justice Fingerprint Applicant Chart;
 - (iii) VA Form 0710, Authority for Release of Information Form;
 - (iv) Optional Form 306, Declaration for Federal Employment;
 - (v) Optional Form 612, Optional Application for Federal Employment.
 - D) The contractor, when notified of an unfavorable determination by the Government, shall withdraw the employee from consideration from working under the contract.
 - E) Failure to comply with the contractor personnel security requirements may result in termination of the contract for default.
- 4) Government Responsibilities -
 - A) The VA Office of Security and Law Enforcement will provide the necessary investigative forms to the contractor or to the contractor's personnel after receiving a list of names and addresses.
 - B) Upon receipt, the VA Office of Security and Law Enforcement will review the completed forms for accuracy and forward the forms to OPM to conduct the background investigation.
 - C) The VA facility will pay for investigations conducted by the Office of Personnel Management (OPM) in advance. In these instances, the contractor will reimburse the VA facility within 30 days.
 - D) The VA Office of Security and Law Enforcement will notify the contracting officer and contractor after adjudicating the results of the background investigations received from OPM.
 - E) The contracting officer will ensure that the contractor provides evidence that investigations have been completed or are in the process of being requested.
- u) Remote Access:
 - 1) All users accessing the One-VA VPN using non-VA owned Other Equipment (OE) shall fully comply with VA Handbook 6500 and meet waiver requirements. The handbook and waivers shall be viewed at <https://media.vpn.va.gov>. VA Handbook 6500 may also be viewed internally (within the VA network) at <http://vaww1.va.gov/vapubs/viewPublication.asp?PubID=364&FType=2>
 - 2) Section C.3 and C.4 of VA Handbook 6500 (beginning on page 61) outline the remote access requirements all One VA VPN users shall adhere to. Section C.4(n) dictates the personal firewall requirements for devices connecting remotely to the VA network. A list of VA approved firewalls shall be viewed at <https://media.vpn.va.gov> by clicking the link entitled *Anti-Vims/Firewall accepted for use on non-government owned equipment attached to the*

One-VA VPN. The following VA approved personal firewall software products are listed in the above referenced document:

- A) McAfee - Personal Firewall Plus
 - B) Zone Labs - Zone Alarm with Antivirus, ZoneAlarm Pro, ZoneAlarm Security Suite (Note: Freeware Zone Alarm is not allowed for business use per License)
 - C) Symantec - Norton Internet Security, Norton Internet Security Pro, Norton Personal Firewall
 - D) Trend Micro - PC-cillin Internet Security firewall application
 - E) Microsoft - Windows Firewall in Windows XP with SP2 installed (Note: previous Internet Connection Firewall (ICF) is not acceptable)
- 3) The VA Host Intrusion Prevention System (HIPS) agent (Proventia). All VPN users connecting via OE using Proventia shall run one of the VA approved personal firewalls. If you elect to run one of the VA approved firewalls, you shall remove Proventia to prevent potential software conflicts. The updated Proventia agent is accessible at <https://media.vpn.va.gov>. Installation instructions are also posted.
- 4) Users accessing the One-VA VPN using VA Government Furnished Equipment (GFE) shall NOT download the Proventia 9.0 software. You will obtain any necessary updates from your local Information Resource Management (IRM) division or desktop support personnel. If you have any questions, please contact the VANSOC Help Desk at 1-800-877-4328.