DEPARTMENT OF VETERANS AFFAIRS

# OFFICE OF INSPECTOR GENERAL

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

# Delays and Deficiencies in Obtaining and Documenting Mammography Services at the Atlanta VA Healthcare System

## Decatur, Georgia

HEALTHCARE INSPECTION | REPORT #17-02679-283 | SEPTEMBER 13, 2018

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# Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to review a complaint alleging a delay in care after a non-VA imaging center reported mammogram results as normal for a patient with known breast cancer at the Atlanta VA Health Care System (Facility), Decatur, Georgia. In January 2017, the OIG Hotline Division received an email from a complainant with specific allegations:

> [X-ray] images interpreted by a non-VA imaging center in spring 2016 failed to identify the critical finding of a known breast cancer patient and reported the results as normal.
>
> A non-VA imaging center reported a spring 2016 breast exam (mammogram) for a Facility patient as "normal and may have delayed the decision to pursue surgery by reporting 'normal' on the report and follow up with screening mammogram."

The subject of the complaint (patient) is a postmenopausal female whose 2003 mammogram showed abnormal breast findings. In 2005, the patient agreed to have a breast biopsy which was positive for cancer and was referred to an oncologist and surgeon to discuss treatment options. The patient declined to undergo surgery, and in 2008 opted for chemotherapy only.

The OIG did not substantiate that mammography images obtained in spring 2016 at a non-VA imaging center failed to identify a critical finding in a breast cancer patient. Based on OIG's review of the electronic health record (EHR), the patient's films had been stable for six years. The OIG substantiated that the spring 2016 results were reported as normal. While a radiologist who knew the patient's medical history may have interpreted the spring 2016 mammogram differently to account for her previous treatment, the radiologist did not know the history, and did not have access to previous mammogram films; therefore, the interpretation of "normal" was reasonable.[1]

The OIG did not substantiate that the "normal" mammography result from spring 2016 delayed the patient's decision to pursue surgery. Since the 2005 cancer diagnosis, the patient has repeatedly declined surgery and the spring 2016 mammography images reflected a stable condition.

[1] In order to interpret the spring 2016 mammogram as BI-RADS 6 (known biopsy-proven malignancy, prior to completion of surgical excision) and identify that the stable calcifications were located in an area of biopsy-proven malignancy, a radiologist would have had to know about a history of cancer that had not been surgically resected. The VA provider had included the patient's history on the consult for non-VA care when it was submitted; however, the radiologist who interpreted the spring 2016 mammogram did not have information about the patient's diagnosis of breast cancer, treatment history, or decision to forego surgery. The OIG was unable to determine why the imaging provider did not have the information.

The Facility did not offer mammograms for patients on-site at the time that the OIG initiated its review in April 2017. Instead, patients were referred to non-VA providers for this service under several programs used by the Veterans Health Administration (VHA) to purchase care.

The OIG identified issues with the scheduling of appointments when the Facility changed non-VA mammography service providers in October 2015. During its first on-site visit, the OIG also became aware that the Facility had not received results of breast imaging studies that had been performed by non-VA imaging providers. The OIG broadened the scope of the inspection and requested data on mammography orders and consults ordered from October 1, 2014, to June 22, 2017, and found apparent delays in scheduling mammograms.

An OIG clinical review team conducted an in-depth review of 4,727 orders and consults to determine if there were delays in scheduling mammograms and receiving results, and potential relationships between order/consult delays and health events. If a potential clinical impact was identified, an OIG physician conducted an additional review.

During its review of the 4,727 orders and consults, the OIG identified 42 patients whose diagnostic mammograms had not been completed and referred them to the Facility for follow-up. In October 2017, Facility staff informed the OIG that they had contacted the patients, had not identified adverse clinical outcomes related to delays in care of the identified patients, and were monitoring the patients' continuing care.

At the time of a second site visit, October 2–4, 2017, the Facility Director told the OIG that staff had found approximately 3,000 stored, unscanned medical documents. The OIG became concerned that the unscanned documents included mammography results of patients who needed follow-up. The OIG returned to the Facility on October 30, 2017, to evaluate the issue presented by the unscanned records and found numerous boxes of medical documents awaiting review and scanning. The Facility initiated a fact-finding team to determine the reasons for the existence of the unscanned documents. However, some staff refused to participate in the fact-finding review. The Facility Director told the OIG that the fact-finding review was halted and initiated administrative action against staff who refused to participate. In 2017, the Facility provided the OIG with a list of 1,448 records from the approximately 3,000 unscanned documents that had been reviewed and scanned into EHRs. Of the 1,448 records, 21 were mammogram results. The Facility reviewed the 1,448 records to determine if delays in care occurred and contacted patients in need of additional care.[2]

[2] In April 2018, the Facility reported to the OIG that Facility staff had completed a first-level review of all unscanned documents and determined the final number of documents was 2,693 rather than 3,000. The Facility was in the process of reviewing 1,112 of the 2,693 documents that had missing items to determine if a second-level review was necessary. As of April 2018, the Facility had identified one patient whose mammogram was delayed for almost four months who may have been adversely impacted by the delay.

The OIG identified process concerns including

- No defined process to track (1) patients whose scheduled appointments were canceled (patients lost to follow-up) during changes in October 2015 in the provision of non-VA mammography services, and (2) patients who may have experienced delays in care;
- The lack of a streamlined process for scheduling mammography imaging studies and retrieving results, and inconsistencies between Facility practice and policy related to the tracking of mammography reports;
- The failure of a physician to consistently determine the clinical appropriateness of requested care when a mammogram was ordered or a consult was submitted;
- A backlog in scanning non-VA documents into patients' VA EHR that may further impede clinical oversight; and
- Deficiencies in the Women Veterans Health Program including the number of available Designated Women's Health Primary Care Providers and executive level committee oversight.

The OIG made seven recommendations to the Facility Director related to ensuring that (1) patients who were transitioned from the mammography contract provider in October 2015 to other non-VA providers received care, (2) Facility policy and practice are consistent (including mammography coordinator responsibilities), (3) non-VA mammograms are timely scheduled and completed, (4) consistent clinical review of the mammogram request is performed, (5) availability of mammogram results is improved, (6) gender-specific care is provided by Women's Health Primary Care Providers, and (7) the Facility provides executive oversight of its Women Veterans Program.

## Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan. (See Appendixes E and F, pages 75-81 for the Directors' comments.) The OIG will follow up on the planned actions until they are completed.

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# Abbreviations

| | |
|---|---|
| BI-RADS | Breast Imaging Reporting and Data System |
| CDW | Corporate Data Warehouse |
| Choice | *Veterans Access, Choice, and Accountability Act of 2014* |
| CPT | current procedural terminology |
| EHR | electronic health record |
| FDA | Food and Drug Administration |
| FY | fiscal year |
| HIMS | Health Information Management System |
| ICD-9-CM | International Classification of Diseases, Ninth Revision, Clinical Modification |
| MSA | medical support assistant |
| MRI | Magnetic Resonance Imaging |
| NP | nurse practitioner |
| NVCC | Non-VA Care Coordination |
| OAE | Office of Audits and Evaluations |
| OIG | Office of Inspector General |
| PC3 | Patient-Centered Community Care |
| SOP | standard operating procedure |
| TPA | third-party administrator |
| VA | Department of Veterans Affairs |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |
| WH-PCP | women's health primary care provider |
| WVHC | Women Veterans Health Committee |

# Introduction

## Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to review a complaint alleging a delay in care after a non-VA imaging center reported mammogram results as normal for a patient with known breast cancer at the Atlanta VA Health Care System (Facility), Decatur, Georgia.

## Background

### Facility Profile

The Facility, part of Veterans Integrated Service Network (VISN) 7, is a tertiary care hospital consisting of a main hospital complex in Decatur, Georgia, and community based outpatient clinics in Atlanta, Austell, Blairsville, Fort McPherson, Fulton County, Gwinnet County, Henderson Mill, Lawrenceville, Newnan, Oakwood, Rome Outreach, Stockbridge, and Trinka Davis Veterans Village. The Facility operates 466 inpatient beds including a 120-bed Community Living Center, a 40-bed domiciliary, and a 21-bed Residential Treatment Program. The Facility is affiliated with Emory University School of Medicine and Morehouse School of Medicine.

In fiscal year (FY) 2016, the Facility, along with its community based outpatient clinics, served 109,077 veterans, of whom 14,180 were women. The Facility's Women Veterans Program has one of the largest women veteran populations in VA and provides gender-specific services including cervical and breast cancer screening, birth control, preconception counseling, menopausal support, as well as mental health care. However, the Facility does not provide mammograms on-site and patients are referred to non-VA providers for these services. Mammograms represent a significant percentage of services obtained from non-VA providers. In FY 2016, the Facility requested 7,762 non-VA care consults, of which 3,099 (40 percent) were for mammograms.[3]

### Prior Reports

In January 2017, the OIG Office of Audits and Evaluations (OAE) published the results of a review conducted to assess concerns raised about the implementation of the Choice program and

[3] VHA Support Service Center summary report of Non-VA Care Choice Consults for all of VA. FY 2016 Choice Consult Detail Report. (Data were obtained from an internal VHA website that was accessed April 18, 2017.)

barriers facing veterans trying to access it.[4] The OIG OAE found that a cumbersome process for scheduling care, inadequate provider networks, and veterans potentially being financially responsible for their care created considerable barriers to care.

## Breast Cancer

Breast cancer is an abnormal growth of breast cells and is the second most common cancer in American women.[5] Breast cancer can start in different parts of the breast. The general types are

- Ductal cancers that start in the ducts that carry milk to the nipple,
- Lobular cancers that start in the glands that make breast milk, and
- Sarcomas and lymphomas that may be found in the breast but are not generally considered breast cancers.[6]

According to the American Cancer Society, "results from many decades of research clearly show that women who have regular mammograms are more likely to have breast cancer found early, are less likely to need aggressive treatment like surgery to remove the breast (mastectomy) and chemotherapy, and are more likely to be cured."[7]

## Mammography

Mammography is a radiological exam that evaluates the breasts for the purpose of detecting breast cancer. In the VA, Mammography Interpreting Physicians provide consultation and guidance to health care providers regarding mammographic technical findings and their implications.[8] The two types of mammograms are screening and diagnostic. Screening exams detect unsuspected breast cancer at an early stage in asymptomatic women.[9] Diagnostic exams

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[4] VA Office of Inspector General, *Review of the Implementation of the Veterans Choice Program,* Report No. 15-04673-333, January 30, 2017. The Choice program was implemented pursuant to the *Veterans Access, Choice, and Accountability Act of 2014*. Veterans are eligible to receive care through the Choice program if they live more than 40 miles from a VA facility and would wait more than 30 days to receive services through VA.

[5] About Breast Cancer: How Common is Breast Cancer? American Cancer Society Web Site. https://www.cancer.org/cancer/breast-cancer/about/how-common-is-breast-cancer.html. (The website was accessed on June 21. 2017.)

[6] About Breast Cancer: Where Breast Cancer Starts. American Cancer Society Web Site. https://www.cancer.org/cancer/breast-cancer/about/what-is-breast-cancer.html. (The website was accessed on June 21, 2017.)

[7] Breast Cancer Early Detection and Diagnosis: American Cancer Society Recommendations for the Early Detection of Breast Cancer. American Cancer Society Web Site. https://www.cancer.org/cancer/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html. (The website was accessed on November 30, 2017.)

[8] VHA Handbook 1105.03. Mammography Program Procedures and Standards, April 28, 2011.

[9] VHA Handbook 1105.03.

provide specific analytic evaluation of patients who have clinical signs or symptoms of breast disease, or screening-detected findings of concern.[10]

The Food and Drug Administration (FDA) requires all FDA-certified breast imaging facilities to include a final assessment of the findings in their mammography reports that categorize results as listed below:[11]

> (A) "Negative:" Nothing to comment upon (if the interpreting physician is aware of clinical findings or symptoms, despite the negative assessment, these shall be explained),
>
> (B) "Benign:" Also a negative assessment,
>
> (C) "Probably Benign:" Finding(s) has a high probability of being benign,
>
> (D) "Suspicious:" Finding(s) without all the characteristic morphology of breast cancer but indicating a definite probability of being malignant,
>
> (E) "Highly suggestive of malignancy:" Finding(s) has a high probability of being malignant, and
>
> In cases where no final assessment category can be assigned due to incomplete work-up, "Incomplete: Need additional imaging evaluation" shall be assigned as an assessment and reasons why no assessment can be made shall be stated by the interpreting physician.

The American College of Radiology (ACR) developed a standardized reporting system for mammogram results, called the Breast Imaging Reporting and Data System (BI-RADS), which combines the wording from the FDA and a numerical score to identify an assessment category, as follows:[12]

- BI-RADS code 1 (Negative): no mammographic evidence of malignancy,
- BI-RADS code 2 (Benign): no mammographic evidence of malignancy,
- BI-RADS code 3 (Probably Benign): reserved for findings that are almost certainly benign, having less than a 2 percent risk of malignancy,
- BI-RADS code 4 (Suspicious): reserved for findings that do not have the classic appearance of malignancy, but have a wide range of probability of malignancy that is greater than those in code 3; per FDA, this is a positive mammogram,

[10] VHA Handbook 1105.03.

[11] FDA Code of Federal Regulations Title 21 900.12(c)(1)(iv). Information in this CFR Title 21 is current as of April 1, 2017.

[12] D'Orsi CJ, Sickles EA, Mendelson EB, Morris EA, et al. (eds), *American College of Radiology Breast Imaging Reporting and Data System BI-RADS,* 5th ed. (American College of Radiology, Reston, VA 2013.) In some instances, Facility documents refer to assessment categories as scores.

- BI-RADS code 5 (Highly Suggestive of Malignancy): high probability [greater than or equal to (≥) 95 percent] of being cancer; includes lesions for which one-stage surgical treatment could be considered without preliminary biopsy; per FDA, this is a positive mammogram,
- BI-RADS code 6 (Known Biopsy Proven Malignancy): reserved for lesions identified on the imaging study with biopsy proof of malignancy prior to complete surgical excision, and
- BI-RADS code 0 (Incomplete: Need Additional Imaging Evaluation): may be used to indicate that additional imaging is necessary or that prior comparison of films or images are needed to complete the interpretation. (According to VHA policy, a Code 0 mammogram interpretation will not be delayed beyond 48 hours due to lack of comparison studies.[13])

VHA requires facilities providing breast imaging studies to be certified either through the FDA, FDA-approved alternate programs, or through VHA. Additionally, VHA staff must enter BI-RADS assessment categories into the EHR.[14]

## Order

In VA, an order is used by a provider as an instruction or direction that care be obtained from another provider or service. The order must contain several items including the date, time the order was written, a complete reason for the exam with a brief clinical history, and the name of the practitioner placing the order. It must be signed and correspond to the provider's clinical privileges or scope of practice as defined by the Facility's bylaws.[15]

## Consults

The Facility did not offer mammograms or breast biopsies in house. Prior to October 29, 2015, the Facility had an arrangement with a non-VA hospital that allowed a provider to enter a mammography order without a consult. After that arrangement expired, providers were required to place both an order and a non-VA Care Coordination (NVCC[16]) consult to obtain a mammogram via a community provider.

[13] VHA Handbook 1105.03.

[14] VHA Handbook 1105.03.

[15] VHA Handbook 1907.01, Health Information Management and Health Records, March 19, 2015.

[16] Within the context of this report, the OIG uses the term NVCC to represent both Non-VA Care and Non-VA Care Coordination as this was terminology used during much of the time frame of events discussed in this report. VHA has since adopted different terminology to describe non-VA care.

VHA Directive 1232(1), *Consult Processes and Procedures,* describes a clinical consult as a

> …document in Computerized Patient Record System (CPRS)[17, 18] used as two-way communication on behalf of a patient consisting of a physician or provider (sender) request seeking opinion, advice, or expertise regarding evaluation or management of a specific problem answered by a physician or other health care provider (receiver).[19]

The clinician enters a consult request for services using the electronic consult package. Because the Facility did not offer mammography services, clinicians had to submit an NVCC consult for the test to be completed outside of the VA. A consult remains unresolved until a specific action is taken to close it. A consult can be closed administratively (for example, discontinued or canceled) by clinical or administrative staff. Alternatively, the consult may be closed by a clinician by properly entering a note into the consult package indicating that the consult has been completed. If the clinician enters a note outside of the consult package, the consult remains open even though care has been rendered.[20]

## Facility Process for Mammogram Consults

As noted above, the Facility does not provide breast imaging studies or breast biopsies on-site. The process for obtaining mammography services from non-VA providers has changed multiple times as VA programs for obtaining care in the community have evolved.

[17] VHA Directive 2008-056. *VHA Consult Policy*, September 16, 2008 was in effect during some of the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1232(1), Consult Processes and Procedures, August 24, 2016, amended Sep 23, 2016.

18 VHA's consult package is incorporated within its Computerized Patient Records System (CPRS).

19 VHA Directive 2008-056, VHA Directive 1232(1). VHA Directive 1232(1) contains similar language regarding the definition of a consult as 2008-056 but distinguishes between a clinical consult (two-way communication) and an administrative consult (one-way communication).

20 VHA Directive 2008-056; VHA Directive 1232(1).

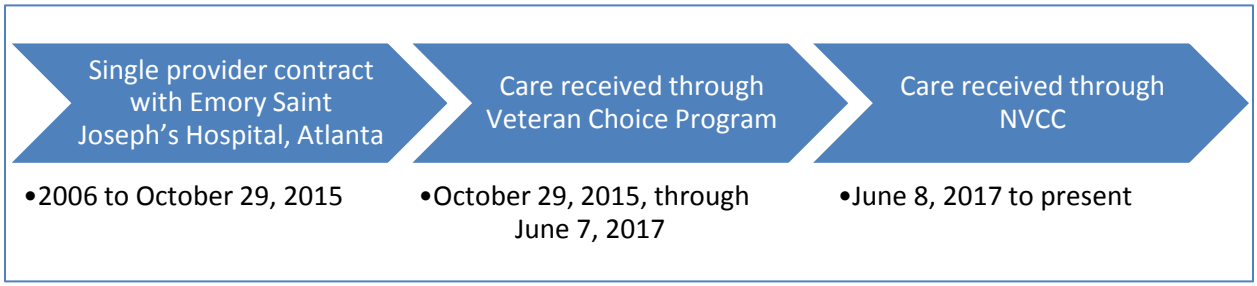


*Figure 1. Timeline for Atlanta VA HCS Mammography Process*
*Source: VA OIG analysis*

## Emory Saint Joseph's Hospital, Atlanta

In FY 2006, the Facility established a single provider contract with Emory Saint Joseph's Hospital, Atlanta (St. Joseph's) for all breast imaging studies, biopsies, and surgical treatment.

Under the St. Joseph's contract, the requesting VA physician entered an order, without a consult, in the EHR. Facility staff first contacted the patient to determine the preferred date and time, and then contacted St. Joseph's staff to schedule mammograms, other diagnostic imaging, or biopsies. Once St. Joseph's staff completed the imaging studies or biopsies, results were sent directly to the patient and the Facility. The St. Joseph's contract expired in October 2015. The Facility initiated the transition to the Choice program effective October 29, 2015.

## Veterans Choice Program

Traditional non-VA care refers to the process through which VA purchases care from community providers without the involvement of third-party administrators (TPAs).[21] Historically, the Facility implemented this through the contract with St. Joseph's whereby the Facility scheduled mammograms and retrieved results directly from St. Joseph's. In October 2015, the Facility transitioned to the *Veterans Access, Choice, and Accountability Act of 2014* (Choice) program, which changed the traditional non-VA care program.

Under Choice, VA contracts with TPAs to purchase care from non-VA community providers.[22] Veterans are eligible to receive care through Choice if

- They live more than 40 miles from a VA facility, and
- They would wait more than 30 days to receive services through VA.

[21] A TPA is an administrator or corporation which performs administrative functions such as overseeing the authorization of medical treatments and payment of claims.

[22] The TPA had already established provider networks under a different community care program, Patient Centered Community Care (PC3).

In cases when care is not available timely in the Facility, the Facility may refer patients for care to other VA medical centers, other non-VA facilities as part of sharing agreements, or non-VA community providers.

The Facility's transition to the Choice program in October 2015 for obtaining mammograms created challenges with the timely scheduling of appointments and retrieving results. When Choice was implemented, the Facility discontinued all current screening and diagnostic mammography orders. Only patients who needed follow-up after completion of an abnormal mammogram were referred to NVCC for care. The Facility had no process to transition requests for previously requested and new mammograms. After transitioning to Choice, requesting mammograms became a two-step process requiring both an order and a consult. Providers were instructed to re-submit an order and initiate a *consult* for the previously ordered, then discontinued mammograms.

VHA issued a Standard Operating Procedure (SOP) for Choice[23] and the Facility adopted additional steps into the consult process:

- NVCC conducted a clinical review.
- The Call Center[24] Medical Support Assistant (MSA) contacted the patient to opt in to the TPA.[25]
- The Call Center MSA completed the VHA Choice Approval for Medical Care form (VA Form 10-0386)[26]
- NVCC staff uploaded the order and the consult to the TPA contractor portal.[27]

[23] Choice First Standard Operating Procedure-Clinical Review. Page 3, paragraph 3, *Clinical Review for NVC Consult.* The Choice First Standard Operating Procedure provides procedures for non-VA Medical Care Consult/Referral Review Process. (This document is located on an internal VA website that is not available to the public. The website was accessed on July 12, 2017.)

[24] The Facility Call Center is a centralized system that allows access to the Facility through a telephone. Call Center staff provide immediate patient assistance for issues such as prescription refills, eligibility for care, and help for veterans with non-emergent healthcare problems. The Call Center operates 24 hours a day, seven days a week.

[25] VHA Directive 1230, Outpatient Scheduling Processes and Procedures, July 15, 2016.

[26] Choice First Standard Operating Procedure.

[27] Choice First Standard Operating Procedure; the TPA contractor portal is the computerized system that serves as a conduit between the Facility NVCC staff and the TPA.

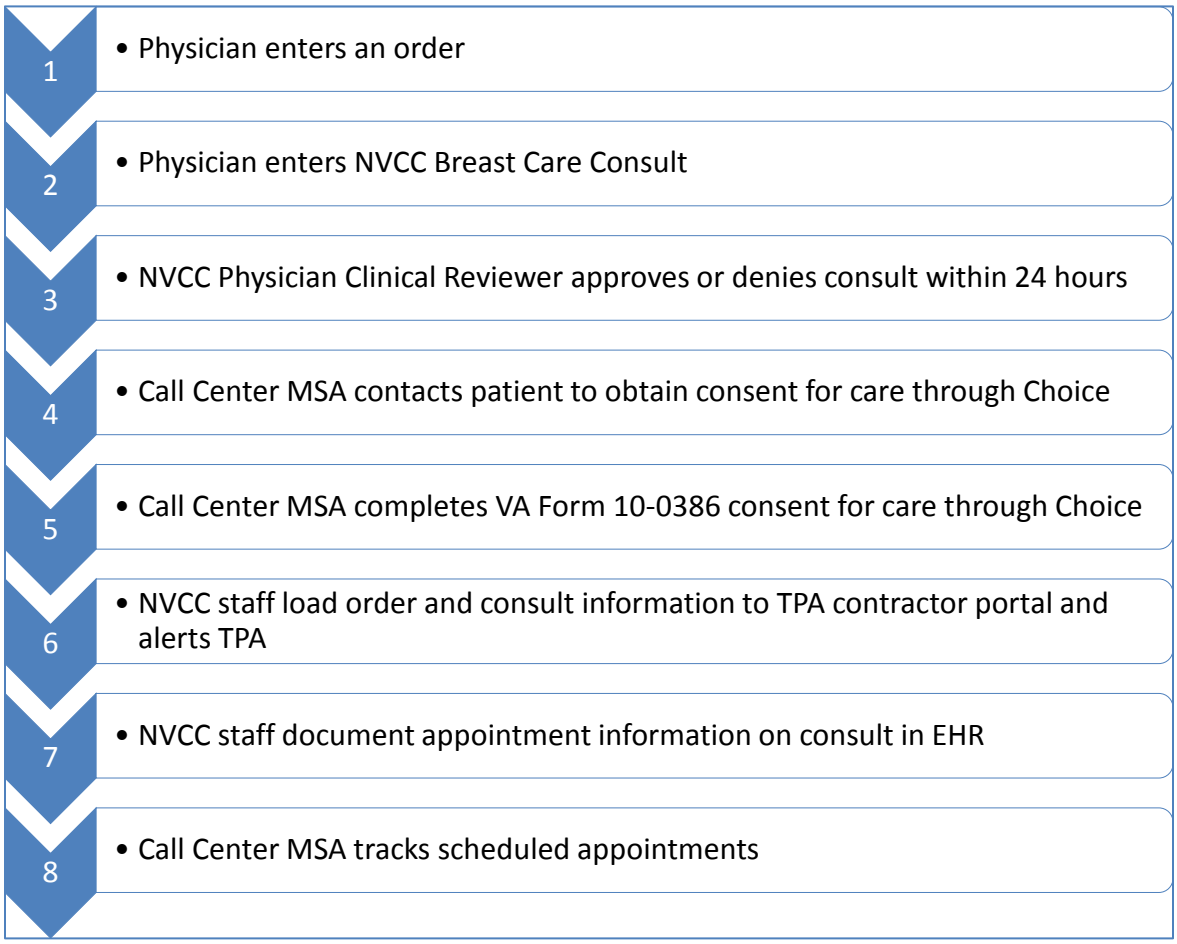


*Figure 2. Atlanta VA HCS Mammography Ordering Process*
*Source: VA OIG analysis of Facility process*

The TPA contacted the patient to determine preferred appointment time, location, and provider. Once an appointment was scheduled, the TPA sent the VA referral packet containing the order and the consult, along with a bar coded facsimile (fax) sheet to the imaging provider. If they were unable to contact the patient or schedule an appointment within contract guidelines, the consult was returned to NVCC.[28]

Upon completion of the mammogram, the imaging center notified the patient of the results and faxed the results report to the TPA. If a bar-coded fax sheet was used, the reports were automatically uploaded from the imaging provider to the TPA system and attached to the patient's consult. If a bar-coded fax sheet was not used, the TPA employee manually uploaded the reports and attached them to the patient's consult. An electronic notification was sent to the Facility that the reports were available.

[28] The TPA had five days to schedule the appointment.

Under Choice, once the Facility received the mammogram reports,[29] NVCC staff downloaded and printed the reports and hand-carried them to the mammography coordinator. The mammography coordinator registered the reports in the radiology package and hand-carried them to the medical records department. Medical records department staff scanned the report into the EHR. Once reports were scanned into the EHR, the mammogram coordinator entered the BI-RADS category and the recommendations from the imaging center. The mammography coordinators contacted the patient's physician to request additional testing if required. The VA ordering provider was responsible for discussing the meaning of the reports and alternatives for further study, treatment, or referral with the patient.[30] Figure 3 illustrates the steps of the retrieval process.

[29] The Facility only received the results of the mammogram. Mammography films were available if specifically requested.

[30] VHA Handbook 1105.3, *Mammography Program Procedures and Standards*, para 25. (j) (2) page 28.

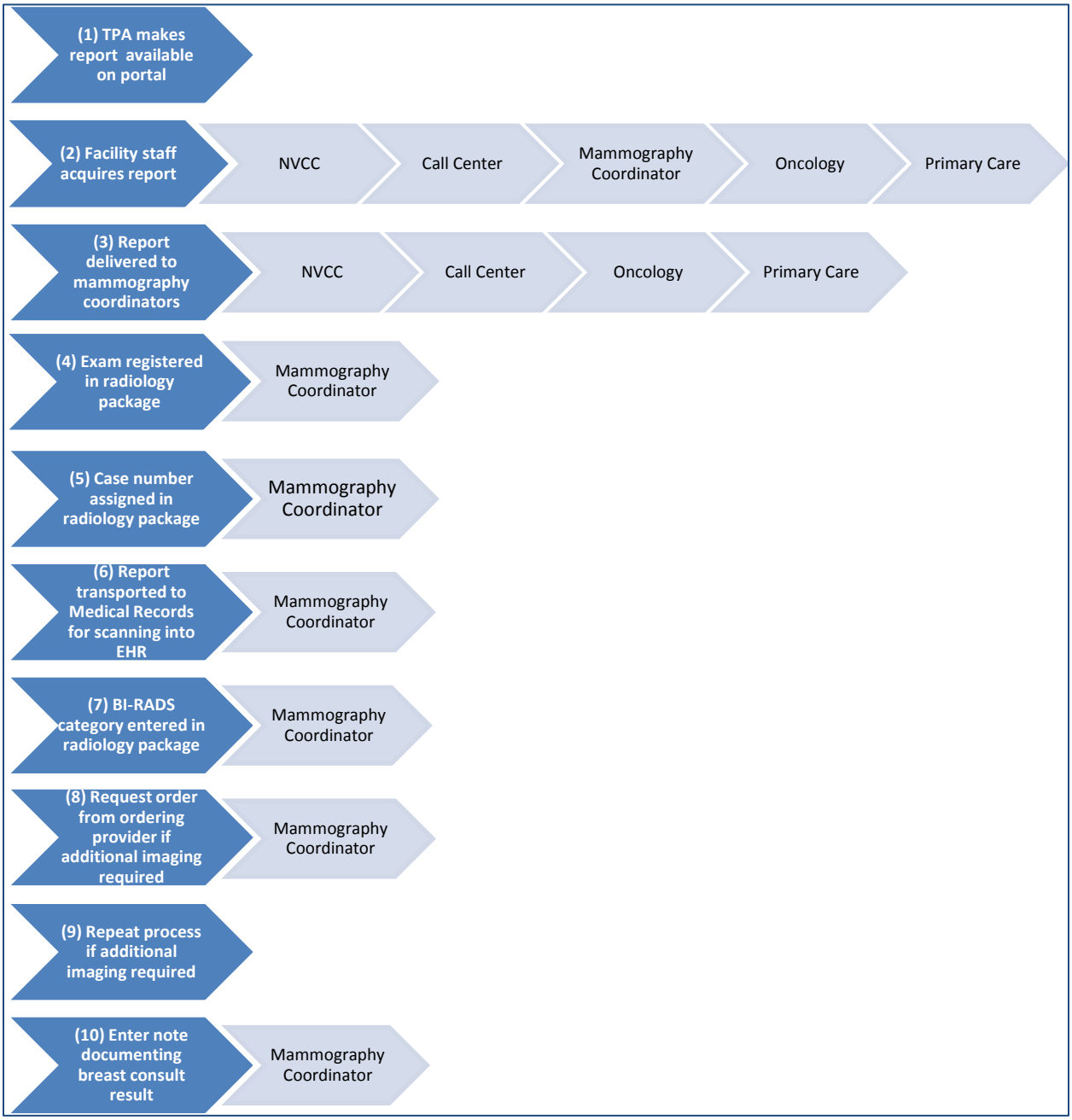


*Figure 3. Atlanta VA HCS Mammography Report Retrieval Process*
*Source: VA OIG analysis of Facility process*

Under the Choice process, which involved more than one imaging center and TPA, the Facility experienced difficulty obtaining mammogram results and developing processes to obtain those results from providers. The Facility elected to return to the previous NVCC process that did not involve TPAs.

### *NVCC*

The *Non-VA Medical Care Consult Referral Management Guide*, October 28, 2014,[31] states that VA may purchase care and/or medical services directly from the community when

- The care/services cannot be physically furnished by VA facilities,
- [The] Veteran cannot safely travel due to medical reasons,
- [Services] Cannot be furnished in a timely manner in VA facilities,
- [Services] Cannot be furnished due to geographic inaccessibility, and
- "Other" Example ACI (Accelerating Care Initiative).

The Facility's process using NVCC involved multiple steps:

- The provider entered (a) an order for a mammogram and (b) an NVCC consult.
- The NVCC Clinical Reviewer approved or denied the consult based on
  - Patient eligibility criteria,
  - Clinical appropriateness of the test (screening mammogram versus diagnostic mammogram), and
  - Duplication of request.
- NVCC staff then
  - Contacted the patient to obtain the preferred testing location and date,
  - Scheduled the mammogram with the imaging provider and contacted the patient to confirm the appointment,
  - Sent an authorization letter to the patient that includes the authorization number, date, and location of appointment, and
  - Documented the appointment information on the mammography consult in the patient's EHR.

Approximately two weeks after the appointment date, NVCC staff contacted the imaging provider to obtain the mammogram reports. Once staff acquired the reports, the process of incorporating the results into patients' VA EHRs was initiated.

[31] The Non-VA Medical Care Consult/Referral Management Guide October 28, 2014.

## Communication of Mammography Test Results

The FDA requires that patients receive a written mammography report from the imaging provider within 30 calendar days of the examination. If the mammogram is "suspicious" (BI-RADS 4) or "highly suggestive of malignancy" (BI-RADS 5), the results must be communicated to the patient as soon as possible; the FDA recommends no longer than five business days.[32]

VHA Directive 1088, *Communicating Test Results to Providers and Patients,* states that

> …all test results requiring action must be communicated by the ordering provider, or designee, to patients no later than 7 calendar days from the date on which the results are available. For test results that require no action, results must be communicated by the ordering provider, or designee, to patients no later than 14 calendar days from the date on which the results are available. Depending on the clinical context, certain test results may require review and communication in shorter timeframes.[33]

## Allegations

In January 2017, the OIG received an email from a complainant with specific allegations:

- [X-ray] images interpreted by a non-VA Imaging Center in spring 2016 failed to identify the critical finding of a known breast cancer patient and reported the results as normal.
- A non-VA imaging center reported a spring 2016 breast exam (mammogram) for a Facility patient as "normal and may have delayed the decision to pursue surgery by reporting 'normal' on the report and follow up with screening mammogram."

## Other Concerns

During the inspection, the OIG identified several issues:

- Lack of a streamlined mammography process including tracking deficiencies
- Delays in care
- A physician failed to consistently determine the clinical appropriateness of requested care when a mammogram was ordered or a consult was submitted
- A scanning backlog

[32] VHA Directive 1330.01, *Health Care Services for Women Veterans,* February 15, 2017. This VHA directive updated the description of the standard requirements for the delivery of health care to women veterans and specified services that must be provided at each VA medical facility.

[33] VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

- Deficiencies in the Facility's Women Veterans Program

# Scope and Methodology

The OIG initiated a review on April 18, 2017; visited the Facility on May 8–12, October 2-4, and October 30, 2017; and conducted follow-up telephone interviews October 31–November 2, 2017. The OIG interviewed the complainant, Facility Director, Chief of Staff, Facility leaders, a Radiology staff physician, Administrative Officer, a subject matter expert for the Breast Cancer Registry, Clinical Director of NVCC, NVCC staff, Assistant Chief of Primary Care, NVCC Physician Clinical Reviewer, Women Veterans Program Manager, mammography coordinators, a Hematology/Oncology clinician, Risk Manager, Call Center staff, and select Choice imaging center providers.

The OIG reviewed relevant VHA directives and handbooks, Facility policies and procedures, Joint Commission standards, FDA standards, and select peer reviewed journals. The OIG also reviewed Facility reports on VA Breast Cancer Registry data, abnormal mammography tracking information, Patient Advocate Tracking data, electronic patient event reports, tort claims data, the Choice Performance of Work Statement, and the Quality Assurance Surveillance Plan.

During an on-site visit, the OIG became aware that the Facility had not received results of 3,000 breast imaging studies that had been performed by non-VA imaging providers. The OIG was informed that the Facility Director became aware of this issue in February 2017 and implemented a plan to address it.

At the time of the transition from the St. Joseph's contract to Choice, about 1,500 mammogram orders had been entered but had not been scheduled. When the St. Joseph contract ended, these orders were discontinued. In order to evaluate the Facility's process for tracking patients whose scheduled appointments were canceled during the transition (patients lost to follow-up) that may have resulted in delays in care, the OIG broadened the scope of its inspection. The OIG analyzed consult and order data obtained from the Corporate Data Warehouse (CDW), a centralized data repository that contains VHA clinical, administrative, and financial data, for apparent delays in patient care from the start of FY 2015 (October 1, 2014) through June 22, 2017.

During telephone interviews in November 2017, Facility staff told the OIG of a growing backlog of unscheduled mammograms. The OIG then incorporated data on mammography orders and mammography consults from June 22, 2017, to November 3, 2017 into the review. The OIG also contacted all 41 non-VA Facility referral imaging centers to discuss their patient results notification processes.

# EHR Methodology

## Study Population

The study population of 28,391 comprised all patients at the Facility who had at least one order and patients with both an order and consult for mammography from October 1, 2014, through June 22, 2017 (study period). The OIG identified the study population using CDW data that were extracted on June 22, 2017.

The OIG analyzed CDW data to

- Obtain occurrences of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and ICD-10 codes[34] (listed in Appendix A) that may be related to breast cancer,
- Identify Current Procedural Terminology (CPT) codes[35] (listed in Appendix A) for outpatient procedures that may be related to cancer therapies,
- Identify patients who were hospitalized, and
- Identify deceased patients and review their EHRS to determine if a cause of death was listed; if no cause of death was listed, the OIG reviewed the most recent progress notes and problem lists to determine if the patient had a diagnosis of breast cancer.

## Patients with at Least One Apparent Order/Consult Delay

The OIG determined that 12,863 patients experienced an apparent order/consult delay if at least one of the patient's mammogram orders/consults was not completed within the physician's requested timeframe documented in the order/consult urgency field. The start date for this timeframe was the order date or the date the physician requested to have the study completed, whichever occurred later. The end date was the date of the first imaging study associated with the order/consult, the date the patient died, the date the order/consult was discontinued, or the data pull date if the order/consult was still in a pending status. For additional information on timeliness expectations based on the documented order urgency, see Appendix A.

## Patients with at Least One "Selected Health Event"

Because a significant number of instances where screening and diagnostic mammograms appeared to be delayed was identified, the OIG assessed whether patients may have experienced

[34] World Health Organization (WHO). *Classifications*. International Classification of Diseases (ICD) is the foundation for the identification of health trends and statistics globally.

[35] Current Procedure Terminology contains standard terms and descriptors to document procedures in the medical record, and communicate accurate information on procedures to insurance agencies and other organizations concerned with claims.

an adverse clinical outcome related to the apparent delay. The OIG analyzed CDW data for patients with at least one adverse health event following the delay, referred to as a selected health event, occurring after the first delayed consult was requested and through June 22, 2017. The selected health events were

- Breast cancer and other breast tissue conditions that may require timely intervention,
- Hospital admission,
- Chemotherapy and radiation therapy,
- Procedures that may be related to cancer therapies, and
- Death.

The OIG selected these health events because they represented those that could potentially be attributed to mammography delays and could be readily identified using VHA's administrative data. The OIG identified 3,284 orders and 1,443 consults for 2,729 patients meeting the delay criteria who had a selected health event.[36]

## Impact of Order/Consult Delays

An OIG clinical review team evaluated the 4,727 orders and consults to determine if (a) an actual delay had occurred, and (b) there was a potential relationship between order/consult delays and selected health events. An order/consult delay could be related to the selected health event if the delay potentially led to the health event or delayed diagnosis and treatment for a breast condition. If potential clinical impact was identified, an OIG physician conducted an additional review.

The OIG did not review the EHRs of those patients who had apparent delays in care but did not have one of the selected health events.

## Factors that Contributed to Delays

To understand factors that contributed to delays, the OIG interviewed leaders and other staff from the Facility, and non-VA community providers familiar with Choice. The OIG also requested and reviewed relevant documentation, including correspondence between Facility staff and leaders, internal reports, and EHRs.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

[36] The OIG's discussion focuses on the number of adverse health events related to the orders and consults and not the number of unique patients.

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to substantiate or not substantiate an allegation when the available evidence is insufficient to determine whether or not an alleged event or action took place.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

# Case Summary

The patient, who is the subject of the complaint, is a postmenopausal female in whom a potential *left* breast mass was identified via shoulder x-ray during an evaluation for left shoulder pain in 2003. A follow-up diagnostic mammogram showed abnormal findings in only the *right* breast. The patient declined to have a breast biopsy because she was averse to the idea that a marker would be left at the biopsy site and because breast imaging studies prior to 2003 had not detected abnormalities.

The patient consented to a right breast biopsy in 2005 after multiple discussions with primary care staff pertaining to the importance of the biopsy in determining whether or not cancer was present in the breast. The biopsy was positive for cancer. The patient was referred to an oncologist and a surgeon to discuss treatment options. She was advised to undergo lumpectomy[37] and sentinel lymph node biopsy.[38] The patient ultimately declined to undergo surgery and cited multiple reasons for this decision during visits to the oncology clinic in the ensuing months. Stated concerns included risks inherent to anesthesia and surgery, a belief that the diagnosis was incorrect because the cancer was only detected on imaging, it could not be palpated in the breast, and fear that should cancer actually be present, surgery would cause the tumor to spread.

The patient continued treatment with her primary care and oncology providers and had a *diagnostic* mammogram completed at Emory University Hospital in 2007 that showed an increase in number and size of the calcifications in the area with biopsy-proven breast malignancy. Magnetic resonance imaging (MRI) was recommended to further assess the abnormalities in the breast; the patient declined to have this done because of claustrophobia and a desire to avoid sedation. The next *diagnostic* mammogram, performed in early 2008, showed an "irregular mass" with associated calcifications that had increased in size since 2007. The patient continued to decline treatment. Later in 2008, the patient informed oncology clinicians that she could feel an enlarging lump in her right breast and examination revealed a mass in the right breast. The patient agreed to undergo a positron emission tomography/computed tomography scan that confirmed a mass in the right breast, as well as reactive lymph nodes in the

[37] A lumpectomy is an operation to remove the cancer and some normal tissue around it, but not the breast itself. It is also called breast-conserving or breast-sparing surgery. NCI Dictionary of Cancer Terms, Available at: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/lumpectomy. (This website was accessed on March 9, 2018.)

[38] A sentinel lymph node biopsy is the removal and examination of the sentinel node(s) - the first lymph node(s) to which cancer cells are likely to spread from a primary tumor. NCI Dictionary of Cancer Terms. https://www.cancer.gov/publications/dictionaries/cancer-terms/def/sentinel-lymph-node-biopsy. (The website was accessed on March 9, 2018.)

area under the right arm.[39] The patient consented to a course of chemotherapy to shrink the tumor to be followed by surgical consultation.

The patient completed chemotherapy in early 2009. Following chemotherapy, the patient had a *diagnostic* mammogram which showed residual calcifications; the radiologist recommended an MRI to assess for residual tumor. The MRI showed resolution of the previously identified large right breast mass with no suspicious abnormalities noted in either breast. The patient declined surgery.

Following chemotherapy, the patient continued to undergo breast imaging at St. Joseph's. Between June 2009 and June 2015, all findings were interpreted as BI-RADS 6 (known biopsy-proven malignancy, prior to complete surgical excision). The patient was seen in the VA Oncology Clinic in 2015 and the plan documented in the EHR was "next mammogram in [two months] (2015)."

In spring 2016 (month 1), the patient went to a different non-VA mammogram provider in the community under the newly implemented Choice program and had a *diagnostic* mammogram of the right breast. The history on the consult submitted by the VA provider indicated that the patient had a history of breast cancer; the results received from the imaging center indicated the reason for the request was "treatment for DCIS in the right breast."[40] The mammogram was interpreted by the radiologist as BI-RADS 1, indicating no evidence of malignancy.[41] The mammogram report noted that the most recent comparison film was from 2012 and that comparison with more recent exams would be useful, if available. The radiologist recommended that the patient return for bilateral mammography in six months.

One month later (month 2), the patient was seen by a VA oncology nurse practitioner (NP). The month 1 diagnostic mammogram in the EHR recommended that the patient follow up with her routine screening mammogram. The NP placed a consult/order in month 2 for the recommended screening mammogram to occur in month 6. However, NVCC staff discontinued the month 2 consult. Reportedly, the TPA was unable to reach the patient and had returned the consult to the Facility. NVCC staff documented that the TPA returned the consult, after several call attempts

[39] A positron emission tomography (PET) scan is a procedure in which a small amount of radioactive glucose (sugar) is injected into a vein; a scanner is used to make detailed, computerized pictures of areas inside the body where the glucose is taken up. Because cancer cells often take up more glucose than normal cells, the pictures can be used to find cancer cells in the body. A PET may be combined with a computed tomography (CT) scan. https://www.cancer.gov/publications/dictionaries/cancer-terms/search?contains=false&q=PET. (The website was accessed on March 9, 2018.)

[40] DCIS or ductal carcinoma in situ is a noninvasive condition in which abnormal cells are found in the lining of a breast duct and have not spread outside the duct to other tissues in the breast. https://www.cancer.gov/publications/dictionaries/cancer-terms/def/dcis. (The website was accessed on March 9, 2018.)

[41] Typically, with known breast cancer, the BI-RADS assessment category would be reported as 6, indicating known tissue diagnosis of malignancy, prior to complete surgical excision.

were made. However, the comments from the TPA about call attempts were related to a mammogram consult/order that had been placed in early 2016. NVCC discontinued the month 2 consult for a screening mammogram that was to be completed in month 6 in error.

Meanwhile, in month 2, the same Facility that performed the mammogram the previous month received mammographic images from 2014 and 2015 and a second radiologist compared the images to the month 1 mammogram. The second radiologist also interpreted the month 1 mammogram as BI-RADS 1 and recommended "annual screening mammogram," but did not specify when this should occur. The report was sent to the VA mammography coordinator for entry of the results into the EHR. The mammography coordinator erroneously recorded the examination as a *screening* mammogram instead of a diagnostic mammogram and changed the follow-up recommendation from "annual screening mammogram" to "next mammography recommended in 12 months" during transcription of the results into the EHR. This documentation occurred after the patient's month 2 Oncology Clinic visit.

A second consult for a bilateral screening mammogram was placed by a staff oncologist in month 4. This consult noted that the patient was due for imaging of the left breast. The month 4 consult was discontinued in the next month by an NVCC nurse who referenced the month 1 study (performed on the right breast) and inaccurately characterized the consult as a "duplicate." The staff oncologist placed an additional, third consult for a bilateral screening mammogram in month 5 and this consult was discontinued by the NVCC Clinical Reviewer because data were missing in multiple required fields. The staff oncologist placed a fourth bilateral screening mammogram consult later in month 5. This consult was also discontinued by an NVCC nurse who again referenced the month 1 report and inaccurately labeled this consult as a "duplicate." In month 8, the patient's primary care provider placed a fifth consult for the bilateral screening mammogram and a screening mammogram was completed at a different (third) imaging center in month 9.

The month 9 mammogram was interpreted as a BI-RADS 6 (known biopsy-proven malignancy, prior to complete surgical excision). The radiologist noted calcifications that were unchanged in the site of the prior area of biopsy-proven malignancy. The radiologist recommended surgical consultation and continued clinical follow-up. The primary care provider and oncology NP placed surgical consult requests and at least one appointment was made at a surgical clinic in the community. However, a staff member at the surgical clinic informed a VA employee that the patient did not keep this appointment. As of late 2017, the patient's EHR did not contain documentation of a surgical evaluation.

# Inspection Results

# Issue 1: Alleged Deficiencies in Mammography Services for the Subject Patient

## Imaging Results Interpretation

The OIG did not substantiate that the month 1, 2016 mammography images obtained at a non-VA community imaging center failed to identify a critical finding in the subject cancer patient. The month 1 mammogram report was interpreted as BI-RADS 1 or "negative" by two radiologists. Prior to the month 1 mammogram, post chemotherapy mammogram reports had been interpreted as BI-RADS 6 which implied a history of biopsy-proven malignancy in the breast, without complete surgical excision (in this case treated with chemotherapy) or abnormalities other than the known cancer, requiring evaluation.[42] Prior BI-RADS 6 mammogram reports noted calcifications in the biopsy-proven malignancy cancer area that had remained stable since 2009 and had even decreased during some of the study intervals.

In order to interpret the month 1 mammogram as BI-RADS 6 and identify that the stable calcifications were located in an area of biopsy-proven malignancy cancer, the radiologists would have had to know about the history of cancer that had not been surgically resected. Although the VA provider had included the patient's history when the consult was submitted, the radiologist who interpreted the month 1 mammogram did not have information about the patient's diagnosis of breast cancer, treatment history, or decision to forego surgery. The OIG was unable to determine why the imaging provider did not have the information. One of the radiologists who interpreted the mammogram in question informed the OIG team that the radiologists generally use the history supplied by the ordering provider or patient for the interpretation. In this case, the history in the interpretation did not correctly state the patient's cancer diagnosis. In addition, the radiologists did not have access to mammography films that pre-dated treatment with chemotherapy.

While the radiologists at the non-VA community imaging center did not use a BI-RADS assessment category consistent with the patient's medical history, the OIG did not find evidence of a missed critical finding in a patient with stable mammograms over a six-year period.

## Potential Delays in the Subject Patient Pursuing Surgery

The OIG did not substantiate that the "normal" mammography report from month 1 delayed the patient's decision to pursue surgery. Since the 2005 cancer diagnosis, the patient repeatedly

[42] American College of Radiology *BI-RADS Atlas* 5th ed. 2013. pp 155-156. This assessment category is used when breast imaging is performed after a tissue diagnosis of malignancy prior to complete surgical excision, for second opinions of previously biopsied findings already shown to be malignant, and for the monitoring of response to neoadjuvant chemotherapy. Breast imaging exams following surgical excision, when the pathology report indicates no tumor at the margins of resection with no additional suspicious findings, would no longer be interpreted as BI-RADS 6.

declined surgery, for expressed reasons including risks inherent to anesthesia and surgery, and fear that if cancer was present, surgery would cause the tumor to spread. When the tumor enlarged and became palpable, the patient opted for chemotherapy to shrink the tumor followed by surgical excision. Following chemotherapy, the patient had a *diagnostic* mammogram which showed residual calcifications and the radiologist recommended an MRI to assess for residual tumor. The MRI showed resolution of the previously identified large right breast mass with no suspicious abnormalities noted in either breast. The patient thereafter declined surgery. The patient was referred to a surgeon once more after completing the month 9 mammogram. As of late 2017, the OIG found no documentation in the EHR that the patient followed through with a surgical consultation.

## Issue 2: Other Concerns—Lack of a Streamlined Mammography Process

During its review and analysis of the Facility's mammography processes, the OIG found delays in scheduling patient appointments and the retrieval of mammogram results. According to Facility policy "[t]he mammogram coordinator at VAMC Atlanta is responsible for coordinating and tracking screening and diagnostic mammograms, ultrasounds, and biopsies. The coordinator is also responsible for obtaining results and scanning them into the EHR."[43] Facility staff told the OIG that the mammogram coordinators were only responsible for diagnostic mammograms, although there was some confusion among staff about the mammogram coordinators' role. The OIG was unable to identify one person with oversight responsibility for all mammography processes, and the multi-level process the Facility had created was only minimally effective in reducing delays in scheduling appointments and timely obtaining mammogram results.

The OIG found both gaps and redundancy in the Facility's processes when they transitioned to Choice and then to NVCC. During follow-up calls in November, the Facility provided the OIG with a list of more than 70 staff from six different units[44] involved in the process of scheduling mammogram appointments and retrieving mammogram results. Figures 2 and 3 detail the processes for scheduling mammograms and retrieving results.[45] The process involved 18 steps from the time the physician submitted the order and consult to the availability of results in the

[43] Medical Center Memorandum 11-04, *Health Care for Women Veterans,* May 17, 2016. While some events discussed in this report occurred prior to the date this policy was issued, the OIG cited this document to support the finding that practice and staff's understanding of the coordinator's role at the time of the review was not consistent with current policy.

[44] The units included NVCC, Call Center, mammography coordinators, Oncology, Radiology, and Primary Care.

[45] In October 2017, the Facility provided the OIG with a newly created standard operating procedure outlining the roles of NVCC and Call Center staff and mammography coordinators regarding scheduling mammography appointments and obtaining results.

EHR. The Facility experienced delays in obtaining mammography results. Without the results, it was impossible to determine if the patient completed the appointment or had ongoing care needs.

Facility processes were cumbersome and none of the employees the OIG interviewed had an understanding of the processes from start to finish. Departments involved in the mammography program had no formal communication process, which led to multiple departments doing the same tasks. In June 2017, following the OIG's initial visit, Facility leaders convened a temporary charter group to suggest possible improvements to the mammography process. The charter group had representatives from all departments involved in the mammogram scheduling and results retrieval process. In October 2017, after creating new SOPs (see Appendixes C and D), the charter group was disbanded without plans for ongoing communication between/among departments or to monitor the new process for effectiveness.

## Issue 3: Other Concerns—Delays in Scheduling and Results Retrieval

VHA's goal is that appointments be scheduled no more than 30 calendar days from the date the physician requests the study be completed.[46] From October 1, 2014, through June 22, 2017, a total of 28,391 mammogram orders and consults were submitted. Of those, 19,969 were completed or administratively closed 30 days beyond the expected timeframe the physician requested the study be completed.

According to staff, the use of a single-source contract with St. Joseph's for mammography worked well and facilitated communication. However, the OIG found that low expectations preceded the transition to Choice in October 2015, and at the time of the transition, orders for about 1,500 mammogram orders had been entered but had not been scheduled. When the St. Joseph contract ended, the Facility canceled all previously ordered mammograms except mammograms ordered for ongoing care.

Facility physicians were instructed to resubmit the order and enter a corresponding consult for mammograms through the Choice program. As of December 2, 2015, 1,398 screening mammograms ordered were resubmitted without a corresponding consult to complete the request. Without the consult, the screening mammogram could not be scheduled. The OIG found the Facility lacked a process to track mammogram orders without a corresponding consult. The OIG included the 1,398 mammogram orders without a corresponding consult in the overall study population. If they met the inclusion criteria, the OIG reviewed the EHR to determine if delays occurred and contributed to adverse clinical outcomes.

[46] VHA Directive 1230, *Outpatient Scheduling Processes and Procedures,* July 15, 2016.The goal is to schedule appointments "no more than 30 calendar days from the date an appointment is deemed clinically appropriate by a VA health care provider;" VHA Directive 2006-041, *Veterans Health Care Service Standards,* June 27, 2006. Patients must be able to schedule an appointment for a routine diagnostic test within 30 days of referral. This Directive expired June 30, 2011, and has not yet been updated; VHA Directive 1330.1.

## Consults Not Scheduled

The OIG found various reasons why consult appointments were not scheduled.

### *Inability to Contact the Patient*

The OIG found 776 of the 1,443 consults (see scope and methodology) reviewed did not have associated clinical results. From October 28, 2015, through June 22, 2017, in accordance with VHA policy,[47] the Facility canceled or discontinued 291 breast imaging consults because either the Facility was unable to contact the patient to opt into Choice or the TPA was unable to contact the patient to schedule the appointment. When a consult is discontinued or canceled, the ordering provider receives an automated notification[48] (see discussion of view alerts below). Per VHA policy on *Health Information Management and Health Records,* the provider must "respond promptly (as defined by local policy)"[49] to view alerts. According to VHA's 2016 consult policy, the provider is expected to "review discontinued or canceled consults to determine if additional clinical measures are necessary."[50] If the provider does not review canceled or discontinued consults, delays in obtaining ongoing care or getting care could result. The OIG did not review whether the provider reviewed the alerts.

### *Patient Declined/Did Not Take Action*

The OIG determined that 178 consults had no results due to patient reasons such as the patient moved, declined to opt in to Choice, did not come to the scheduled appointment, or no longer wanted the mammogram. Of the remaining 307 consults without results, 75 were duplicate requests reducing the number of consults without associated results to 232.

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[47] VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures,* June 9, 2010. Attachment A discusses requirement to make two telephone calls and send a letter. If the patient does not respond, the consult can be discontinued. VHA Directive 1232(1) discusses requirement to make one telephone call and send a letter. If the patient does not respond, the consult can be discontinued.

[48] Notifications are messages that provide information or prompt action on a clinical event. Clinical events, such as a critical lab value or a change in orders, trigger a notification to be sent to all recipients identified by the triggering package (such as Lab, CPRS, or Radiology). The notifications are located at the bottom of the Patient Selection screen. When processing notifications that require an action, such as signing an order, CPRS brings up the chart tab and the specific item (such as a note requiring a signature) that the provider needs to see.

[49] VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014. "Providers and practitioners must monitor and take appropriate action on their computerized prompts for signature, currently known as 'View-Alerts.'" This VHA handbook was rescinded and replaced by VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015, which contains the same language as the 2014 handbook regarding view alerts.

[50] VHA Directive 1232(1).

### *Clinical Inactivity*

Seventy-five of the 232 consults were canceled due to "clinical inactivity."[51] NVCC staff told OIG inspectors that an informal Facility practice allowed them to cancel consults due to "clinical inactivity," which was defined as "a consult placed for clinical services greater than 90 days prior with no documentation of a visit viewable in the system." Similar to cancelations for other reasons (inability to contact the patient), the physician would receive a view alert when the consult was canceled for clinical inactivity. The NVCC staff did not consistently apply this definition for canceling consults.

### *Duplicate Consults*

The OIG found that some of the 75 duplicate consults were still open and some were canceled with no documentation indicating why they were canceled and a new order/consult written. The NVCC Physician Clinical Reviewer reviewed and approved each consult, creating a duplicate request for imaging services. This created additional work for the Call Center MSA, who contacted patients twice to opt in to Choice, and NVCC scheduled duplicate appointments for patients, which also increased work for the TPA. Based on OIG's review of these patients' EHRs, adverse clinical outcomes did not result, but additional and unnecessary work may have contributed to delays in obtaining mammography services.

## Delays in Scheduling Routine Mammograms

According to VHA, the Facility should schedule routine mammograms within 30 days of the date the physician requested the mammogram be completed.[52] The OIG found anecdotal evidence of delays in opting the patient in to Choice, uploading documents to the TPA, and contacting the patient to schedule the appointment. Two examples are discussed below:

> *Patient 1 had a Choice mammogram consult entered in 2016, with a request to have the study completed in spring 2016.[53] It was approved by the NVCC Clinical Physician Reviewer the same day. The patient opted in to Choice 79 days later. The patient's consult information was uploaded to the TPA portal approximately six weeks later; the appointment was scheduled for approximately 4 weeks later. The EHR does not include an explanation for either the 79-day delay in the patient's opt in to Choice or the six-week delay to upload the consult to the TPA.*

[51] These 75 cancellations are separate and are not included in the 291 consults that were canceled or discontinued due to failure to contact the patient.

[52] VHA Directive 1232(1); VHA Directive 2006-041.

[53] Although the clinically indicated date was marked as the next day, the provider noted on the consult that it was "routine" urgency.

*This led to a six-month delay from the date the physician wanted the test completed to the date of the appointment.*

*Patient 2 had a Choice mammogram consult entered spring 2016, and the NVCC physician Clinical Reviewer approved it the same day. The patient consented to opt in to Choice, 44 days after the consult was requested. NVCC staff uploaded information to the TPA portal and generated an electronic message to the TPA to schedule the mammogram 56 days after the patient opted in to Choice. This resulted in a 100-day delay.*

## Tracking Mammography Appointments

For consults that were managed under Choice, after the Facility uploaded the consult to the TPA portal, the TPA was responsible for contacting the patient to schedule the mammogram. According to the contract, appointments were to be scheduled within five business days of receiving the authorization. The date of the appointment should be within 30 days of the request, or the date the physician specified in the consult if available. The only MSA in the Facility Call Center was responsible for tracking all scheduled appointments and opting patients in to Choice. The OIG requested, but the Facility did not produce, a policy regarding how often the Call Center MSA was required to check the TPA portal to determine if mammograms had been scheduled by the TPA. Leaders who were interviewed stated the Facility did not have the staff required to track mammograms from the date requested until the TPA scheduled the appointment.

The OIG found that when consults were managed under Choice, the Facility had no consistent process for determining if the patient completed the mammogram. Facility leaders told OIG inspectors they ran a daily report of consults with scheduled appointments, which was used to contact imaging facilities to obtain mammogram reports, and that overall performance was reported weekly. However, patients who had mammograms ordered but did not have a scheduled appointment were not on this report. In addition, the Facility did not run a report of all mammography consults entered. The Facility also had no process to monitor orders without a consult, or orders with a consult but without an appointment, to determine how many required a consult in order that a mammogram appointment could be scheduled.

## Delays in Care

The OIG analyzed CDW data and identified 2,729 unique patients with 4,727 mammogram orders and consults that met the delay criteria and had a selected health event. The OIG then

conducted an in-depth review of the 4,727 orders and consults[54] to determine if the mammogram was delayed and the selected health event was related to that delay.[55] The OIG found that an average of 83.85 days elapsed between the date the physician requested the mammogram and the date it was completed.[56] Of the 2,287 mammography orders obtained from the CDW that were entered in FY 2015, during the timeframe of the St. Joseph's contract, 542 (23.7 percent) did not contain EHR documentation that the mammogram had been completed as of June 22, 2017.

Of the 2,729 patients reviewed, the OIG identified 102 patients with orders or consults for diagnostic mammograms whose results were not in their EHRs. The OIG determined that the 102 patients had experienced a selected health event and met pre-defined criteria for a more in-depth clinical review. An OIG physician-reviewer could not determine whether 42 of the 102 patients received needed care, including the ordered mammogram. The OIG sent the names of the 42 patients to Facility leaders and asked that they contact the patients to determine if diagnostic mammograms and necessary follow-up care had been offered and/or completed. As of October 13, 2017, Facility staff had completed contacting the patients and informed the OIG that they had not identified adverse clinical outcomes related to delays in care to the identified patients, and were continuing to review and ensure the patients had appropriate follow-up (see Appendix B).

## Delays in Receiving Results of Completed Breast Imaging Studies

The Choice contract required TPAs to obtain medical records from non-VA providers and submit them to VA. Mammogram reports were to be returned within 14 days of the appointment. Generally, the "return" of mammogram reports was to be accomplished by TPAs uploading results to the portal and alerting the Facility that results were available. Facility staff were responsible for retrieving the report from the portal. NVCC staff stated that results were not always uploaded to the portal according to contract requirements, and TPAs did not consistently alert the Facility when results were uploaded.[57]

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[54] This included mammograms ordered during the St. Joseph contract with just an order and those ordered under Choice with both an order and a consult from October 1, 2014, through June 22, 2017.

[55] A selected health event, as previously defined, is a diagnosis of breast cancer after the delayed mammogram, inpatient hospitalization, death, outpatient therapies that may be related to the treatment of breast cancer, chemotherapy, or radiation therapy. The selected health event may not be related to the mammography delay.

[56] Only orders and consults with associated results received from the imaging Facility were used for this calculation. Patient reported results were excluded.

[57] An inability to promptly obtain medical documentation from providers and TPAs has not been limited to this Facility. The OIG has identified this issue in prior reports. For an example, see *Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 15* (Report No. 17-00481-117, March 13, 2018). *VA OIG Consult Delays and Management Concerns VA Montana Healthcare System Fort Harrison, Montana,* (Report No. 16-00621-175, March 10, 2017).

OIG inspectors learned during a May 2017 interview that the Facility Director became aware of a backlog in obtaining mammogram reports from non-VA providers in November 2016. The Facility Director requested that the Director of NVCC develop a plan to reduce the reported backlog which had reached 3,000 in early 2017.[58] The Facility Director had not yet received the plan at the time of the May 2017 OIG interview although the backlog had been reduced to 180. The Facility Director initially tasked NVCC staff with contacting imaging facilities directly for the reports. The mammography coordinators were also attempting to obtain reports from the imaging providers. When Facility leaders recognized the continuing delay with the return of mammography reports, they involved additional staff from the Call Center, Primary Care, Radiology, and Oncology in an attempt to reduce the report backlog. Rather than identifying a single entry-point for mammography reports, staff in six separate services were duplicating efforts.

## Consults Closed Without Results

The OIG identified 136 consults that were administratively closed without evidence that the mammogram was completed. Documentation of attempts to contact the patient was not consistently completed. According to National Non-VA Medical Care Consult Referral Management Process Guidelines, when clinical reports are not available from a non-VA care provider, the Facility must document in the EHR three attempts to obtain reports. The guidelines also state that non-VA Care Consults "…***should not be administratively closed without appropriate clinical review" [emphasis in original text]***.

View alerts are sent to the provider at the time the consult is administratively closed whether or not the results are available in the EHR. Providers are not able to inactivate such view alerts.

A notification view alert,[59] which is only viewable from the patient selection screen prior to entering the EHR, does not contain detailed information about the subject matter of the alert. In order to view specifics about the consult, the physician must select the view alert and access the EHR. The OIG was unable to validate through the EHR review that providers were accessing the EHR to review view alerts. An example of a consult that was administratively closed is discussed below:

> *Patient 3 was in her 60s. In late 2016, a physician entered a Choice screening mammogram consult for Patient 3 whose last known mammogram was in 2011. The NVCC Physician Clinical Reviewer approved the consult the next day. The*

[58] The 3,000 records were included in the data that were evaluated for significant health events.

[59]Notifications are messages that (1) provide information or (2) prompt action on a clinical event. Clinical events, such as a critical laboratory value or a change in orders trigger a notification to be sent to all recipients identified by the triggering package (such as Lab, CPRS, or Radiology). The notifications are located at the bottom of the Patient Selection screen. Information-only notifications are deleted after viewing. Notifications requiring action (such as signing an order) will bring up the item needing action after viewing.

*patient opted in to Choice five days later and the mammogram was scheduled for three months later. NVCC made the first attempt to obtain the medical records for this mammogram approximately two months later (day 1). The second attempt was on day 2, and the third attempt on day 5. NVCC staff administratively completed the consult on day 6. The OIG found no documentation in the EHR that the physician was aware that the consult had been closed as completed without the imaging center report.*

In addition to consults being administratively closed without evidence of completion of the requested mammogram or documentation of attempts to obtain reports, the OIG found significant delays in the receipt of reports, including instances when the Facility received reports months after completion of the mammogram. An example of a delayed receipt of results is discussed below:

*Patient 4's physician ordered a screening mammogram for spring 2016, which was completed the next month. NVCC staff did not document attempts to obtain the report. Ten months after the completion of the mammogram, NVCC staff documented that the report had been scanned into the EHR. Three days later, the mammography coordinator entered a note summarizing the results and closing the consult.*

OIG inspectors contacted all of the 41 imaging centers who offered mammography services to Facility patients to discuss patient results notification processes.[60] Staff at the 41 imaging centers indicated that they followed FDA requirements for patient notification of mammography results. If the non-VA imaging centers followed FDA patient-notification requirements as reported, Facility patients who received services from the 41 non-VA providers would have received their results even if the ordering VA provider did not.[61]

## Issue 4: Other Concerns—Physician Review for Clinical Appropriateness

The National Non-VA Care Program Office (NPPO) developed guidance in collaboration with Non-VA Care Coordination, National Radiology Program, and Women's Health Program for the management of mammography referrals and reports. The guidance recommends that the NVCC

[60] The Facility provided a list of 41 imaging centers used for mammography services.

[61] The FDA requires imaging facilities send a written summary of normal mammography results to the patient within 30 days of the test. If the results are "suspicious" or "highly suggestive of malignancy," the imaging Facility must make every attempt to notify the patient as soon as possible.

team "performs clinical review of consults for non-VA Care mammography referrals."[62] The Director of Clinical Care for NVCC told OIG inspectors that an employee under his supervision, the NVCC Physician Clinical Reviewer, evaluates clinical aspects of mammography orders for appropriateness, including the type of study ordered and presence of duplicate orders. The reviewer can also access the EHR for previous study results and orders to determine if the care requested is clinically appropriate. The Chief of the NVCC Clinical Unit stated that if a screening mammogram is ordered for a patient with a history of a palpable mass, NVCC has the authority to determine that the patient requires a diagnostic mammogram, and by doing so "can avoid the back and forth." The OIG reviewed the functional statement of the NVCC Clinical Reviewer, which specified that the incumbent "…reviews all consults being requested to determine if clinically appropriate for the care and is covered by VA by law."

During the EHR review, the OIG noted multiple instances in which physicians entered clinically inappropriate orders/consults for mammograms and the Physician Reviewer did not take action to ensure that a clinically appropriate study was ordered, contributing to delays in obtaining the appropriate study. Two examples are described below:

> *Patient 5 was in her 50s in spring 2016 when her primary care physician evaluated her for a "lump in right armpit." The provider entered an order for a screening mammogram that day rather than a diagnostic mammogram. The NVCC Physician Clinical Reviewer approved the screening mammogram the same day. Approximately three months later, the mammography coordinator noted that the patient required a diagnostic mammogram and requested the screening mammogram consult be canceled. The ordering provider re-entered the correct order/consult into the EHR and the patient completed the diagnostic mammogram approximately five weeks later. The radiologist interpreted the mammogram as BI-RADs 3. The report was entered into the EHR seven months later. The patient underwent an ultrasound for the "lump in right armpit" approximately 15 months later. The patient completed her routine annual screening mammogram the next month, which was also a BI-RADS 3.*
>
> *Patient 6 was in her 40s with a family history of breast cancer when she was evaluated in summer 2016 by a primary care physician for a breast lump. The physician requested a screening mammogram the same day rather than a diagnostic exam. The NVCC Physician Clinical Reviewer reviewed and approved*

[62] This guidance developed in accordance with VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 2011, and VHA Handbook 1330.01, *Health Care Services for Women Veteran,* May 21, 2010 "provides 'best practice' guidance for VHA Radiology services and VHA stakeholders who manage and process non-VA mammography referrals and reports." It is "designed to help stakeholders perform their related daily tasks and serves as an overview of highly recommended processes for standardizing the required VHA operating procedures for managing mammography services obtained through non-VA providers."

*the screening mammogram request the next day. The screening mammogram was completed in fall 2016 and was interpreted as BI-RADS 0 and noted that additional images (a diagnostic study) were required to make a determination of findings. There is no EHR documentation indicating that the patient completed additional diagnostic imaging as recommended.*

The mammography coordinators told OIG inspectors that the Facility NVCC Physician Clinical Reviewer did not perform clinical reviews and only reviewed consults for eligibility. The coordinators also stated that many consults were approved in error because the wrong test was ordered or the consult was a duplicate. NVCC staff told OIG inspectors that patients were turned away from imaging centers because orders were incorrect.

The NVCC Physician Clinical Reviewer (Reviewer) had worked as an NVCC clinical reviewer since 2005. When interviewed, the Reviewer described the review process as follows: look over the consult to see if it was entered correctly and not mislabeled, verify the patient's eligibility, make sure all fields were correctly filled out, and put the approval statement on the consult. The Reviewer characterized the review as a clinical one, but confirmed that the Reviewer's process did not include looking at the EHR, verifying that the clinically appropriate test was ordered, or checking for duplicate consults. The Reviewer discussed not wanting to "overreach" a provider and was "never going to not authorize care that a patient needs." The Reviewer was uncomfortable canceling duplicate consults due to the risk that someone would not get care and it was "better to have too many rather than not enough."

## Issue 5: Other Concerns—Unscanned Documents

During the OIG's October 2–4, 2017, site visit, the Facility Director indicated that staff had found approximately 3,000 stored, unscanned medical records in the NVCC staff office, which raised the concern that the unscanned documents contained missing mammography results. The OIG returned to the Facility on October 30, 2017, to review the Facility scanning processes in order to determine if the unscanned NVCC documents included mammography reports and whether other departments had unscanned documents that might include mammography reports. Unscanned mammogram reports would not be available to the ordering VHA physician for review and determination of patient ongoing care needs. The OIG inspected the following areas: NVCC, Health Information Management Service (HIMS), Call Center, Oncology, Radiation Oncology, and the mammography coordinators' office.

- In the NVCC staff office, OIG inspectors found 13 boxes of documents and could not readily determine if the documents had been scanned into the EHR.
- In HIMS, OIG inspectors found two tables with stacks of unscanned documents on the table, unscanned documents under the tables, and unscanned documents on a desk. OIG inspectors were informed about an additional eight boxes of unscanned out-of-state medical record documents. HIMS staff told the OIG they received about 100 pieces of

mail per day and 300 inches of mail per week containing outside medical records and other healthcare-related documentation.

The OIG did not find significant amounts of unscanned medical record documentation in the Call Center, Oncology, Radiation Oncology, or the mammography coordinators' office.

The Facility took several actions:

- NVCC staff completed scanning 7 of 13 boxes of documents. The oldest documents scanned dated back to 2015 and 2016. The remaining documents were from 2017.
- NVCC nursing staff conducted an audit of the documents in the remaining six boxes.[63] The Facility provided the OIG with a list of 1,448 records, 21 of which were mammograms. The list included the consult date, the date the document was scanned into the EHR, consult results, and actions taken.
- A fact-finding review was reportedly being conducted to identify process failures and resolve the NVCC scanning issues. However, when contacted on December 15, 2017, the Facility Director told the OIG that the fact-finding review was not completed due to staff re-organization and refusal of some staff to participate in the fact finding. Per VA policy, "VA employees are required to cooperate with administrative investigations in accordance with 38 CFR § 0.735-12(b) and other applicable authorities."[64] Because of the refusal to participate, the Facility Director "chartered disciplinary action for three levels of management who were responsible for oversight of the Call Center."
- A VISN representative analyzed mammography and scanning work flow processes. The Facility Director told the OIG that the VISN work flow analysis demonstrated that the scanning issues had been resolved, but the processes of scheduling mammograms and retrieving results still needed oversight. The Facility Director removed managers who were in charge of NVCC and appointed an acting Associate Nurse Executive to oversee the Call Center and NVCC. The Associate Nurse Executive reports directly to the Facility Director.
- HIMS staff told the OIG that their backlog resulted from an issue with a national scanning program. The backlog was resolved by October 18, 2017, and a contingency plan was developed should the issue reoccur.

[63] In April 2018, the Facility reported to the OIG that Facility staff had completed a first level review of all unscanned documents – the final number of documents was 2,693 rather than 3,000. The Facility was in the process of conducting a re-review of 1,112 of the 2,693 documents with missing items to determine if a second-level review was necessary. As of April 2018, the Facility had identified one patient whose mammogram was delayed almost four months who may have been adversely impacted by the delay.

[64] VA Directive 0700, *Administrative Investigations,* March 25, 2002.

## Issue 6: Other Concerns—Women Veterans Program

According to VHA Directive 1330.01, February 15, 2017, *Health Care Services for Women Veterans,*

> [t]he Department of Veterans Affairs (VA) is improving access, services, resources, facilities, and workforce capacity to make health care more accessible, more sensitive to gender-specific needs, and of the highest quality for the women Veterans of today and tomorrow. While women Veterans constitute a minority of Veterans, they deserve the same level of services provided to male Veterans. VHA Women's Health Services works to ensure that timely, equitable, high-quality, comprehensive health care services are provided in a sensitive and safe environment at VA medical facilities nationwide. VA strives to be a national leader in the provision of health care for women, thereby raising the standard of care for all women.[65]

The OIG determined that the Facility, which has one of the largest female populations of all VA facilities, did not consistently demonstrate VA's commitment to be a national leader in women veterans health care.

VA utilizes designated women's health primary care providers (WH-PCP)[66] to care for female veterans. Each Facility must ensure that an appropriate number of WH-PCPs are available at every site, with a stated goal of having 85 percent of enrolled women veterans assigned to a WH-PCP.[67] As of February 2018, 56 percent of the Facility's women veterans were assigned to WH-PCPs. Facility leaders told the OIG that 31 providers had undergone training to qualify to treat women veterans; 29 of those were designated as WH-PCPs, but only 13 were functioning as such.

Issues with gender-specific care of female veterans were noted. OIG inspectors found episodes of care in which providers lacked basic knowledge as outlined in VA Women's Health

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[65] VHA Directive 1330.01, *Health Care Services for Women Veterans,* February 15, 2017. This directive was in effect for a portion of the timeframe of the events discussed in this report. The 2017 VHA Directive 1330.01 rescinded and replaced VHA Handbook 1330.01, *Health Care Services for Women Veterans,* May 21, 2010; it was in effect for the remaining timeframe of the events discussed in this report. The 2010 handbook contained the same or similar language as the 2017 directive concerning women veterans health care.

[66] A Designated Women's Health Primary Care Provider is a primary care provider who is trained and experienced in women's health. Within the context of this report, the OIG considered the term provider to include physicians and nurse practitioners.

[67] The 2010 VHA handbook 1330.0, Section 14 (1) required that all enrolled women veterans receive comprehensive primary care from a designated WH PCP. The 2017 VHA directive 1330.01 states that "[t]he goal is that at least 85% of women Veterans should be assigned to a WH-PCP."

Competency Domains[68] such as incorrectly ordering screening mammograms rather than diagnostic ones. Delays in obtaining mammograms occurred when such errors had to be corrected. OIG inspectors found a lack of patient-specific documentation in an EHR note, including instances in which the utilization of templates designed for male veterans referenced male genitalia in female veteran EHR notes. VHA Directive 1330.01 defines Comprehensive Primary Care for Women Veterans as "the provision of complete primary care and care coordination at one site." Facility leaders told us that not all providers provided routine gynecologic examinations and referred women veterans to the VA women's clinic for care.[69]

The OIG observed a culture of apathy surrounding women's health issues, from front-line employees to executive leadership. Multiple staff described difficulties in recruiting providers to become WH-PCPs and participating in the care of female veterans. The Facility Chief of Staff, who is responsible for holding primary care leaders accountable for identifying WH-PCPs,[70] was aware that only 56 percent of the Facility's female veterans were assigned to WH-PCPs. The COS was also aware that multiple providers had been sent for training to become WH-PCPs, but the providers "still felt that they should not be part of Women's Health." He further indicated that he was "disappointed" in primary care leaders' failure to meet the 85 percent goal; however, OIG inspectors did not identify actions taken to correct this deficiency.

The OIG was informed of an inability of non-VA mammography imaging providers to reach VA providers by phone or email. Provider phone numbers were not consistently entered on the consults. If the phone number was on the consult, the VA provider did not always answer a phone call. OIG inspectors were informed during an interview with one of the non-VA imaging providers that the imaging provider had attempted unsuccessfully to reach a VA provider that morning. OIG inspectors attempted to call the phone number listed on one of the non-VA imaging provider's consults. The call was unanswered after ringing 20 times. The OIG subsequently learned that the number called was assigned to the medical officer of the day and would not be answered until the evening. OIG inspectors were also told that some WH-PCPs in community based outpatient clinics did not return email correspondence. Facility leaders did not foster a culture of accountability in addressing issues related to the care of the Facility's women veterans.

[68] The 2010 VHA handbook 1330.01 used the term Competency Standards while 2017 directive 1330.01uses the term Competency Domains to describe competencies required for WH-PCPs treating women veterans.

[69] VHA Directive 1330.01. Consistent with the 2017 VHA directive 1330.01, the 2010 VHA handbook, Section 4 (5) stated all sites that offer primary care services must offer comprehensive primary care to women Veterans and noted: "*Primary Care may be delivered utilizing a team mode, but it is expected that gender-specific primary care is provided by the same clinician that renders other routine Primary Care, preferably without multiple encounters or visits scheduled over different days." (Italics in original text.)*

[70] VHA Directive 1330.01.

VHA policy specifies that the Women Veterans Health Committee (WVHC) report to executive leadership with signed minutes at the Clinical Executive Board level.[71] The OIG reviewed the Executive Committee of the Medical Staff (ECMS) minutes from January 2017 through September 2017. The WVHC was on the agenda twice, in June 2017 and September 2017, with discussion only during the June 2017 meeting. The OIG reviewed WVHC minutes from April through September 2017 to determine if the minutes were signed by the Chief of Staff. The first signature does not appear until July 25, 2017, and in one instance, the minutes remained unsigned for more than 5 months. The OIG was told that the minutes were posted to a computerized Facility-wide document management program (SharePoint) and were viewable by the remainder of the executive leadership team, although no requirement existed that the minutes be reviewed or signed by executive team members.

[71] VHA Directive 1330.01. "The committee must maintain an active charter, meet quarterly at a minimum, and report to leadership with *signed* [emphasis added] minutes at the Clinical Executive Board (CEB) level." While the 2010 VHA Handbook 1330.01did not specifically indicate the minutes must be signed, the reporting requirements were otherwise similar: "[m]inutes of the committee must be distributed to committee members with reporting requirements to include routing to the Clinical Executive Leadership and the medical Facility Director."

# Conclusion

With regard to the allegations pertaining to the patient

- The OIG did not substantiate that mammography images obtained in spring 2016 at a community imaging Facility failed to identify a critical finding in the subject cancer patient, and
- The OIG did not substantiate that the report of the spring 2016 BI-RADS 1 negative mammogram may have delayed the decision to pursue surgery.

The OIG noted other areas of concern. At the time that the St Joseph's contract ended in 2015, a backlog existed of 1,500 patients waiting to be scheduled for mammograms. Scheduling issues continued after the transition to the Choice program in January 2016 and solutions were not effectively pursued.

The OIG found that the Facility had multiple departments involved in the process to schedule mammograms and retrieve reports; however, staff who were interviewed did not have a clear understanding as to who was responsible for each step in the process. The OIG also found that the Facility had one Call Center MSA assigned the responsibility of contacting all patients to opt in to Choice and to track all scheduled appointments. A lack of formal communication between and among departments led to process redundancy.

The OIG found the Facility did not have a process for ensuring that patients with screening or diagnostic mammogram orders in an active, pending, or scheduled status were not lost to follow-up during the transition from the St. Joseph's contract to Choice. However, the Facility ensured that patients with abnormal mammograms who needed further imaging or diagnostic studies received services through NVCC.

While the intent of having a physician Clinical Reviewer is to facilitate care specific to the patient's needs, the OIG found that the process followed by the NVCC Clinical Reviewer did not accomplish that objective. A failure to facilitate care may result in scheduling delays and additional administrative burden in an already complex and inefficient system. An ordering process with appropriate clinical oversight is likely to improve efficiency by reducing scheduling delays and the duplication of efforts by administrative staff, as well as to improve the quality of care.

The OIG identified that issues with scanning external non-VA medical documentation into the EHR were compounded by a decentralized scanning process and multiple work-arounds for receiving documentation and scanning it into the EHR. Staff refused to participate in a scanning fact finding. The Facility Director took action regarding the staff refusal; for that reason, the OIG did not make a recommendation on that issue.

The OIG observed a culture of apathy surrounding women veterans health issues. For example,

- The Facility was not meeting VHA's goal of assigning 85 percent of the Facility's women veterans to a WH-PCP who would provide all gender-specific care,
- The OIG found use of a template designed for male patients that referenced male genitalia in a female veteran EHR note, and
- There was a lack of executive oversight of the Women Veterans Health Committee

The OIG made seven recommendations.

## Recommendations 1–7

1. The Atlanta VA Health Care System Director ensures that a review is conducted of patients with mammography orders in an active, pending, or scheduled status as of October 28, 2015, to ensure that clinical care was provided and results are documented in the electronic health record.

2. The Atlanta VA Health Care System Director makes certain that Medical Center Memorandum 11-04, *Health Care for Women Veterans*, May 17, 2016, is updated to reflect current Facility processes, including but not limited to mammography coordinator responsibilities.

3. The Atlanta VA Health Care System Director ensures compliance with Veterans Health Administration Directive 1232(1), *Consult Processes and Procedures* (amended September 23, 2016), including the completion of mammograms by the order date or the date the physician requested the study be completed and that a process is established for review when consults exceed established timeliness thresholds.

4. The Atlanta VA Health Care System Director improves mammography processes to schedule appointments and receive, account for, scan, upload, and provide external diagnostic imaging results to the appropriate clinical areas and Veterans Health Administration providers and that the process is monitored.

5. The Atlanta VA Health Care System Director confirms that clinical appropriateness reviews of mammography consults are performed to ensure that the correct imaging study is ordered for the patient's clinical presentation and that performance of reviews is monitored.

6. The Atlanta VA Health Care System Director verifies that providers who are trained in provision of women veterans health care are designated as Women's Health Primary Care Providers, have the required number of women assigned to their panel, and provide gender-specific care in accordance with Veterans Health Administration policy.

7. The Atlanta VA Health Care System Director provides executive level oversight of the Women Veterans Program to ensure that service level functions are coordinated, processes are streamlined, and identified actions are tracked to resolution.

# Appendix A: Additional Scope and Methodology Information

This appendix provides supplemental scope and methodology information related to OIG's evaluation of the timeliness of mammography orders and consults placed from October 1, 2014, through June 22, 2017, and the impact of delays on patients.

## Table 1. CDW Data that were Extracted and Analyzed by the OIG

| CDW Location (database.schema.table) | How Extracted Data were Used |
|---|---|
| CDWWORK.DIM.STA3N | Obtained station numbers for study population |
| CDWWORK.DIM.LOCATION | Decoded VA station physical location (for reference only) |
| CDWWORK.DIM.REQUESTSERVICE | Distinguished between administrative from clinical consults |
| CDWWORK.DIM.CLINICALTERM | Decoded clinical terminology (for reference only) |
| CDWWORK.DIM.PROVIDERNARRATIVE | Decoded provider narrative (for reference only) |
| CDWWORK.DIM.CPT | Obtained CPT codes and descriptions (for reference only) |
| CDWWORK.DIM.ICD9 | Obtained ICD-9-CM codes |
| CDWWORK.DIM.ICD9DESCRIPTIONVERSION | Obtained ICD-9-CM descriptions |
| CDWWORK.DIM.ICD10 | Obtained ICD-10 codes |
| CDWWORK.DIM.ICD10DESCRIPTIONVERSION | Obtained ICD-10 descriptions |
| CDWWORK.CON.CONSULT | Obtained all consults for selected stations |
| CDWWORK.DIM.STA3N | Obtained station numbers for study population |
| CDWWORK.DIM.LOCATION | Decoded VA station physical location (for reference only) |
| CDWWORK.DIM.REQUESTSERVICE | Distinguished between administrative from clinical consults |
| CDWWORK.DIM.CPT | Obtained CPT codes and descriptions |
| CDWWORK.DIM.PROVIDERNARRATIVE | Used to decode provider narrative; not used, for reference only |
| CDWWORK.DIM.CLINICALTERM | Used to decode clinical terminology; not used, for reference only |
| CDWWORK.DIM.ICD9 | Obtained ICD-9-CM codes |
| CDWWORK.DIM.ICD9DESCRIPTIONVERSION | Obtained ICD-9-CM descriptions |
| CDWWORK.DIM.ICD10 | Obtained ICD-10 codes |
| CDWWORK.DIM.ICD10DESCRIPTIONVERSION | Obtained ICD-10 descriptions |
| CDWWORK.CON.CONSULT | Obtained all consults for selected stations |
| CDWWORK.CON.CONSULTACTIVITY | Identified consult activities for cancellation or closure without patient encounters |
| CDWWORK.SPATIENT.SCONSULTREASON | Obtained text identifying the reason for the consult |
| CDWWORK.SPATIENT.SPATIENT | Obtained patient identifiable information, including date of death |
| CDWWORK.APPT.APPOINTMENT | Identified appointments created from consults; if applicable |

| CDW Location (database.schema.table) | How Extracted Data were Used |
|---|---|
| CDWWORK.OUTPAT.VISIT | Identified if patient physically visited station during timeframe for an outpatient encounter |
| CDWWORK.OUTPAT.VPROCEDURE | Obtained full record of patient visit containing adverse event outpatient procedure |
| CDWWORK.OUTPAT.VDIAGNOSIS | Identified if patient had a diagnosis of any type at visit |
| CDWWORK.INPAT.INPATIENT | Identified if patient had an inpatient stay during timeframe at VA station |
| CDWWORK.INPAT.INPATIENTDISCHARGEDIAGNOSIS | Identified if patient had a discharge diagnosis of any type during inpatient stay |
| CDWWORK.INPAT.INPATIENTFEEDIAGNOSIS | Obtained FEE inpatient records showing hospitalization and obtaining either discharge or admit diagnosis |
| CDWWORK.SSTAFF.SSTAFF | Used to obtain provider information if required; not used |
| CDWWORK.FBCS.DSS_AUTHSUPPDATA | Provided a link between FEE encounters and ordered consult by authorization |
| CDWWORK.FEE.FEEAUTHORIZATION | Obtained FEE authorizations linked to consults by ID |
| CDWWORK.FEE.FEEINITIALTREATMENT | Obtained FEE visits linking the authorization to the type of treatment |
| CDWWORK.FEE.FEESERVICEPROVIDED | Obtained FEE outpatient records for patients |
| CDWWORK.FEE.FEEINPATINVOICE | Obtained FEE inpatient records showing hospitalization |
| CDWWORK.FEE.FEEINPATINVOICEICDDIAGNOSIS | Obtained diagnosis for FEE inpatient visits |
| CDWWORK.DIM.ORDERABLEITEM | Obtained the name of the item that will be used for displaying and searching |
| CDWWORK.CPRSORDER.CPRSORDER | Obtained the items ordered through CPRS |
| CDWWORK.CPRSORDER.OrderedItem | Obtained the actual item (test, procedure, diet, drug, etc.) being ordered from the Orderable Items file. |
| CDWWORK.RADIOLOGY.RADNUC_MED_ORDERS_75_1 | Obtained all information pertaining to an imaging order entered for a patient. |

*Source: VA OIG analysis of CDW data*

## Table 2. Consult Urgencies and Associated Timeframes Used to Identify Delays

| Consult Urgency | Expected Timeframe |
|---|---|
| Routine | Within 30 days |
| Next available | Within 30 days |
| Within 1 month | Within 30 days |
| Within 1 week | Within 7 days |
| Within 72 hours | Within 3 days |
| Within 48 hours | Within 2 days |
| Within 24 hours | Within 1 day |
| Today | Same day |
| STAT | Within 1 day |
| Emergency | Within 1 day |

*Source: VA OIG and VA OIG analysis of VA documents*

Note: According to VHA's consult business rules at the time of the review, STAT and emergency consults should be addressed within six and four hours, respectively. However, for the purposes of the analysis, the OIG considered those consults to be timely if they were completed within one day to account for lags in entering documentation that can occur in urgent or emergent situations.

## Table 3. ICD-9-CM Diagnostic Codes Used to Identify Health Events

| Health Event | Diagnostic Codes |
|---|---|
| UNSPECIFIED LUMP IN BREAST | 611.72 |
| OTHER SIGNS AND SYMPTOMS IN BREAST | 611.79 |
| MALIGNANT NEOPLASM OF OVERLAPPING SITES OF UNSPECIFIED MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF UNSPECIFIED SITE OF LEFT FEMALE BREAST | 174.9 |
| SECONDARY MALIGNANT NEOPLASM OF BREAST | 198.81 |
| MALIGNANT NEOPLASM OF UNSPECIFIED SITE OF RIGHT MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF UNSPECIFIED SITE OF LEFT MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF UNSPECIFIED SITE OF UNSPECIFIED MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF UNSPECIFIED SITE OF RIGHT FEMALE BREAST | 174.9 |
| MALIGNANT NEOPLASM OF UNSPECIFIED SITE OF UNSPECIFIED FEMALE BREAST | 174.9 |
| LOBULAR CARCINOMA IN SITU OF UNSPECIFIED BREAST | 233.0 |
| LOBULAR CARCINOMA IN SITU OF RIGHT BREAST | 233.0 |
| LOBULAR CARCINOMA IN SITU OF LEFT BREAST | 233.0 |
| INTRADUCTAL CARCINOMA IN SITU OF UNSPECIFIED BREAST | 233.0 |
| INTRADUCTAL CARCINOMA IN SITU OF RIGHT BREAST | 233.0 |
| OTHER SPECIFIED TYPE OF CARCINOMA IN SITU OF UNSPECIFIED BREAST | 233.0 |
| INTRADUCTAL CARCINOMA IN SITU OF LEFT BREAST | 233.0 |
| OTHER SPECIFIED TYPE OF CARCINOMA IN SITU OF RIGHT BREAST | 233.0 |
| NEOPLASM OF UNSPECIFIED BEHAVIOR OF BREAST | 239.3 |
| OTHER SPECIFIED TYPE OF CARCINOMA IN SITU OF LEFT BREAST | 233.0 |
| UNSPECIFIED TYPE OF CARCINOMA IN SITU OF UNSPECIFIED BREAST | 233.0 |
| UNSPECIFIED TYPE OF CARCINOMA IN SITU OF RIGHT BREAST | 233.0 |
| UNSPECIFIED TYPE OF CARCINOMA IN SITU OF LEFT BREAST | 233.0 |
| NEOPLASM OF UNCERTAIN BEHAVIOR OF UNSPECIFIED BREAST | 238.3 |
| NEOPLASM OF UNCERTAIN BEHAVIOR OF RIGHT BREAST | 238.3 |
| NEOPLASM OF UNCERTAIN BEHAVIOR OF LEFT BREAST | 238.3 |
| ENCOUNTER FOR SCREENING MAMMOGRAM FOR MALIGNANT NEOPLASM OF BREAST | V76.12 |
| GENETIC SUSCEPTIBILITY TO MALIGNANT NEOPLASM OF BREAST | V84.01 |
| ENCOUNTER FOR OTHER SCREENING FOR MALIGNANT NEOPLASM OF BREAST | V76.10 V76.19 |
| ENCOUNTER FOR BREAST RECONSTRUCTION FOLLOWING MASTECTOMY | V51.0 |
| ENCOUNTER FOR PROPHYLACTIC REMOVAL OF BREAST | V50.41 |
| MALIGNANT NEOPLASM OF CENTRAL PORTION OF RIGHT MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF CENTRAL PORTION OF LEFT MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF CENTRAL PORTION OF UNSPECIFIED MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF UPPER-INNER QUADRANT OF RIGHT FEMALE BREAST | 174.9 |
| MALIGNANT NEOPLASM OF UPPER-OUTER QUADRANT OF UNSPECIFIED FEMALE BREAST | 174.4 |

| | |
|---|---|
| MALIGNANT NEOPLASM OF UPPER-OUTER QUADRANT OF RIGHT MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF UPPER-OUTER QUADRANT OF LEFT MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF UPPER-OUTER QUADRANT OF UNSPECIFIED MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF OVERLAPPING SITES OF RIGHT FEMALE BREAST | 174.8 |
| MALIGNANT NEOPLASM OF OVERLAPPING SITES OF LEFT FEMALE BREAST | 174.8 |
| MALIGNANT NEOPLASM OF OVERLAPPING SITES OF UNSPECIFIED FEMALE BREAST | 174.8 |
| MALIGNANT NEOPLASM OF CENTRAL PORTION OF RIGHT FEMALE BREAST | 174.1 |
| MALIGNANT NEOPLASM OF CENTRAL PORTION OF UNSPECIFIED FEMALE BREAST | 174.1 |
| MALIGNANT NEOPLASM OF UPPER-INNER QUADRANT OF LEFT FEMALE BREAST | 174.2 |
| MALIGNANT NEOPLASM OF UPPER-INNER QUADRANT OF RIGHT MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF LOWER-INNER QUADRANT OF LEFT MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF UPPER-OUTER QUADRANT OF RIGHT FEMALE BREAST | 174.4 |
| MALIGNANT NEOPLASM OF LOWER-OUTER QUADRANT OF LEFT FEMALE BREAST | 174.5 |
| MALIGNANT NEOPLASM OF LOWER-OUTER QUADRANT OF RIGHT MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF AXILLARY TAIL OF UNSPECIFIED FEMALE BREAST | 174.6 |
| MALIGNANT NEOPLASM OF AXILLARY TAIL OF LEFT MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF NIPPLE AND AREOLA, RIGHT FEMALE BREAST | 174.0 |
| MALIGNANT NEOPLASM OF NIPPLE AND AREOLA, LEFT FEMALE BREAST | 174.0 |
| MALIGNANT NEOPLASM OF NIPPLE AND AREOLA, UNSPECIFIED FEMALE BREAST | 174.0 |
| MALIGNANT NEOPLASM OF NIPPLE AND AREOLA, RIGHT MALE BREAST | 175.0 |
| MALIGNANT NEOPLASM OF NIPPLE AND AREOLA, LEFT MALE BREAST | 175.0 |
| MALIGNANT NEOPLASM OF UPPER-INNER QUADRANT OF UNSPECIFIED MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF LOWER-INNER QUADRANT OF RIGHT FEMALE BREAST | 174.3 |
| MALIGNANT NEOPLASM OF LOWER-INNER QUADRANT OF LEFT FEMALE BREAST | 174.3 |
| MALIGNANT NEOPLASM OF LOWER-INNER QUADRANT OF UNSPECIFIED FEMALE BREAST | 174.3 |
| MALIGNANT NEOPLASM OF LOWER-OUTER QUADRANT OF LEFT MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF LOWER-OUTER QUADRANT OF UNSPECIFIED MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF AXILLARY TAIL OF RIGHT FEMALE BREAST | 174.6 |
| MALIGNANT NEOPLASM OF AXILLARY TAIL OF LEFT FEMALE BREAST | 174.6 |
| BENIGN NEOPLASM OF RIGHT BREAST | 217 |
| BENIGN NEOPLASM OF LEFT BREAST | 217 |
| BENIGN NEOPLASM OF UNSPECIFIED BREAST | 217 |
| MALIGNANT NEOPLASM OF OVERLAPPING SITES OF RIGHT MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF NIPPLE AND AREOLA, UNSPECIFIED MALE BREAST | 175.0 |
| MALIGNANT NEOPLASM OF CENTRAL PORTION OF LEFT FEMALE BREAST | 174.1 |
| MALIGNANT NEOPLASM OF UPPER-INNER QUADRANT OF UNSPECIFIED FEMALE BREAST | 174.2 |
| MALIGNANT NEOPLASM OF UPPER-INNER QUADRANT OF LEFT MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF LOWER-INNER QUADRANT OF RIGHT MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF LOWER-INNER QUADRANT OF UNSPECIFIED MALE BREAST | 175.9 |

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| MALIGNANT NEOPLASM OF UPPER-OUTER QUADRANT OF LEFT FEMALE BREAST | 174.4 |
| MALIGNANT NEOPLASM OF LOWER-OUTER QUADRANT OF RIGHT FEMALE BREAST | 174.6 |
| MALIGNANT NEOPLASM OF LOWER-OUTER QUADRANT OF UNSPECIFIED FEMALE BREAST | 174.5 |
| MALIGNANT NEOPLASM OF AXILLARY TAIL OF RIGHT MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF AXILLARY TAIL OF UNSPECIFIED MALE BREAST | 175.9 |
| MALIGNANT NEOPLASM OF OVERLAPPING SITES OF LEFT MALE BREAST | 175.9 |
| MAMMOGRAPHIC CALCIFICATION FOUND ON DIAGNOSTIC IMAGING OF BREAST | 793.89 |
| MAMMOGRAPHIC MICROCALCIFICATION FOUND ON DIAGNOSTIC IMAGING OF BREAST | 793.81 |
| OTHER ABNORMAL AND INCONCLUSIVE FINDINGS ON DIAGNOSTIC IMAGING OF BREAST | 793.80 793.89 |
| PERSONAL HISTORY OF MALIGNANT NEOPLASM OF BREAST | V10.3 |
| FAMILY HISTORY OF MALIGNANT NEOPLASM OF BREAST | V16.3 |
| PERSONAL HISTORY OF IN-SITU NEOPLASM OF BREAST | V13.89 |

*Source: VA OIG analysis of CDW data*

## Table 4. ICD-10 Diagnostic Codes Used to Identify Health Events

| Health Event | Diagnostic Codes |
|---|---|
| UNSPECIFIED LUMP IN BREAST | N63. |
| OTHER SIGNS AND SYMPTOMS IN BREAST | N64.59 |
| MALIGNANT NEOPLASM OF OVERLAPPING SITES OF UNSPECIFIED MALE BREAST | C50.829 |
| MALIGNANT NEOPLASM OF UNSPECIFIED SITE OF LEFT FEMALE BREAST | C50.912 |
| SECONDARY MALIGNANT NEOPLASM OF BREAST | C79.81 |
| MALIGNANT NEOPLASM OF UNSPECIFIED SITE OF RIGHT MALE BREAST | C50.921 |
| MALIGNANT NEOPLASM OF UNSPECIFIED SITE OF LEFT MALE BREAST | C50.922 |
| MALIGNANT NEOPLASM OF UNSPECIFIED SITE OF UNSPECIFIED MALE BREAST | C50.929 |
| MALIGNANT NEOPLASM OF UNSPECIFIED SITE OF RIGHT FEMALE BREAST | C50.911 |
| MALIGNANT NEOPLASM OF UNSPECIFIED SITE OF UNSPECIFIED FEMALE BREAST | C50.919 |
| LOBULAR CARCINOMA IN SITU OF UNSPECIFIED BREAST | D05.00 |
| LOBULAR CARCINOMA IN SITU OF RIGHT BREAST | D05.01 |
| LOBULAR CARCINOMA IN SITU OF LEFT BREAST | D05.02 |
| INTRADUCTAL CARCINOMA IN SITU OF UNSPECIFIED BREAST | D05.10 |
| INTRADUCTAL CARCINOMA IN SITU OF RIGHT BREAST | D05.11 |
| OTHER SPECIFIED TYPE OF CARCINOMA IN SITU OF UNSPECIFIED BREAST | D05.80 |
| INTRADUCTAL CARCINOMA IN SITU OF LEFT BREAST | D05.12 |
| OTHER SPECIFIED TYPE OF CARCINOMA IN SITU OF RIGHT BREAST | D05.81 |
| NEOPLASM OF UNSPECIFIED BEHAVIOR OF BREAST | D49.3 |
| OTHER SPECIFIED TYPE OF CARCINOMA IN SITU OF LEFT BREAST | D05.82 |
| UNSPECIFIED TYPE OF CARCINOMA IN SITU OF UNSPECIFIED BREAST | D05.90 |
| UNSPECIFIED TYPE OF CARCINOMA IN SITU OF RIGHT BREAST | D05.91 |
| UNSPECIFIED TYPE OF CARCINOMA IN SITU OF LEFT BREAST | D05.92 |
| NEOPLASM OF UNCERTAIN BEHAVIOR OF UNSPECIFIED BREAST | D48.60 |
| NEOPLASM OF UNCERTAIN BEHAVIOR OF RIGHT BREAST | D48.61 |
| NEOPLASM OF UNCERTAIN BEHAVIOR OF LEFT BREAST | D48.62 |
| ENCOUNTER FOR SCREENING MAMMOGRAM FOR MALIGNANT NEOPLASM OF BREAST | Z12.31 |
| GENETIC SUSCEPTIBILITY TO MALIGNANT NEOPLASM OF BREAST | Z15.01 |
| ENCOUNTER FOR OTHER SCREENING FOR MALIGNANT NEOPLASM OF BREAST | Z12.39 |
| ENCOUNTER FOR BREAST RECONSTRUCTION FOLLOWING MASTECTOMY | Z42.1 |
| ENCOUNTER FOR PROPHYLACTIC REMOVAL OF BREAST | Z40.01 |
| MALIGNANT NEOPLASM OF CENTRAL PORTION OF RIGHT MALE BREAST | C50.121 |
| MALIGNANT NEOPLASM OF CENTRAL PORTION OF LEFT MALE BREAST | C50.122 |
| MALIGNANT NEOPLASM OF CENTRAL PORTION OF UNSPECIFIED MALE BREAST | C50.129 |
| MALIGNANT NEOPLASM OF UPPER-INNER QUADRANT OF RIGHT FEMALE BREAST | C50.211 |
| MALIGNANT NEOPLASM OF UPPER-OUTER QUADRANT OF UNSPECIFIED FEMALE BREAST | C50.419 |

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| MALIGNANT NEOPLASM OF UPPER-OUTER QUADRANT OF RIGHT MALE BREAST | C50.421 |
| MALIGNANT NEOPLASM OF UPPER-OUTER QUADRANT OF LEFT MALE BREAST | C50.422 |
| MALIGNANT NEOPLASM OF UPPER-OUTER QUADRANT OF UNSPECIFIED MALE BREAST | C50.429 |
| MALIGNANT NEOPLASM OF OVERLAPPING SITES OF RIGHT FEMALE BREAST | C50.811 |
| MALIGNANT NEOPLASM OF OVERLAPPING SITES OF LEFT FEMALE BREAST | C50.812 |
| MALIGNANT NEOPLASM OF OVERLAPPING SITES OF UNSPECIFIED FEMALE BREAST | C50.819 |
| MALIGNANT NEOPLASM OF CENTRAL PORTION OF RIGHT FEMALE BREAST | C50.111 |
| MALIGNANT NEOPLASM OF CENTRAL PORTION OF UNSPECIFIED FEMALE BREAST | C50.119 |
| MALIGNANT NEOPLASM OF UPPER-INNER QUADRANT OF LEFT FEMALE BREAST | C50.212 |
| MALIGNANT NEOPLASM OF UPPER-INNER QUADRANT OF RIGHT MALE BREAST | C50.221 |
| MALIGNANT NEOPLASM OF LOWER-INNER QUADRANT OF LEFT MALE BREAST | C50.322 |
| MALIGNANT NEOPLASM OF UPPER-OUTER QUADRANT OF RIGHT FEMALE BREAST | C50.411 |
| MALIGNANT NEOPLASM OF LOWER-OUTER QUADRANT OF LEFT FEMALE BREAST | C50.512 |
| MALIGNANT NEOPLASM OF LOWER-OUTER QUADRANT OF RIGHT MALE BREAST | C50.521 |
| MALIGNANT NEOPLASM OF AXILLARY TAIL OF UNSPECIFIED FEMALE BREAST | C50.619 |
| MALIGNANT NEOPLASM OF AXILLARY TAIL OF LEFT MALE BREAST | C50.622 |
| MALIGNANT NEOPLASM OF NIPPLE AND AREOLA, RIGHT FEMALE BREAST | C50.011 |
| MALIGNANT NEOPLASM OF NIPPLE AND AREOLA, LEFT FEMALE BREAST | C50.012 |
| MALIGNANT NEOPLASM OF NIPPLE AND AREOLA, UNSPECIFIED FEMALE BREAST | C50.019 |
| MALIGNANT NEOPLASM OF NIPPLE AND AREOLA, RIGHT MALE BREAST | C50.021 |
| MALIGNANT NEOPLASM OF NIPPLE AND AREOLA, LEFT MALE BREAST | C50.022 |
| MALIGNANT NEOPLASM OF UPPER-INNER QUADRANT OF UNSPECIFIED MALE BREAST | C50.229 |
| MALIGNANT NEOPLASM OF LOWER-INNER QUADRANT OF RIGHT FEMALE BREAST | C50.311 |
| MALIGNANT NEOPLASM OF LOWER-INNER QUADRANT OF LEFT FEMALE BREAST | C50.312 |
| MALIGNANT NEOPLASM OF LOWER-INNER QUADRANT OF UNSPECIFIED FEMALE BREAST | C50.319 |
| MALIGNANT NEOPLASM OF LOWER-OUTER QUADRANT OF LEFT MALE BREAST | C50.522 |
| MALIGNANT NEOPLASM OF LOWER-OUTER QUADRANT OF UNSPECIFIED MALE BREAST | C50.529 |
| MALIGNANT NEOPLASM OF AXILLARY TAIL OF RIGHT FEMALE BREAST | C50.611 |
| MALIGNANT NEOPLASM OF AXILLARY TAIL OF LEFT FEMALE BREAST | C50.612 |
| BENIGN NEOPLASM OF RIGHT BREAST | D24.1 |
| BENIGN NEOPLASM OF LEFT BREAST | D24.2 |
| BENIGN NEOPLASM OF UNSPECIFIED BREAST | D24.9 |
| MALIGNANT NEOPLASM OF OVERLAPPING SITES OF RIGHT MALE BREAST | C50.821 |
| MALIGNANT NEOPLASM OF NIPPLE AND AREOLA, UNSPECIFIED MALE BREAST | C50.029 |
| MALIGNANT NEOPLASM OF CENTRAL PORTION OF LEFT FEMALE BREAST | C50.112 |
| MALIGNANT NEOPLASM OF UPPER-INNER QUADRANT OF UNSPECIFIED FEMALE BREAST | C50.219 |
| MALIGNANT NEOPLASM OF UPPER-INNER QUADRANT OF LEFT MALE BREAST | C50.222 |
| MALIGNANT NEOPLASM OF LOWER-INNER QUADRANT OF RIGHT MALE BREAST | C50.321 |
| MALIGNANT NEOPLASM OF LOWER-INNER QUADRANT OF UNSPECIFIED MALE BREAST | C50.329 |

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| MALIGNANT NEOPLASM OF UPPER-OUTER QUADRANT OF LEFT FEMALE BREAST | C50.412 |
| MALIGNANT NEOPLASM OF LOWER-OUTER QUADRANT OF RIGHT FEMALE BREAST | C50.511 |
| MALIGNANT NEOPLASM OF LOWER-OUTER QUADRANT OF UNSPECIFIED FEMALE BREAST | C50.519 |
| MALIGNANT NEOPLASM OF AXILLARY TAIL OF RIGHT MALE BREAST | C50.621 |
| MALIGNANT NEOPLASM OF AXILLARY TAIL OF UNSPECIFIED MALE BREAST | C50.629 |
| MALIGNANT NEOPLASM OF OVERLAPPING SITES OF LEFT MALE BREAST | C50.822 |
| MAMMOGRAPHIC CALCIFICATION FOUND ON DIAGNOSTIC IMAGING OF BREAST | R92.1 |
| MAMMOGRAPHIC MICROCALCIFICATION FOUND ON DIAGNOSTIC IMAGING OF BREAST | R92.0 |
| OTHER ABNORMAL AND INCONCLUSIVE FINDINGS ON DIAGNOSTIC IMAGING OF BREAST | R92.8 |
| PERSONAL HISTORY OF MALIGNANT NEOPLASM OF BREAST | Z85.3 |
| FAMILY HISTORY OF MALIGNANT NEOPLASM OF BREAST | Z80.3 |
| PERSONAL HISTORY OF IN-SITU NEOPLASM OF BREAST | Z86.000 |

*Source: VA OIG analysis of CDW data*

## Table 5. CPT Codes Used to Identify Health Events

| Health Event | Description | CPT Code |
|---|---|---|
| NOT OTHERWISE CLASSIFIED, BREAST INCISION | | T1899 |
| EXCISION OF CYST, FIBROADENOMA OR OTHER BENIGN TUMOR, ABERRANT BREAST TISSUE, DUCT LESION ON NIPPLE (EXCEPT 0465/19140 OR 047 1/19161), MALE, OR FEMALE, ONE OR MORE LESIONS; BILATERAL | | T1950 |
| Mastectomy, All Types | | T1952-T1973 |
| RECONSTRUCTION OF NIPPLE AND/OR AREOLA INCLUDING LABIAL OTHER GRAFTS; BILATERAL | | T1976 |
| REVISION RELEASE OF SCAR CONTRACTURES BREAST, FOLLOWING MAMMOPLASTY; UNILATERAL | | T2100 |
| REVISION (RELEASE OF SCAR CONTRACTURE(S), BREAST, FOLLOWING MAMMOPLASTY BILATERAL | | T2105 |
| BREAST MAMMOGRAPHY | | 77051-77067 |
| QUANTITATIVE NON-HER2 IMMUNOHISTOCHEMISTRY (IHC) EVALUATION OF BREAST CANCER (E.G., TESTING FOR ESTROGEN OR PROGESTERONE RECEPTORS [ER/PR]) PERFORMED (PATH) | CARDIOVASCULAR SYSTEM | 3394F |
| BIOPSY DEVICE, BREAST, ABBI DEVICE | CARDIOVASCULAR SYSTEM | 3395F |
| PROSTHESIS, BREAST (IMPLANTABLE) | CMS HOSPITAL OUTPATIENT PAYMENT SYSTEM | C1170 |
| PROSTHESIS, BREAST, MENTOR SALINE-FILLED CONTOUR PROFILE, MENTOR SILTEX SPECTRUM MAMMARY PROSTHESIS | CMS HOSPITAL OUTPATIENT PAYMENT SYSTEM | C1789 |
| PROSTHESIS, BREAST, MENTOR SALINE-FILLED SPECTRUM | CMS HOSPITAL OUTPATIENT PAYMENT SYSTEM | C3400 |
| MAGNETIC RESONANCE IMAGING WITH CONTRAST, BREAST; UNILATERAL | CMS HOSPITAL OUTPATIENT PAYMENT SYSTEM | C3401 |
| MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST, BREAST; UNILATERAL | CMS HOSPITAL OUTPATIENT PAYMENT SYSTEM | C8903 |
| MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, BREAST; UNILATERAL | CMS HOSPITAL OUTPATIENT PAYMENT SYSTEM | C8904 |
| MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, BREAST; UNILATERAL | CMS HOSPITAL OUTPATIENT PAYMENT SYSTEM | C8905 |
| MAGNETIC RESONANCE IMAGING WITH CONTRAST, BREAST; BILATERAL | CMS HOSPITAL OUTPATIENT PAYMENT SYSTEM | C8905 |
| MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST, BREAST; BILATERAL | CMS HOSPITAL OUTPATIENT PAYMENT SYSTEM | C8906 |
| MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, BREAST; BILATERAL | CMS HOSPITAL OUTPATIENT PAYMENT SYSTEM | C8907 |

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| MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, BREAST; BILATERAL | CMS HOSPITAL OUTPATIENT PAYMENT SYSTEM | C8908 |
| PLACEMENT OF BALLOON CATHETER INTO THE BREAST FOR INTERSTITIAL RADIATION THERAPY FOLLOWING A PARTIAL MASTECTOMY; CONCURRENT/IMMEDIATE (ADD-ON) | CMS HOSPITAL OUTPATIENT PAYMENT SYSTEM | C8908 |
| PLACEMENT OF BALLOON CATHETER INTO THE BREAST FOR INTERSTITIAL RADIATION THERAPY FOLLOWING A PARTIAL MASTECTOMY; DELAYED | CMS HOSPITAL OUTPATIENT PAYMENT SYSTEM | C9714 |
| PLACEMENT AND REMOVAL (IF PERFORMED) OF APPLICATOR INTO BREAST FOR INTRAOPERATIVE RADIATION THERAPY, ADD-ON TO PRIMARY BREAST PROCEDURE | CMS HOSPITAL OUTPATIENT PAYMENT SYSTEM | C9715 |
| PLACEMENT AND REMOVAL (IF PERFORMED) OF APPLICATOR INTO BREAST FOR RADIATION THERAPY | CMS HOSPITAL OUTPATIENT PAYMENT SYSTEM | C9726 |
| FINE NEEDLE ASPIRATION; SUPERFICIAL TISSUE (E.G., THYROID, BREAST, PROSTATE) | CMS HOSPITAL OUTPATIENT PAYMENT SYSTEM | C9726 |
| COMPUTER AIDED DETECTION (COMPUTER ALGORITHM ANALYSIS OF DIGITAL IMAGE DATA FOR LESION DETECTION) WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION, WITH OR WITHOUT DIGITIZATION OF FILM RADIOGRAPHIC IMAGES; DIAGNOSTIC MAMMOGRAPHY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) | CYTOPATHOLOGY | 88170 |
| COMPUTER AIDED DETECTION (COMPUTER ALGORITHM ANALYSIS OF DIGITAL IMAGE DATA FOR LESION DETECTION) WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION, WITH OR WITHOUT DIGITIZATION OF FILM RADIOGRAPHIC IMAGES; SCREENING MAMMOGRAPHY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) | DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING) | 76082 |
| DIGITIZATION OF FILM RADIOGRAPHIC IMAGES WITH COMPUTER ANALYSIS FOR LESION DETECTION AND FURTHER PHYSICIAN REVIEW FOR INTERPRETATION, MAMMOGRAPHY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) | DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING) | 76083 |
| DIGITIZATION OF FILM RADIOGRAPHIC IMAGES WITH COMPUTER ANALYSIS FOR LESION DETECTION AND FURTHER PHYSICIAN REVIEW FOR INTERPRETATION, MAMMOGRAPHY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) PROCEDURE) | DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING) | 76085 |
| MAMMARY DUCTOGRAM OR GALACTOGRAM, SINGLE DUCT, RADIOLOGICAL SUPERVISION AND INTERPRETATION | DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING) | 76085 |
| MAMMARY DUCTOGRAM OR GALACTOGRAM, MULTIPLE DUCTS, RADIOLOGICAL SUPERVISION AND INTERPRETATION | DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING) | 76086 |
| MAMMOGRAPHY; UNILATERAL | DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING) | 76088 |
| MAMMOGRAPHY; BILATERAL | DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING) | 76090 |
| SCREENING MAMMOGRAPHY, BILATERAL (TWO VIEW FILM STUDY OF EACH BREAST) | DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING) | 76091 |
| MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT AND/OR WITH CONTRAST MATERIAL(S); UNILATERAL | DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING) | 76092 |
| MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT AND/OR WITH CONTRAST MATERIAL(S); BILATERAL | DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING) | 76093 |
| STEREOTACTIC LOCALIZATION GUIDANCE FOR BREAST BIOPSY OR NEEDLE PLACEMENT (EG, FOR WIRE LOCALIZATION OR FOR INJECTION), EACH LESION, RADIOLOGICAL SUPERVISION AND INTERPRETATION | DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING) | 76094 |

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| MAMMOGRAPHIC GUIDANCE FOR NEEDLE PLACEMENT, BREAST (EG, FOR WIRE LOCALIZATION OR FOR INJECTION), EACH LESION, RADIOLOGICAL SUPERVISION AND INTERPRETATION | DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING) | 76095 |
| LOCALIZATION OF BREAST NODULE OR CALCIFICATION BEFORE OPERATION, WITH MARKER AND CONFIRMATION OF ITS POSITION WITH APPROPRIATE IMAGING (EG, RADIOLOGIC OR ULTRASOUND); EACH ADDITIONAL LOCALIZATION | DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING) | 76096 |
| STEREOTACTIC LOCALIZATION GUIDANCE FOR BREAST BIOPSY OR NEEDLE PLACEMENT (EG, FOR WIRE LOCALIZATION OR FOR INJECTION), EACH LESION, RADIOLOGICAL SUPERVISION AND INTERPRETATION | DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING) MISCELLANEOUS | 76097 |
| MAMMOGRAPHIC GUIDANCE FOR NEEDLE PLACEMENT, BREAST (EG, FOR WIRE LOCALIZATION OR FOR INJECTION), EACH LESION, RADIOLOGICAL SUPERVISION AND INTERPRETATION | DIAGNOSTIC SCREENING PROCESSES OR RESULTS | 3014F |
| LOCALIZATION OF BREAST NODULE OR CALCIFICATION BEFORE OPERATION, WITH MARKER AND CONFIRMATION OF ITS POSITION WITH APPROPRIATE IMAGING (EG, RADIOLOGIC OR ULTRASOUND); EACH ADDITIONAL LOCALIZATION | DIAGNOSTIC SCREENING PROCESSES OR RESULTS | 3315F |
| SCREENING MAMMOGRAPHY RESULTS DOCUMENTED AND REVIEWED (PV) | DIAGNOSTIC SCREENING PROCESSES OR RESULTS | 3316F |
| ESTROGEN RECEPTOR (ER) OR PROGESTERONE RECEPTOR (PR) POSITIVE BREAST CANCER (ONC) | DIAGNOSTIC SCREENING PROCESSES OR RESULTS | 3340F |
| ESTROGEN RECEPTOR (ER) AND PROGESTERONE RECEPTOR (PR) NEGATIVE BREAST CANCER (ONC) | DIAGNOSTIC SCREENING PROCESSES OR RESULTS | 3341F |
| MAMMOGRAM ASSESSMENT CATEGORY OF INCOMPLETE: NEED ADDITIONAL IMAGING EVALUATION, DOCUMENTED (RAD) | DIAGNOSTIC SCREENING PROCESSES OR RESULTS | 3342F |
| MAMMOGRAM ASSESSMENT CATEGORY OF NEGATIVE, DOCUMENTED (RAD) | DIAGNOSTIC SCREENING PROCESSES OR RESULTS | 3343F |
| MAMMOGRAM ASSESSMENT CATEGORY OF BENIGN, DOCUMENTED (RAD) | DIAGNOSTIC SCREENING PROCESSES OR RESULTS | 3344F |
| MAMMOGRAM ASSESSMENT CATEGORY OF PROBABLY BENIGN, DOCUMENTED (RAD) | DIAGNOSTIC SCREENING PROCESSES OR RESULTS | 3345F |
| MAMMOGRAM ASSESSMENT CATEGORY OF SUSPICIOUS, DOCUMENTED (RAD) | DIAGNOSTIC SCREENING PROCESSES OR RESULTS | 3350F |
| MAMMOGRAM ASSESSMENT CATEGORY OF HIGHLY SUGGESTIVE OF MALIGNANCY, DOCUMENTED (RAD) | DIAGNOSTIC SCREENING PROCESSES OR RESULTS | 3370F |
| MAMMOGRAM ASSESSMENT CATEGORY OF KNOWN BIOPSY PROVEN MALIGNANCY, DOCUMENTED (RAD) | DIAGNOSTIC SCREENING PROCESSES OR RESULTS | 3372F |
| AJCC BREAST CANCER STAGE 0 DOCUMENTED (ONC) | DIAGNOSTIC SCREENING PROCESSES OR RESULTS | 3374F |
| AJCC BREAST CANCER STAGE I: T1MIC, T1A OR T1B (TUMOR SIZE <= 1 CM) DOCUMENTED (ONC) | DIAGNOSTIC SCREENING PROCESSES OR RESULTS | 3376F |
| AJCC BREAST CANCER STAGE I: T1C (TUMOR SIZE > 1 CM TO 2 CM) DOCUMENTED (ONC) | DIAGNOSTIC SCREENING PROCESSES OR RESULTS | 3378F |
| AJCC BREAST CANCER STAGE II DOCUMENTED (ONC) | DIAGNOSTIC SCREENING PROCESSES OR RESULTS | 3380F |
| AJCC BREAST CANCER STAGE III DOCUMENTED (ONC) | DIAGNOSTIC ULTRASOUND | 76641 |
| AJCC BREAST CANCER STAGE IV DOCUMENTED (ONC) | DIAGNOSTIC ULTRASOUND | 76642 |
| ULTRASOUND, BREAST, UNILATERAL, REAL TIME WITH IMAGE DOCUMENTATION, INCLUDING AXILLA WHEN PERFORMED; COMPLETE | DIAGNOSTIC ULTRASOUND | 76645 |
| ULTRASOUND, BREAST, UNILATERAL, REAL TIME WITH IMAGE DOCUMENTATION, INCLUDING AXILLA WHEN PERFORMED; LIMITED | FOLLOW-UP OR OTHER OUTCOMES | 5060F |

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| ULTRASOUND, BREAST(S) (UNILATERAL OR BILATERAL), REAL TIME WITH IMAGE DOCUMENTATION | FOLLOW-UP OR OTHER OUTCOMES | 5062F |
| FINDINGS FROM DIAGNOSTIC MAMMOGRAM COMMUNICATED TO PRACTICE MANAGING PATIENT'S ON-GOING CARE WITHIN 3 BUSINESS DAYS OF EXAM INTERPRETATION (RAD) | INTEGUMENTARY SYSTEM | 19081 |
| FINDINGS FROM DIAGNOSTIC MAMMOGRAM COMMUNICATED TO THE PATIENT WITHIN 5 DAYS OF EXAM INTERPRETATION (RAD) | INTEGUMENTARY SYSTEM | 19082 |
| BIOPSY, BREAST, WITH PLACEMENT OF BREAST LOCALIZATION DEVICE(S) (EG, CLIP, METALLIC PELLET), WHEN PERFORMED, AND IMAGING OF THE BIOPSY SPECIMEN, WHEN PERFORMED, PERCUTANEOUS; FIRST LESION, INCLUDING STEREOTACTIC GUIDANCE | INTEGUMENTARY SYSTEM | 19083 |
| BIOPSY, BREAST, WITH PLACEMENT OF BREAST LOCALIZATION DEVICE(S) (EG, CLIP, METALLIC PELLET), WHEN PERFORMED, AND IMAGING OF THE BIOPSY SPECIMEN, WHEN PERFORMED, PERCUTANEOUS; EACH ADDITIONAL LESION, INCLUDING STEREOTACTIC GUIDANCE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) | INTEGUMENTARY SYSTEM | 19084 |
| BIOPSY, BREAST, WITH PLACEMENT OF BREAST LOCALIZATION DEVICE(S) (EG, CLIP, METALLIC PELLET), WHEN PERFORMED, AND IMAGING OF THE BIOPSY SPECIMEN, WHEN PERFORMED, PERCUTANEOUS; FIRST LESION, INCLUDING ULTRASOUND GUIDANCE | INTEGUMENTARY SYSTEM | 19085 |
| BIOPSY, BREAST, WITH PLACEMENT OF BREAST LOCALIZATION DEVICE(S) (EG, CLIP, METALLIC PELLET), WHEN PERFORMED, AND IMAGING OF THE BIOPSY SPECIMEN, WHEN PERFORMED, PERCUTANEOUS; EACH ADDITIONAL LESION, INCLUDING ULTRASOUND GUIDANCE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) | INTEGUMENTARY SYSTEM | 19086 |
| BIOPSY, BREAST, WITH PLACEMENT OF BREAST LOCALIZATION DEVICE(S) (EG, CLIP, METALLIC PELLET), WHEN PERFORMED, AND IMAGING OF THE BIOPSY SPECIMEN, WHEN PERFORMED, PERCUTANEOUS; FIRST LESION, INCLUDING MAGNETIC RESONANCE GUIDANCE | INTEGUMENTARY SYSTEM | 19100 |
| BIOPSY, BREAST, WITH PLACEMENT OF BREAST LOCALIZATION DEVICE(S) (EG, CLIP, METALLIC PELLET), WHEN PERFORMED, AND IMAGING OF THE BIOPSY SPECIMEN, WHEN PERFORMED, PERCUTANEOUS; EACH ADDITIONAL LESION, INCLUDING MAGNETIC RESONANCE GUIDANCE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) | INTEGUMENTARY SYSTEM | 19101 |
| BIOPSY OF BREAST; PERCUTANEOUS, NEEDLE CORE, NOT USING IMAGING GUIDANCE (SEPARATE PROCEDURE) | INTEGUMENTARY SYSTEM | 19102 |
| BIOPSY OF BREAST; OPEN, INCISIONAL | INTEGUMENTARY SYSTEM | 19103 |
| BIOPSY OF BREAST; PERCUTANEOUS, NEEDLE CORE, USING IMAGING GUIDANCE | INTEGUMENTARY SYSTEM | 19120 |
| BIOPSY OF BREAST; PERCUTANEOUS, AUTOMATED VACUUM ASSISTED OR ROTATING BIOPSY DEVICE, USING IMAGING GUIDANCE | INTEGUMENTARY SYSTEM | 19125 |
| EXCISION OF CYST, FIBROADENOMA, OR OTHER BENIGN OR MALIGNANT TUMOR, ABERRANT BREAST TISSUE, DUCT LESION, NIPPLE OR AREOLAR LESION (EXCEPT 19300), OPEN, MALE OR FEMALE, 1 OR MORE LESIONS | INTEGUMENTARY SYSTEM | 19126 |
| EXCISION OF BREAST LESION IDENTIFIED BY PREOPERATIVE PLACEMENT OF RADIOLOGICAL MARKER, OPEN; SINGLE LESION | INTEGUMENTARY SYSTEM | 19281 |
| EXCISION OF BREAST LESION IDENTIFIED BY PREOPERATIVE PLACEMENT OF RADIOLOGICAL MARKER, OPEN; EACH ADDITIONAL LESION SEPARATELY IDENTIFIED BY A PREOPERATIVE RADIOLOGICAL MARKER (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) | INTEGUMENTARY SYSTEM | 19282 |
| PLACEMENT OF BREAST LOCALIZATION DEVICE(S) (EG, CLIP, METALLIC PELLET, WIRE/NEEDLE, RADIOACTIVE SEEDS), PERCUTANEOUS; FIRST LESION, INCLUDING MAMMOGRAPHIC GUIDANCE | INTEGUMENTARY SYSTEM | 19283 |
| PLACEMENT OF BREAST LOCALIZATION DEVICE(S) (EG, CLIP, METALLIC PELLET, WIRE/NEEDLE, RADIOACTIVE SEEDS), PERCUTANEOUS; EACH | INTEGUMENTARY SYSTEM | 19284 |

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| ADDITIONAL LESION, INCLUDING MAMMOGRAPHIC GUIDANCE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) | | |
| PLACEMENT OF BREAST LOCALIZATION DEVICE(S) (EG, CLIP, METALLIC PELLET, WIRE/NEEDLE, RADIOACTIVE SEEDS), PERCUTANEOUS; FIRST LESION, INCLUDING STEREOTACTIC GUIDANCE | INTEGUMENTARY SYSTEM | 19285 |
| PLACEMENT OF BREAST LOCALIZATION DEVICE(S) (EG, CLIP, METALLIC PELLET, WIRE/NEEDLE, RADIOACTIVE SEEDS), PERCUTANEOUS; EACH ADDITIONAL LESION, INCLUDING STEREOTACTIC GUIDANCE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) | INTEGUMENTARY SYSTEM | 19286 |
| PLACEMENT OF BREAST LOCALIZATION DEVICE(S) (EG, CLIP, METALLIC PELLET, WIRE/NEEDLE, RADIOACTIVE SEEDS), PERCUTANEOUS; FIRST LESION, INCLUDING ULTRASOUND GUIDANCE | INTEGUMENTARY SYSTEM | 19287 |
| PLACEMENT OF BREAST LOCALIZATION DEVICE(S) (EG, CLIP, METALLIC PELLET, WIRE/NEEDLE, RADIOACTIVE SEEDS), PERCUTANEOUS; EACH ADDITIONAL LESION, INCLUDING ULTRASOUND GUIDANCE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) | INTEGUMENTARY SYSTEM | 19288 |
| PLACEMENT OF BREAST LOCALIZATION DEVICE(S) (EG CLIP, METALLIC PELLET, WIRE/NEEDLE, RADIOACTIVE SEEDS), PERCUTANEOUS; FIRST LESION, INCLUDING MAGNETIC RESONANCE GUIDANCE | INTEGUMENTARY SYSTEM | 19290 |
| PLACEMENT OF BREAST LOCALIZATION DEVICE(S) (EG CLIP, METALLIC PELLET, WIRE/NEEDLE, RADIOACTIVE SEEDS), PERCUTANEOUS; EACH ADDITIONAL LESION, INCLUDING MAGNETIC RESONANCE GUIDANCE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) | INTEGUMENTARY SYSTEM | 19291 |
| PREOPERATIVE PLACEMENT OF NEEDLE LOCALIZATION WIRE, BREAST; | INTEGUMENTARY SYSTEM | 19295 |
| PREOPERATIVE PLACEMENT OF NEEDLE LOCALIZATION WIRE, BREAST; EACH ADDITIONAL LESION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) | INTEGUMENTARY SYSTEM | 19296 |
| IMAGE GUIDED PLACEMENT, METALLIC LOCALIZATION CLIP, PERCUTANEOUS, DURING BREAST BIOPSY/ASPIRATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) | INTEGUMENTARY SYSTEM | 19297 |
| PLACEMENT OF RADIOTHERAPY AFTER LOADING EXPANDABLE CATHETER (SINGLE OR MULTICHANNEL) INTO THE BREAST FOR INTERSTITIAL RADIOELEMENT APPLICATION FOLLOWING PARTIAL MASTECTOMY, INCLUDES IMAGING GUIDANCE; ON DATE SEPARATE FROM PARTIAL MASTECTOMY | INTEGUMENTARY SYSTEM | 19298 |
| PLACEMENT OF RADIOTHERAPY AFTER LOADING EXPANDABLE CATHETER (SINGLE OR MULTICHANNEL) INTO THE BREAST FOR INTERSTITIAL RADIOELEMENT APPLICATION FOLLOWING PARTIAL MASTECTOMY, INCLUDES IMAGING GUIDANCE; CONCURRENT WITH PARTIAL MASTECTOMY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) | INTEGUMENTARY SYSTEM | 19301 |
| PLACEMENT OF RADIOTHERAPY AFTER LOADING BRACHYTHERAPY CATHETERS (MULTIPLE TUBE AND BUTTON TYPE) INTO THE BREAST FOR INTERSTITIAL RADIOELEMENT APPLICATION FOLLOWING (AT THE TIME OF OR SUBSEQUENT TO) PARTIAL MASTECTOMY, INCLUDES IMAGING GUIDANCE | INTEGUMENTARY SYSTEM | 19302 |
| MASTECTOMY, PARTIAL (EG, LUMPECTOMY, TYLECTOMY, QUADRANTECTOMY, SEGMENTECTOMY); | INTEGUMENTARY SYSTEM | 19303 |
| MASTECTOMY, PARTIAL (EG, LUMPECTOMY, TYLECTOMY, QUADRANTECTOMY, SEGMENTECTOMY); WITH AXILLARY LYMPHADENECTOMY | INTEGUMENTARY SYSTEM | 19304 |
| MASTECTOMY, SIMPLE, COMPLETE | INTEGUMENTARY SYSTEM | 19305 |
| MASTECTOMY, SUBCUTANEOUS | INTEGUMENTARY SYSTEM | 19306 |
| MASTECTOMY, RADICAL, INCLUDING PECTORAL MUSCLES, AXILLARY LYMPH NODES | INTEGUMENTARY SYSTEM | 19307 |

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| MASTECTOMY, RADICAL, INCLUDING PECTORAL MUSCLES, AXILLARY AND INTERNAL MAMMARY LYMPH NODES (URBAN TYPE OPERATION) | INTEGUMENTARY SYSTEM | 19340 |
| MASTECTOMY, MODIFIED RADICAL, INCLUDING AXILLARY LYMPH NODES, WITH OR WITHOUT PECTORALIS MINOR MUSCLE, BUT EXCLUDING PECTORALIS MAJOR MUSCLE | INTEGUMENTARY SYSTEM | 19342 |
| IMMEDIATE INSERTION OF BREAST PROSTHESIS FOLLOWING MASTOPEXY, MASTECTOMY OR IN RECONSTRUCTION | INTEGUMENTARY SYSTEM | 19357 |
| DELAYED INSERTION OF BREAST PROSTHESIS FOLLOWING MASTOPEXY, MASTECTOMY OR IN RECONSTRUCTION | INTEGUMENTARY SYSTEM | 19360 |
| BREAST RECONSTRUCTION, IMMEDIATE OR DELAYED, WITH TISSUE EXPANDER, INCLUDING SUBSEQUENT EXPANSION | INTEGUMENTARY SYSTEM | 19361 |
| BREAST RECONSTRUCTION WITH MUSCLE OR MYOCUTANEOUS FLAP | INTEGUMENTARY SYSTEM | 19362 |
| BREAST RECONSTRUCTION WITH LATISSIMUS DORSI FLAP, WITHOUT PROSTHETIC IMPLANT | INTEGUMENTARY SYSTEM | 19364 |
| BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS FLAP (TRAM), INCLUDING CLOSURE OF DONOR SITE, SINGLE OR DOUBLE PEDICLE, WITH OR WITHOUT MICROVASCULAR ANASTOMOSIS | INTEGUMENTARY SYSTEM | 19366 |
| BREAST RECONSTRUCTION WITH FREE FLAP | INTEGUMENTARY SYSTEM | 1936719 297 |
| PLACEMENT OF RADIOTHERAPY AFTER LOADING EXPANDABLE CATHETER (SINGLE OR MULTICHANNEL) INTO THE BREAST FOR INTERSTITIAL RADIOELEMENT APPLICATION FOLLOWING PARTIAL MASTECTOMY, INCLUDES IMAGING GUIDANCE; ON DATE SEPARATE FROM PARTIAL MASTECTOMY | INTEGUMENTARY SYSTEM | 19368 |
| BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS FLAP (TRAM), SINGLE PEDICLE, INCLUDING CLOSURE OF DONOR SITE; | INTEGUMENTARY SYSTEM | 19369 |
| BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS FLAP (TRAM), SINGLE PEDICLE, INCLUDING CLOSURE OF DONOR SITE; WITH MICROVASCULAR ANASTOMOSIS (SUPERCHARGING) | INTEGUMENTARY SYSTEM | 19370 |
| BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS FLAP (TRAM), DOUBLE PEDICLE, INCLUDING CLOSURE OF DONOR SITE | INTEGUMENTARY SYSTEM | 19371 |
| OPEN PERIPROSTHETIC CAPSULOTOMY, BREAST | INTEGUMENTARY SYSTEM | 19380 |
| PERIPROSTHETIC CAPSULECTOMY, BREAST | INTEGUMENTARY SYSTEM | 19396 |
| REVISION OF RECONSTRUCTED BREAST | INTEGUMENTARY SYSTEM | 19499 |
| PREPARATION OF MOULAGE FOR CUSTOM BREAST IMPLANT | MOLECULAR PATHOLOGY | 81162 |
| UNLISTED PROCEDURE, BREAST | MOLECULAR PATHOLOGY | 81211 |
| BRCA1, BRCA2 (BREAST CANCER 1 AND 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS AND FULL DUPLICATION/DELETION ANALYSIS | MOLECULAR PATHOLOGY | 81212 |
| BRCA1, BRCA2 (BREAST CANCER 1 AND 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS AND COMMON DUPLICATION/DELETION VARIANTS IN BRCA1 (IE, EXON 13 DEL 3.835KB, EXON 13 DUP 6KB, EXON 14-20 DEL 26KB, EXON 22 DEL 510BP, EXON 8-9 DEL 7.1KB) | MOLECULAR PATHOLOGY | 81213 |
| BRCA1, BRCA2 (BREAST CANCER 1 AND 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; 185DELAG, 5385INSC, 6174DELT VARIANTS | MOLECULAR PATHOLOGY | 81214 |
| BRCA1, BRCA2 (BREAST CANCER 1 AND 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; UNCOMMON DUPLICATION/DELETION VARIANTS | MOLECULAR PATHOLOGY | 81215 |

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| BRCA1 (BREAST CANCER 1) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS AND COMMON DUPLICATION/DELETION VARIANTS (IE, EXON 13 DEL 3.835KB, EXON 13 DUP 6KB, EXON 14-20 DEL 26KB, EXON 22 DEL 510BP, EXON 8-9 DEL 7.1KB) | MOLECULAR PATHOLOGY | 81216 |
| BRCA1 (BREAST CANCER 1) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; KNOWN FAMILIAL VARIANT | MOLECULAR PATHOLOGY | 81217 |
| BRCA2 (BREAST CANCER 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS | MOLECULAR PATHOLOGY | 81432 |
| BRCA2 (BREAST CANCER 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; KNOWN FAMILIAL VARIANT | MOLECULAR PATHOLOGY | 81433 |
| HEREDITARY BREAST CANCER-RELATED DISORDERS (EG, HEREDITARY BREAST CANCER, HEREDITARY OVARIAN CANCER, HEREDITARY ENDOMETRIAL CANCER); GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE SEQUENCING OF AT LEAST 14 GENES, INCLUDING ATM, BRCA1, BRCA2, BRIP1, CDH1, MLH1, MSH2, MSH6, NBN, PALB2, PTEN, RAD51C, STK11, AND TP53 | MOLECULAR PATHOLOGY | 81519 |
| HEREDITARY BREAST CANCER-RELATED DISORDERS (EG, HEREDITARY BREAST CANCER, HEREDITARY OVARIAN CANCER, HEREDITARY ENDOMETRIAL CANCER); DUPLICATION/DELETION ANALYSIS PANEL, MUST INCLUDE ANALYSES FOR BRCA1, BRCA2, MLH1, MSH2, AND STK11 | OTHER RADIOLOGIC GUIDANCE | 77031 |
| ONCOLOGY (BREAST), MRNA, GENE EXPRESSION PROFILING BY REAL-TIME RT-PCR OF 21 GENES, UTILIZING FORMALIN-FIXED PARAFFIN EMBEDDED TISSUE, ALGORITHM REPORTED AS RECURRENCE SCORE | OTHER RADIOLOGIC GUIDANCE | 77032 |
| STEREOTACTIC LOCALIZATION GUIDANCE FOR BREAST BIOPSY OR NEEDLE PLACEMENT (EG, FOR WIRE LOCALIZATION OR FOR INJECTION), EACH LESION, RADIOLOGICAL SUPERVISION AND INTERPRETATION | PATIENT | 0046T |
| MAMMOGRAPHIC GUIDANCE FOR NEEDLE PLACEMENT, BREAST (EG, FOR WIRE LOCALIZATION OR FOR INJECTION), EACH LESION, RADIOLOGICAL SUPERVISION AND INTERPRETATION | PATIENT | 0047T |
| CATHETER LAVAGE OF A MAMMARY DUCT(S) FOR COLLECTION OF CYTOLOGY SPECIMEN(S), IN HIGH RISK INDIVIDUALS (GAIL RISK SCORING OR PRIOR PERSONAL HISTORY OF BREAST CANCER), EACH BREAST; SINGLE DUCT | PATIENT | 0060T |
| CATHETER LAVAGE OF A MAMMARY DUCT(S) FOR COLLECTION OF CYTOLOGY SPECIMEN(S), IN HIGH RISK INDIVIDUALS (GAIL RISK SCORING OR PRIOR PERSONAL HISTORY OF BREAST CANCER), EACH BREAST; EACH ADDITIONAL DUCT | PATIENT | 0061T |
| ELECTRICAL IMPEDANCE SCAN OF THE BREAST, BILATERAL (RISK ASSESSMENT DEVICE FOR BREAST CANCER) | PATIENT | 0159T |
| DESTRUCTION/REDUCTION OF MALIGNANT BREAST TUMOR INCLUDING BREAST CARCINOMA CELLS IN THE MARGINS, MICROWAVE PHASED ARRAY THERMOTHERAPY, DISPOSABLE CATHETER WITH COMBINED TEMPERATURE MONITORING PROBE AND MICROWAVE SENSOR, EXTERNALLY APPLIED MICROWAVE ENERGY, INCLUDING INTERSTITIAL PLACEMENT OF SENSOR | STRUCTURAL | 7020F |
| COMPUTER-AIDED DETECTION, INCLUDING COMPUTER ALGORITHM ANALYSIS OF MRI IMAGE DATA FOR LESION DETECTION/CHARACTERIZATION, PHARMACOKINETIC ANALYSIS, WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION, BREAST MRI (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) | STRUCTURAL | 7025F |
| SURGICAL PATHOLOGY | | 88305 - 88309 |
| LEVEL V - SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC EXAMINATION CERVIX, CONIZATION COLON, SEGMENTAL RESECTION, OTHER THAN FOR TUMOR EXTREMITY, AMPUTATION, NON-TRAUMATIC EYE, ENUCLEATION KIDNEY, PARTIAL/TOTAL NEPHRECTOMY LARYNX, PARTIAL/TOTAL RESECTION LIVER, BIOPSY - NEEDLE/WEDGE LIVER, PARTIAL RESECTION | TEMPORARY NATIONAL CODES (NON MEDICARE) | S3854 |

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| LUNG, WEDGE BIOPSY LYMPH NODES, REGIONAL RESECTION ADRENAL, RESECTION MEDIASTINUM, MASS MYOCARDIUM, BIOPSY ODONTOGENIC TUMOR OVARY WITH OR WITHOUT TUBE, NEOPLASTIC PANCREAS, BIOPSY PLACENTA, THIRD TRIMESTER PROSTATE, EXCEPT RADICAL RESECTION SALIVARY GLAND SENTINEL LYMPH NODE SMALL INTESTINE, RESECTION, OTHER THAN FOR TUMOR BONE - BIOPSY/CURETTINGS SOFT TISSUE MASS (EXCEPT LIPOMA) - BIOPSY/SIMPLE EXCISION STOMACH - SUBTOTAL/TOTAL RESECTION, OTHER THAN FOR TUMOR TESTIS, BIOPSY THYMUS, TUMOR THYROID, TOTAL/LOBE URETER, RESECTION URINARY BLADDER, TUR UTERUS, WITH OR WITHOUT TUBES AND OVARIES, OTHER THAN NEOPLASTIC/PROLAPSE BONE FRAGMENT(S), PATHOLOGIC FRACTURE BRAIN, BIOPSY BRAIN/MENINGES, TUMOR RESECTION BREAST, EXCISION OF LESION, REQUIRING MICROSCOPIC EVALUATION OF SURGICAL MARGINS BREAST, MASTECTOMY - PARTIAL/SIMPLE | | |
| LEVEL VI - SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC EXAMINATION LUNG - TOTAL/LOBE/SEGMENT RESECTION PANCREAS, TOTAL/SUBTOTAL RESECTION PROSTATE, RADICAL RESECTION SMALL INTESTINE, RESECTION FOR TUMOR SOFT TISSUE TUMOR, EXTENSIVE RESECTION STOMACH - SUBTOTAL/TOTAL RESECTION FOR TUMOR TESTIS, TUMOR TONGUE/TONSIL - RESECTION FOR TUMOR URINARY BLADDER, PARTIAL/TOTAL RESECTION UTERUS, WITH OR WITHOUT TUBES AND OVARIES, NEOPLASTIC BONE RESECTION VULVA, TOTAL/SUBTOTAL RESECTION BREAST, MASTECTOMY - WITH REGIONAL LYMPH NODES COLON, SEGMENTAL RESECTION FOR TUMOR COLON, TOTAL RESECTION ESOPHAGUS, PARTIAL/TOTAL RESECTION EXTREMITY, DISARTICULATION FETUS, WITH DISSECTION LARYNX, PARTIAL/TOTAL RESECTION - WITH REGIONAL LYMPH NODES | TEMPORARY NATIONAL CODES (NON MEDICARE) | S8080 |
| BREAST CANCER TREATMENT | TEMPORARY NATIONAL CODES ESTABLISHED BY PRIVATE PAYERS | S2066 |
| SCINTIMAMMOGRAPHY (RADIOIMMUNOSCINTIGRAPHY OF THE BREAST), UNILATERAL, INCLUDING SUPPLY OF RADIOPHARMACEUTICAL | TEMPORARY NATIONAL CODES ESTABLISHED BY PRIVATE PAYERS | S2066 |
| BREAST RECONSTRUCTION WITH GLUTEAL ARTERY PERFORATOR (GAP) FLAP, INCLUDING HARVESTING OF THE FLAP, MICROVASCULAR TRANSFER, CLOSURE OF DONOR SITE AND SHAPING THE FLAP INTO A BREAST, UNILATERAL | TEMPORARY NATIONAL CODES ESTABLISHED BY PRIVATE PAYERS | S2067 |
| BREAST RECONSTRUCTION WITH GLUTEAL ARTERY PERFORATOR (GAP) FLAP, INCLUDING HARVESTING OF THE FLAP, MICROVASCULAR TRANSFER, CLOSURE OF DONOR SITE AND SHAPING THE FLAP INTO A BREAST, UNILATERAL | TEMPORARY NATIONAL CODES ESTABLISHED BY PRIVATE PAYERS | S2067 |
| BREAST RECONSTRUCTION OF A SINGLE BREAST WITH STACKED DEEP INFERIOR EPIGASTRIC PERFORATOR (DIEP) FLAP(S) AND/OR GLUTEAL ARTERY PERFORATOR (GAP) FLAP(S), INCLUDING HARVESTING OF THE FLAP(S), MICROVASCULAR TRANSFER, CLOSURE OF DONOR SITE(S) AND SHAPING THE FLAP INTO A BREAST, UNILATERAL | TEMPORARY NATIONAL CODES ESTABLISHED BY PRIVATE PAYERS | S2068 |
| BREAST RECONSTRUCTION OF A SINGLE BREAST WITH STACKED DEPP INFERIOR EPIGASTRIC PERFORATOR (DIEP) FLAP(S) AND/OR GLUTEAL ARTERY PERFORATOR (GAP) FLAP(S), INCLUDING HARVESTING OF THE FLAP(S), MICROVASCULAR TRANSFER, CLOSURE OF DONOR SITE(S) AND SHAPING THE FLAP INTO A BREAST, UNILATERAL | TEMPORARY NATIONAL CODES ESTABLISHED BY PRIVATE PAYERS | S2068 |
| BREAST RECONSTRUCTION WITH DEEP INFERIOR EPIGASTRIC PERFORATOR (DIEP) FLAP OR SUPERFICIAL INFERIOR EPIGASTRIC ARTERY (SIEA) FLAP, INCLUDING HARVESTING OF THE FLAP, MICROVASCULAR TRANSFER, CLOSURE OF DONOR SITE AND SHAPING THE FLAP INTO A BREAST, UNILATERAL | TEMPORARY NATIONAL CODES ESTABLISHED BY PRIVATE PAYERS | S3820 |
| BREAST RECONSTRUCTION WITH DEEP INFERIOR EPIGASTRIC PERFORATOR (DIEP) FLAP OR SUPERFICIAL INFERIOR EPIGASTRIC ARTERY (SIEA) FLAP, INCLUDING HARVESTING OF THE FLAP, MICROVASCULAR TRANSFER, CLOSURE OF DONOR SITE AND SHAPING THE FLAP INTO A BREAST, UNILATERAL | TEMPORARY NATIONAL CODES ESTABLISHED BY PRIVATE PAYERS | S3822 |

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| COMPLETE BRCA1 AND BRCA2 GENE SEQUENCE ANALYSIS FOR SUSCEPTIBILITY TO BREAST AND OVARIAN CANCER | TEMPORARY NATIONAL CODES ESTABLISHED BY PRIVATE PAYERS | S3823 |
| SINGLE MUTATION ANALYSIS (IN INDIVIDUAL WITH A KNOWN BRCA1 OR BRCA2 MUTATION IN THE FAMILY) FOR SUSCEPTIBILITY TO BREAST AND OVARIAN CANCER | TEMPORARY NATIONAL CODES ESTABLISHED BY PRIVATE PAYERS | S8075 |
| THREE-MUTATION BRCA1 AND BRCA2 ANALYSIS FOR SUSCEPTIBILITY TO BREAST AND OVARIAN CANCER IN ASHKENAZI INDIVIDUALS | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G0202 |
| COMPUTER ANALYSIS OF FULL-FIELD DIGITAL MAMMOGRAM AND FURTHER PHYSICIAN REVIEW FOR INTERPRETATION, MAMMOGRAPHY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G0204 |
| SCREENING MAMMOGRAPHY, BILATERAL (2-VIEW STUDY OF EACH BREAST), INCLUDING COMPUTER-AIDED DETECTION (CAD) WHEN PERFORMED | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G0206 |
| DIAGNOSTIC MAMMOGRAPHY, INCLUDING COMPUTER-AIDED DETECTION (CAD) WHEN PERFORMED; BILATERAL | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G0236 |
| DIAGNOSTIC MAMMOGRAPHY, INCLUDING COMPUTER-AIDED DETECTION (CAD) WHEN PERFORMED; UNILATERAL | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G0252 |
| DIGITIZATION OF FILM RADIOGRAPHIC IMAGES WITH COMPUTER ANALYSIS FOR LESION DETECTION, OR COMPUTER ANALYSIS OF DIGITAL MAMMOGRAM FOR LESION DETECTION, AND FURTHER PHYSICIAN REVIEW FOR INTERPRETATION, DIAGNOSTIC MAMMOGRAPHY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G0252 |
| PET IMAGING, FULL AND PARTIAL-RING PET SCANNERS ONLY, FOR INITIAL DIAGNOSIS OF BREAST CANCER AND/OR SURGICAL PLANNING FOR BREAST CANCER (E.G., INITIAL STAGING OF AXILLARY LYMPH NODES) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G0253 |
| PET IMAGING, FULL AND PARTIAL-RING PET SCANNERS ONLY, FOR INITIAL DIAGNOSIS OF BREAST CANCER AND/OR SURGICAL PLANNING FOR BREAST CANCER (E.G. INITIAL STAGING OF AXILLARY LYMPH NODES) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G0254 |
| PET IMAGING FOR BREAST CANCER, FULL AND PARTIAL-RING PET SCANNERS ONLY, STAGING/RESTAGING OF LOCAL REGIONAL RECURRENCE OR DISTANT METASTASES (I.E., STAGING/RESTAGING AFTER OR PRIOR TO COURSE OF TREATMENT) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G0279 |
| PET IMAGING FOR BREAST CANCER, FULL AND PARTIAL- RING PET SCANNERS ONLY, EVALUATION OF RESPONSE TO TREATMENT, PERFORMED DURING COURSE OF TREATMENT | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8873 |
| DIAGNOSTIC DIGITAL BREAST TOMOSYNTHESIS, UNILATERAL OR BILATERAL (LIST SEPARATELY IN ADDITION TO G0204 OR G0206) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8873 |
| PATIENTS WITH NEEDLE LOCALIZATION SPECIMENS WHICH ARE NOT AMENABLE TO INTRAOPERATIVE IMAGING SUCH AS MRI NEEDLE WIRE LOCALIZATION, OR TARGETS WHICH ARE TENTATIVELY IDENTIFIED ON MAMMOGRAM OR ULTRASOUND WHICH DO NOT CONTAIN A BIOPSY MARKER BUT WHICH CAN BE VERIFIED ON INTRAOPERATIVE INSPECTION OR PATHOLOGY (E.G., NEEDLE BIOPSY SITE WHERE THE BIOPSY MARKER IS REMOTE FROM THE ACTUAL BIOPSY SITE) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8873 |
| PATIENTS WITH NEEDLE LOCALIZATION SPECIMENS WHICH ARE NOT AMENABLE TO INTRAOPERATIVE IMAGING SUCH AS MRI NEEDLE WIRE LOCALIZATION, OR TARGETS WHICH ARE TENTATIVELY IDENTIFIED ON MAMMOGRAM OR ULTRASOUND WHICH DO NOT CONTAIN A BIOPSY MARKER BUT WHICH CAN BE VERIFIED ON INTRAOPERATIVE INSPECTION OR PATHOLOGY | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8875 |

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| PATIENTS WITH NEEDLE LOCALIZATION SPECIMENS WHICH ARE NOT AMENABLE TO INTRAOPERATIVE IMAGING SUCH AS MRI NEEDLE WIRE LOCALIZATION, OR TARGETS WHICH ARE TENTATIVELY IDENTIFIED ON MAMMOGRAM OR ULTRASOUND WHICH DO NOT CONTAIN A BIOPSY MARKER BUT WHICH CAN BE VERIFIED ON INTRAOPERATIVE INSPECTION OR PATHOLOGY (E.G., NEEDLE BIOPSY SITE WHERE THE BIOPSY MARKER IS REMOTE FROM THE ACTUAL BIOPSY SITE) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8875 |
| CLINICIAN DIAGNOSED BREAST CANCER PREOPERATIVELY BY A MINIMALLY INVASIVE BIOPSY METHOD | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8876 |
| CLINICIAN DIAGNOSED BREAST CANCER PREOPERATIVELY BY A MINIMALLY INVASIVE BIOPSY METHOD | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8876 |
| DOCUMENTATION OF REASON(S) FOR NOT PERFORMING MINIMALLY INVASIVE BIOPSY TO DIAGNOSE BREAST CANCER PREOPERATIVELY (E.G., LESION TOO CLOSE TO SKIN, IMPLANT, CHEST WALL, ETC., LESION COULD NOT BE ADEQUATELY VISUALIZED FOR NEEDLE BIOPSY, PATIENT CONDITION PREVENTS NEEDLE BIOPSY [WEIGHT, BREAST THICKNESS, ETC.], DUCT EXCISION WITHOUT IMAGING ABNORMALITY, PROPHYLACTIC MASTECTOMY, REDUCTION MAMMOPLASTY, EXCISIONAL BIOPSY PERFORMED BY ANOTHER PHYSICIAN) MAMMOPLASTY, EXCISIONAL BIOPSY PERFORMED BY ANOTHER PHYSICIAN | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8876 |
| DOCUMENTATION OF REASON(S) FOR NOT PERFORMING MINIMALLY INVASIVE BIOPSY TO DIAGNOSE BREAST CANCER PREOPERATIVELY (E.G., CLINICAL AND IMAGING FINDINGS CONSISTENT WITH A BENIGN LESION, LESION TOO CLOSE TO SKIN, IMPLANT, CHEST WALL, ETC., LESION COULD NOT BE ADEQUATELY VISUALIZED FOR NEEDLE BIOPSY, PATIENT CONDITION PREVENTS NEEDLE BIOPSY [WEIGHT, BREAST THICKNESS, ETC. ], DUCT EXCISION WITHOUT IMAGING ABNORMALITY, PROPHYLACTIC MASTECTOMY, REDUCTION MAMMOPLASTY, EXCISIONAL BIOPSY PERFORMED BY ANOTHER PHYSICIAN | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8877 |
| DOCUMENTATION OF REASON(S) FOR NOT PERFORMING MINIMALLY INVASIVE BIOPSY TO DIAGNOSE BREAST CANCER PREOPERATIVELY | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8877 |
| CLINICIAN DID NOT ATTEMPT TO ACHIEVE THE DIAGNOSIS OF BREAST CANCER PREOPERATIVELY BY A MINIMALLY INVASIVE BIOPSY METHOD, REASON NOT GIVEN SPECIFIED | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8877 |
| CLINICIAN DID NOT ATTEMPT TO ACHIEVE THE DIAGNOSIS OF BREAST CANCER PREOPERATIVELY BY A MINIMALLY INVASIVE BIOPSY METHOD, REASON NOT GIVEN SPECIFIED | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8878 |
| CLINICIAN DID NOT ATTEMPT TO ACHIEVE THE DIAGNOSIS OF BREAST CANCER PREOPERATIVELY BY A MINIMALLY INVASIVE BIOPSY METHOD, REASON NOT OTHERWISE SPECIFIED | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8879 |
| SENTINEL LYMPH NODE BIOPSY PROCEDURE PERFORMED | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8879 |
| CLINICALLY NODE NEGATIVE (T1N0M0 OR T2N0M0) INVASIVE BREAST CANCER | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8880 |
| CLINICALLY NODE NEGATIVE (T1N0M0) OR T2N0M0) INVASIVE BREAST CANCER | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8880 |
| DOCUMENTATION OF REASON(S) SENTINEL LYMPH NODE BIOPSY NOT PERFORMED (E.G., REASONS COULD INCLUDE BUT NOT LIMITED TO; NON-INVASIVE CANCER, INCIDENTAL DISCOVERY OF BREAST CANCER ON PROPHYLACTIC MASTECTOMY, INCIDENTAL DISCOVERY OF BREAST CANCER ON REDUCTION MAMMOPLASTY, PRE-OPERATIVE BIOPSY PROVEN LYMPH NODE (LN) METASTASES, INFLAMMATORY CARCINOMA, STAGE 3 LOCALLY ADVANCED CANCER, RECURRENT INVASIVE BREAST CANCER, | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8880 |

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| PATIENT REFUSAL AFTER INFORMED CONSENT) CANCER, PATIENT REFUSAL AFTER INFORMED CONSENT) | | |
| DOCUMENTATION OF REASON(S) SENTINEL LYMPH NODE BIOPSY NOT PERFORMED (E.G., REASONS COULD INCLUDE BUT NOT LIMITED TO; NON-INVASIVE CANCER, INCIDENTAL DISCOVERY OF BREAST CANCER ON PROPHYLACTIC MASTECTOMY, INCIDENTAL DISCOVERY OF BREAST CANCER ON REDUCTION MAMMOPLASTY, PRE- OPERATIVE BIOPSY PROVEN LYMPH NODE (LN) METASTASES, INFLAMMATORY CARCINOMA, STAGE 3 LOCALLY ADVANCED CANCER, RECURRENT INVASIVE BREAST CANCER, PATIENT REFUSAL AFTER INFORMED CONSENT) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8880 |
| DOCUMENTATION OF REASON(S) SENTINEL LYMPH NODE BIOPSY NOT PERFORMED | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8881 |
| DOCUMENTATION OF REASON(S) SENTINEL LYMPH NODE BIOPSY NOT PERFORMED (E.G., CANCER DIAGNOSED AT PROPHYLACTIC MASTECTOMY, NON-INVASIVE CANCER, INCIDENTAL DISCOVERY OF BREAST CANCER ON PROPHYLACTIC MASTECTOMY, INCIDENTAL DISCOVERY OF BREAST CANCER ON REDUCTION MAMMOPLASTY, BIOPSY PROVEN LYMPH NODE (LN) METASTASES [E.G., PRE-OP FNA OR CORE BIOPSY, INFLAMMATORY CARCINOMA, RECURRENT INVASIVE BREAST CANCER] PATIENT REFUSAL AFTER INFORMED CONSENT) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8882 |
| STAGE OF BREAST CANCER IS GREATER THAN T1N0M0 OR T2N0M0 | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8882 |
| SENTINEL LYMPH NODE BIOPSY PROCEDURE NOT PERFORMED | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8882 |
| SENTINEL LYMPH NODE BIOPSY PROCEDURE NOT PERFORMED, REASON NOT GIVEN | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G8946 |
| SENTINEL LYMPH NODE BIOPSY PROCEDURE NOT PERFORMED, REASON NOT GIVEN | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9071 |
| MINIMALLY INVASIVE BIOPSY METHOD ATTEMPTED BUT NOT DIAGNOSTIC OF BREAST CANCER (E.G., HIGH RISK LESION OF BREAST SUCH AS ATYPICAL DUCTAL HYPERPLASIA, LOBULAR NEOPLASIA, ATYPICAL LOBULAR CARCINOMA IN SITU, ATYPICAL COLUMNAR HYPERPLASICA, FLAT EPITHELIAL ATYPIA, RADIAL SCAR, COMPLEX SCLEROSING LESION, PAPILLARY LESION, OR ANY LESION WITH SPINDLE CELLS) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9072 |
| ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; STAGE I OR STAGE IIA-IIB; OR T3, N1, M0; AND ER AND/OR PR POSITIVE; WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9072 |
| ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; STAGE I, OR STAGE IIA-IIB; OR T3, N1, M0; AND ER AND PR NEGATIVE; WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9073 |
| ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; STAGE I, OR STAGE IIA-IIB; OR T3, N1, M0; AND ER AND PR NEGATIVE; WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9074 |

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| ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; STAGE IIIA-IIIB; AND NOT T3, N1, M0; AND ER AND/OR PR POSITIVE; WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9074 |
| ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; STAGE IIIA-IIIB; AND NOT T3, N1, M0; AND ER AND PR NEGATIVE; WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9075 |
| ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; STAGE IIIA-IIIB; AND NOT T3, N1, M0; AND ER AND PR NEGATIVE; WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9075 |
| ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; M1 AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9076 |
| ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; M1 AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9131 |
| ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, PRE-SURGICAL OR NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9131 |
| ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, STAGING IN PROGRESS, OR NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9704 |
| ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, STAGING IN PROGRESS, OR NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT) | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9705 |
| AJCC BREAST CANCER STAGE I: T1 MIC OR T1A DOCUMENTED | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9705 |
| AJCC BREAST CANCER STAGE I: T1B (TUMOR > 0.5 CM BUT <= 1 CM IN GREATEST DIMENSION) DOCUMENTED | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9825 |
| AJCC BREAST CANCER STAGE I: T1B (TUMOR > 0.5 CM BUT <= 1 CM IN GREATEST DIMENSION) DOCUMENTED | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9827 |
| HER-2/NEU NEGATIVE OR UNDOCUMENTED/UNKNOWN | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9828 |

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| HER2-TARGETED THERAPIES NOT ADMINISTERED DURING THE INITIAL COURSE OF TREATMENT | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9829 |
| HER2-TARGETED THERAPIES ADMINISTERED DURING THE INITIAL COURSE OF TREATMENT | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9830 |
| BREAST ADJUVANT CHEMOTHERAPY ADMINISTERED | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9831 |
| HER-2/NEU POSITIVE | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9832 |
| AJCC STAGE AT BREAST CANCER DIAGNOSIS = II OR III | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9832 |
| AJCC STAGE AT BREAST CANCER DIAGNOSIS = I (IA OR IB) AND T-STAGE AT BREAST CANCER DIAGNOSIS DOES NOT EQUAL = T1, T1A, T1B | TEMPORARY PROCEDURES/PROFESSIONAL SERVICES | G9834 |
| AJCC STAGE AT BREAST CANCER DIAGNOSIS = I (IA OR IB) AND T-STAGE AT BREAST CANCER DIAGNOSIS DOES NOT EQUAL = T1, T1A, T1B | TEMPORARY SURGERY PROCEDURES | 0301T |
| PATIENT HAS METASTATIC DISEASE AT DIAGNOSIS | TEMPORARY SURGERY PROCEDURES | 0351T |
| DESTRUCTION/REDUCTION OF MALIGNANT BREAST TUMOR WITH EXTERNALLY APPLIED FOCUSED MICROWAVE, INCLUDING INTERSTITIAL PLACEMENT OF DISPOSABLE CATHETER WITH COMBINED TEMPERATURE MONITORING PROBE AND MICROWAVE FOCUSING SENSOCATHETER UNDER ULTRASOUND THERMOTHERAPY GUIDANCE | TEMPORARY SURGERY PROCEDURES | 0352T |
| OPTICAL COHERENCE TOMOGRAPHY OF BREAST OR AXILLARY LYMPH NODE, EXCISED TISSUE, EACH SPECIMEN; REAL TIME INTRAOPERATIVE | TEMPORARY SURGERY PROCEDURES | 0352T |
| OPTICAL COHERENCE TOMOGRAPHY OF BREAST OR AXILLARY LYMPH NODE, EXCISED TISSUE, EACH SPECIMEN; INTERPRETATION AND REPORT, REAL TIME OR REFERRED | TEMPORARY SURGERY PROCEDURES | 0353T |
| OPTICAL COHERENCE TOMOGRAPHY OF BREAST, SURGICAL CAVITY; REAL TIME INTRAOPERATIVE | TEMPORARY SURGERY PROCEDURES | 0354T |
| OPTICAL COHERENCE TOMOGRAPHY OF BREAST, SURGICAL CAVITY; INTERPRETATION AND REPORT, REAL TIME OR REFERRED | TEMPORARY SURGERY PROCEDURES | 0422T |
| THORAX (CHEST WALL AND SHOULDER GIRDLE) | THORAX (CHEST WALL AND SHOULDER GIRDLE) | 00402 - 00406 |
| CHEMOTHERAPY ADMINISTRATION | | 96400 - 96549 |
| CHEMOTHERAPY DRUGS | | J9000-J9999 |

*Source: VA OIG analysis of CDW data*

# Appendix B: Additional Information Received from the Facility

**Department of Veterans Affairs**

**Memorandum**

Date: OCT 1 3 2017

From: Director, Atlanta VA Medical Center (508/00)

Subj: Mammography Patient Follow-Up and Action Plan

To: (OIG)

1. This is in response to your request for the Atlanta VA Medical Center to provide a follow-up status and action plan for forty-three (43) deficiencies (42 unique patients) identified by the OIG Office of Healthcare Inspection Team during the October 2-4, 2017 on site review. An interdisciplinary team met to review the care provided and developed the attached action plan to address the outcomes including timelines and responsible parties. Below is a brief overview of this plan:

- Chart reviews were completed on 42 unique patients with no adverse outcomes identified as of today, October 13, 2017.
- Communication was completed for all patients as follows:
  - Phone (32), Voice Mail Message (7), Letter (3) and Provider Follow-Up (1)
  - Vendor contact occurred as needed to secure supporting documentation
- **Finding:** Twelve (12) patients never completed the scheduling process.
  **Action:** These Veterans are actively followed by their primary care providers. The provider/designee will place orders as clinically indicated.
- **Finding:** Five (5) patients have unscheduled consults greater than 30 days.
  **Action:** Non-VA Care staff will initiate the scheduling process for these veterans.
- **Finding:** Fifteen (15) consults were closed without documentation of clinical review per VA Community Care guidelines.
  **Action:** To date, 6 (40%) of the clinical reviews are complete and 9 (60%) are pending provider evaluation. Going forward all failed scheduling initiatives will be clinically reviewed prior to closure.
- **Finding**: Fourteen (14) scheduled cases found without documentation of results in the medical record.
  **Action**: Efforts will be made to verify appointment attendance and secure records from vendor locations.
- **Finding:** Six (6) cases were in the middle of care requiring additional imaging.
  **Action:** The PACT team will communicate and document the imaging recommendation to the veteran. Upon verification of vendor authorization, the veterans will be scheduled with the imaging facility.
- **Finding**: Surgery was recommended for 3 veterans.
  - Complete (1), Pending Review (1), Veteran cancellation (1)

Subject: Mammography Patient Follow-Up and Action Plan Page 2.

- **Action:** Patients will be followed up to evaluate surgical status and obtain supporting documentation for notification of Primary Care Provider (PCP) and upload to Vista Imaging.

2. The Atlanta VA Medical Center consult closure procedures were in accordance with VA Community Care guidelines; however, we will continue to improve patient care outcomes through enhanced Mammogram Program tracking, schedule coordination, record retrieval, timely communication and documentation of test results. If you have any questions or require further information, please feel free to me directly at 404) 321- 6111, extension 7601.

Annette P. Walker
Director, Atlanta VA Medical Center

# Appendix C: Facility Revised Standard Operating Procedure for Mammography

| Action | Assignment |
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| **Providers Identify patients who need screening mammograms and enter both an Order & a Consult**<br>1. Providers use the CPRS Mammogram Quick Order menu to enter a radiology Mammogram order. The entry of the radiology mammogram order automatically triggers a Non-VA Care Breast Consult<br>2. Consults include authorization for the mammogram as well as reflex f/u breast imaging tests<br>3. The consult includes a single VA contact number that is designated to be used by the outside Non-VA providers to contact VA providers (1-800 224 4087/ 404 329 2222 This is the Atlanta VA Call Center number) and a single E-Fax number (Streem Fax number 404-639-9329) that is to be used for ALL Mammogram reports<br>4. The E-Fax number delivers reports to a secure server that is accessible remotely by a designated mail group. (Ideally the Mammogram Coordinators, NVCC Breast Teamlet and the Call Center). The Mammogram Coordinators will receive an email alert whenever a new fax comes in<br>5. Consults/orders should not be entered more (than) 60 days before the desired date/clinically indicted date<br>6. See Appendix for the Call Center's Mammogram SCRIPT that will be used for all Mammogram related calls | **Providers** |

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| **Non-VA Consult/Referral is reviewed by the designated NVCC Clinical Reviewer. Once approved the appropriate NVCC team member will be alerted**<br>1. Clinical Reviewer will review order within (TIME LINE check with Dr. PB) and consult for accuracy (e.g. order signed by MD, appropriate for veteran's gender)<br>2. Incomplete inappropriate or duplicate consults are discontinued or returned to ordering provider<br>3. Consults that are more than 90 days before the desired date/ clinically indicted date are discontinued<br>4. NVCC Reviewer will ALERT the assigned Teamlet/team member and include the Teamlet name in the consult approval documentation<br>5. Approval changes the consult's status from Pending to Active | **NVCC** |
| **Contact Veteran to Identify Availability and Preferences: Contact the Veteran to discuss availability to attend non-VA appointment(s).**<br>1. Identify patient availability, Veteran preferences for non-VA provider selection<br>2. Provide Veteran with VA contact information in the event they need to cancel/reschedule<br>3. Document Veteran preferences and/or failed attempts to contact Veteran on consult in CPRS using consult toolbox | **NVCC** |
| **Contact Non-VA Provider to Schedule the Appointment: Contact the non-VA provider to schedule the appointment(s) for the Veteran**.<br>1. Fax the Orders & Consult to the Non-VA Provider (Based on Veteran Preferences)<br>2. Contact the Non-VA Provider's office to Identify available openings<br>3. Identify any requirements (e.g. orders, authorization, films or reports prior to scheduling, etc.)<br>4. Schedule the appointment with the non-VA provider<br>5. Document appointment information using consult toolbox (appointment tracking) | **NVCC** |

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| **Schedule Appointment in Vista Appointment Management**<br>1. All outside appointments must be documented in VISTA using a Non-Count Mammogram clinic. This is reportable in the consult toolbox reports | **NVCC** |
| **Complete Authorization in FBCS**<br>1. Complete the authorization by entering all appropriate non-VA provider information and appointment information in the authorization | **NVCC** |
| **Create & Send Patient Appointment Letter and Copy of Authorization to the Veteran**<br>1. Use the approved *Non-VA Care Coordination Patient Letter* progress note template to create and send the patient appointment letter to the Veteran<br>2. Send a copy of the authorization to the veteran | **NVCC** |
| **Send Authorization & Appropriate Documentation to Non-VA Provider**<br>1. Send the appointment authorization and any required information to the non-VA provider in advance of the appointment<br>2. Document Release of Clinical Records for Accounting of Disclosure per Local Policy: Follow local policy when releasing any clinical documentation to a non-VA provider | **NVCC** |

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| **Follow up with the Non-VA care provider to request records and to confirm that the appointment took place**<br>1. At approximately two weeks post Appointment date NVCC should<br>2. Check the record to determine if reports/ results have been received by E-Fax or uploaded by other team members. Review the reports to confirm that there is sufficient documentation to close the NVCC consult<br>3. Follow-up with the non-VA provider to obtain required authenticated clinical documentation associated with the Veteran's appointment if not already received<br>4. Document request for records and or patient contact using the consult toolbox<br>5. Encourage outside providers to use the Single E-Fax number<br>6. Use the Single E-FAX number for all reports that come to NVCC<br>7. If the appointment did not occur – contact patient to assist with rescheduling appointments , document telephone contacts using the consult tool | **NVCC** |

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| **Patient Tracking beings (* see APPENDIX 1 MMG Coordinator SOP)**<br>1. Receive and Process mammography reports that arrive via E-Fax from Non-VA Providers, NVCC or DOMA<br>2. Use the Radiology Technologist's Menu to register the report. Each individual radiology exam is assigned a case number in VISTA and the exam is linked to the order by the case number. If no open appropriate order is available, contact a provider and request an order<br>3. Add the case number to the Radiology report<br>4. E-Fax Results are updated with the case number using Adobe desktop. The updated report is placed in a Zip file and sent electronically to Medical Records for scanning into Vista Imaging<br>5. Hardcopy report are annotated by hand with the case number and transported to medical records for scanning into Vista imaging | **Mammogram Coordinators** |
| **Upload of Reports to CPRS**<br>1. Use Local Policy to Scan Documentation into VISTA Imaging & Close Original Consult/Referral<br>2. Medical Records Scans the report into the appropriate system (e.g., FBCS Doc Manager, CPRS/Vista Imaging, etc.) | **Medical Records /HIMS** |
| **Completing the NVCC Consult**<br>1. Attaching the report to the consult completes the NVCC consult<br>2. If the report is attached to the Radiology order the NVCC must complete the associated Non-VA Consult/Referral in CPRS using the NON-VA CARE CONSULT RESULT note<br>3. Document records received using the consult toolbox | **NVCC** |

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| **Complete the radiology order by entering the BIRAD score**<br>1. Close imaging order – using Outside report entry<br>2. Enter case number<br>3. Transcribe the BIRAD score into the Primary Diagnosis section in the radiology Menu* See Job Aide for entering outside mammograms | **Mammogram Coordinators** |
| **Ordering Provider / PCP Notification**<br>1. Verify imaging results scanned into VISTA imaging<br>2. Transcribe a mammogram results note including documented next step of care based on BIRAD score<br>3. Request signature acknowledgement from ordering MD & PCP | **Mammogram Coordinators** |
| **Review the Report, notify the patient of the results and explain next step of care to the patient**<br><br>The PCP/ Ordering provider should use the Clinical Reminder Mammogram note template to document the report, next step of care and method of patient notification | **Providers** |

# Appendix D: Mammogram Coordinator Results Processing SOP[72]

- **Results received via E-fax**
    a. Open document
        i. Identify date of image
        ii. Identify Imaging modality (may be multiple)
- **Breast Exam Registration and Vista Imaging Uploading**
    a. Select **Radiology Technologist Menu Option: Register Patient for Exams**
    b. Select patient
    c. Select order matching imaging modality
        i. Verify that a closed case does not exist with the same date/modality to avoid duplication
        ii. If there is NO pending order
            1. Request order from mid-level/PCP or
            2. Add procedure to existing registered exam only If multiple procedures performed on same day, i.e., ultrasound
        iii. If the order does not match imaging modality
            - Change order to imaging modality associated with results received as a Radiology Service Correction, i.e. unilateral vs. bilateral
    d. Enter the date and time of exam (found on report)
    e. Press enter until Select Patient option returns
        i. Pregnant? (on those females less than 50)
            1. Always respond "NO" otherwise will not complete registration process.
    f. Record Case Number

[72] In October 2017, the Facility provided OIG with a newly created standard operating procedure outlining the roles of NVCC and Call Center staff and mammography coordinators regarding scheduling mammography appointments and obtaining results.

i. See attachment for all steps involved in "Registering Patient for Exam-Radiology Package" attachment _X_

g. Edit the mammogram result PDF using Adobe Acrobat XL Pro

h. Add first letter of last name, last 4 SSN (VAID) and case number, i.e. S 1234 C# 1234

i. Make copy of PDF for multiple case numbers if needed

i. Save document as PDF

j. Save PDF to dedicated folder

k. Convert folder to zip folder

l. Email zip folder to dedicated Medical Records personnel to upload document to VISTA Imaging.

- **Physician Notification - CPRS**
  a. Verify imaging results scanned into VISTA imaging
  b. Transcribe results note using date of service with "Mammogram Test Results" template
  c. Request signature acknowledgement from ordering MD & PCP
- **Close/Complete Imaging Order – VISTA**
  a. Select **Radiology Technologist Menu Option: Outside Report Entry/Edit**
  b. Enter Case Number
  c. Select 'Standard' Report to Copy: 24 Mammography Canned Text Report
  d. Answer "Yes" to "Are you sure you want the 'Mammography Canned Text Report' standard report? No//"
  e. Transcribe **PRIMARY DIAGNOSTIC CODE/BI-RADS CATEGORY** per interpreted report done outside this Facility.
     i. See attachment for all steps involved in completing the order with BI-RADS Category "Entering BI-RADS Category – Radiology Package (VISTA)" attachment _X_
- **Status Tracking of Exams (Weekly)**
  a. Review incomplete case numbers ("Incomplete Exam Report" and "Status Tracking")
  b. Problem solve registration for appropriate closure of case number/order

- **Abnormal Imaging Tracking**
    a. Use **Breast Health Navigator**
        i. Review all "Need Review" exams
            - Assign a follow-up date to abnormal imaging - BI-RADS 0,3,4,5,6 to verify services received
        ii. Review "Follow-up" list
            - See **Mammogram Tracking Process** attachment _X_
        iii. Document an "**Abnormal Mammogram Tracking Note**" in CPRS alerting ordering provider/PCP of pertinent information relating to the pending completion of diagnostic follow-up imaging.
- **6 Month Follow-up Review (Monthly)**
    a. Access National Breast Care Registry (BCR)
        i. Download BI-RADS
            - CVS format
        ii. Filter BI-RADS 3
        iii. Identify the 6 month interval for the following month
        iv. Evaluate readiness for successful imaging completion
            - Confirm order for recommended imaging
                - If no order, place note prompting PCP to review recommendation and place order if clinically indicated.
            - Confirm active Non-VA Care consult
                - If not, alert PCP if consult needed and/or NVCC RN for assistance with scheduling
    b. Update local **Breast Health Navigator** tracking tool
        i. Set follow-up date for the last week of the month to verify if veteran has been scheduled for the short-term follow-up

**Call Center Scripts**

**1) Call Center Script for Mammogram Reports or Provider Calls**

Hello

My name is ---------- This is the Atlanta VAMC Call Center, If this is about a mammogram result please Fax the report to the following Secure Fax mail box 404-639-9329.

Please ensure that the patient's Full Name and Date of Birth is listed on the Report.

I am happy to document any additional message and forward it to the patient's PC provider.

At the Atlanta VA all outside Mammogram results must be faxed to 404-639-9329.

**2) Call Center Script for contacting patient regarding OPT-In to CHOICE Health Net**

My name is _____and I am calling because your VA provider requested you receive a (mammogram).

Currently, VA is unable to provide this service for you at a VA medical Facility. As a result, you are now eligible for the Patient Centered Community Care Program. This program allows you an option to receive the care you need in the community. We would like to refer you to the Patient Centered Care Program through our community health care partner, Healthnet, who will assist you in scheduling this care. I will forward your information to Healthnet and they will reach out to you to schedule your appointment. Healthnet will contact you within the next few business days to schedule this appointment. If you would like to reach out to them in advance of this timeframe, you may contact them at 800-979-9620.

# Appendix E: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 10, 2018.

From: Director, VA Southeast Network (10N7)

Subj: Healthcare Inspection—Delays and Deficiencies in Obtaining and Documenting Mammography Services, Atlanta VA Health Care System, Decatur, Georgia.

To: Director, Washington DC Office of Healthcare Inspections (54DC)
Director, Management Review Service (VHA 10E1D MRS Action)

1. I have had the opportunity to review the Healthcare Inspection—*Delays and Deficiencies in Obtaining and Documenting Mammography Services*, Atlanta VA Health Care System, Decatur, Georgia.
2. Atlanta VA Healthcare system submits the attached draft report concurring with recommendations 1–7. I concur with the *Delays and Deficiencies in Obtaining and Documenting Mammography Services, Atlanta VA Health Care System*, Decatur, Georgia.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer at (678) 924-5700.

*(Original signed by:)*

Leslie Wiggins

# Appendix F: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 9, 2018

From: Director, Atlanta VA Health Care System (508/00)

Subj: Healthcare Inspection—*Delays and Deficiencies in Obtaining and Documenting Mammography Services, Atlanta VA Health Care System, Decatur,* Georgia

To: Director, VA Southeast Network (10N7)

1. I have reviewed and concur with the draft report of the OIG Healthcare Inspection—*Delays and Deficiencies in Obtaining and Documenting Mammography Services*, Atlanta VA Health Care System, which was conducted May 8, 2017, through May 12, 2017.
2. Thank you for the opportunity to review our processes to ensure we continue to provide excellent care to our women Veterans. Corrective action plans have been developed and target dates established as detailed in attached report.

*(Original signed by:)*

Annette P. Walker
Director, Atlanta VA Health Care System

# Comments to OIG's Report

## Recommendation 1

The Atlanta VA Health Care System Director ensures that a review is conducted of patients with mammography orders in an active, pending, or scheduled status as of October 28, 2015, to ensure that clinical care was provided and results are documented in the electronic health record.

Concur.

Target date for completion: September 30, 2018

### Director Comments

Appropriate clinical care has been validated and results documented in the electronic record for 1312 of the 1352 (97%) total patients with mammography orders that were in an active, pending, or scheduled status as of October 28, 2015. On May 11, 2017, the Chief of Staff certified implementation of the nationally mandated Standardized Episode of Care (SEOC) to the Deputy Under Secretary for Health Operation and Management (DUSHOM), which is a comprehensive pre-authorization for non-VA providers to render clinically indicated care as appropriate to avoid potential delays in care. As of June 13, 2018, there have been no adverse outcomes identified. The remaining 40 (3%) Veterans have been contacted and scheduled to complete follow-up mammograms or procedures by September 30, 2018. These patients are being tracked to resolution per a spreadsheet.

## Recommendation 2

The Atlanta VA Health Care System Director makes certain that Medical Center Memorandum 11-04, *Health Care for Women Veterans*, May 17, 2016, is updated to reflect current Facility processes, including but not limited to mammography coordinator responsibilities.

Concur.

Target date for completion: September 30, 2018

### Director Comments

Medical Center Memorandum 11-04, *Health Care for Women Veterans*, has been updated to reflect current Facility processes in accordance with the Atlanta *VACC Mammogram Consult Management* Standard Operating Procedure (SOP) to include the responsibilities of the mammography coordinators, and is being routed for approval. Applicable staff have been designated, by position, to complete the related Talent Management System (TMS) training module on the newly revised policy by September 30, 2018.

## Recommendation 3

The Atlanta VA Health Care System Director ensures compliance with VHA Directive 1232(1), *Consult Processes and Procedures*, (amended September 23, 2016), including the completion of mammograms by the order date or the date the physician requested the study be completed and that a process is established for review when consults exceed established timeliness thresholds.

Concur.

Target date for completion: September 30, 2018

### Director Comments

The Atlanta VA Community Care (VACC) Mammogram Consult Management Standard Operating Procedure (SOP) was implemented effective January 31, 2018, and delineates the process for mammogram completion as requested by the provider based on his/her clinically indicated date, not the order date. The current SOP was recently revised to include the review process for consults that exceed the established timeliness thresholds. The Atlanta VACC managers utilize a centralized VA Community Care Consult Report to actively manage consults and implement real time corrective action for those nearing the established 30-day timeliness thresholds.

The Atlanta Office of VA Community Care (VACC) utilizes a report detailing the daily status of community care mammography consults that is obtained from data available from VHA Support Service Center (VSSC). This report demonstrates the daily movement of community care mammogram consults in pending, active, scheduled, complete, discontinued and cancelled status. This report was created by the VACC program analysts and is presented by VACC management to the Director during morning report meeting where the status of low risk screening mammograms and high-risk diagnostic mammograms is presented. Color coding indicates progress of the consults from pending to complete and guides adjustments in work necessary to meet timeline goals. For consults that have exceeded timeliness thresholds, a clinical review is conducted to determine the status of the consult, the clinical impact of the exceeded threshold, and recommendations to VACC regarding the next steps in care.

## Recommendation 4

The Atlanta VA Health Care System Director improves mammography processes to schedule appointments and receive, account for, scan, upload, and provide external diagnostic imaging results to the appropriate clinical areas and Veterans Health Administration providers and that the process is monitored.

Concur.

Target date for completion: September 30, 2018

### Director Comments

All mammography services for Veterans of the Atlanta VA Health Care System are currently performed by non-VA providers. Atlanta VA Community Care (VACC) implemented the *VA Community Care (VACC) Mammogram Consult Management* Standard Operating Procedure (SOP) as of June 13, 2018. The SOP outlines the process to schedule appointments and receive, account for, scan, and provide diagnostic imaging exam results to the appropriate clinical areas and VHA providers. As of November 22, 2017, the Facility is compliant with the nationally mandated use of the "One Consult Toolbox" in the Computerized Patient Record System (CPRS) which allows monitoring of each step of the mammography consult process via the Corporate Data Warehouse. In December 2017, the Atlanta VACC section was realigned under the Health Care System Director.

Since the realignment, the mammography team has been retrained on the new processes, and audits have been incorporated. A new mammography scheduling training guide was also implemented. The VACC mammography team and supervisory staff completed 40 hours of training on the new processes in June-July 2018. Monitoring of the mammography process is scheduled to report to the Executive Leadership Council for tracking, trending, and discussion of action plan follow-up with documentation in the committee minutes.

## Recommendation 5

The Atlanta VA Health Care System Director confirms that clinical appropriateness reviews of mammography consults are performed to ensure that the correct imaging study is ordered for the patient's clinical presentation and that performance of reviews is monitored.

Concur.

Target date for completion: September 30, 2018

### Director Comments

In accordance with the *VA Community Care (VACC) Mammography Consult Management* Standard Operating Procedure (SOP) implemented January 31, 2018, the Atlanta VA Community Care (VACC) clinical reviewer confirms the clinical appropriateness of mammography consults and monitors performance of the reviews to ensure that the correct imaging study is ordered by each provider for the patient's clinical presentation.

The Atlanta VA Health Care System has implemented two (2) review levels for verification of appropriateness of mammogram consults. A first level review is completed daily by a Licensed Independent Practitioner (LIP) (physician, nurse practitioner, or physician assistant) during regular business hours at their work sites or terminals following VA guidelines for breast cancer screening as well as Inter-Qual criteria. LIPs are trained on VA Guidelines provided by the VHA National Center for Health Promotion and Disease Prevention (NCP) via intranet, well as

Inter-Qual criteria through interactive dynamic processes using the licensed Inter-Qual website portal from McKesson. A second level review is completed quarterly by a VA physician, the Chief of VACC Clinical Care Unit (or designee) using a random sampling for inter-rater reliability; the Chief of VACC Clinical Care Unit possesses applicable up-to-date credentials. The second level inter-rater reliability results are presented to the Women Veterans Program Committee quarterly which then reports to the Executive Committee of the Medical Staff (ECMS).

## Recommendation 6

The Atlanta VA Health Care System Director verifies that providers who are trained in provision of women veterans health care are designated as Women's Health Primary Care Providers, have the required number of women assigned to their panel, and provide gender-specific healthcare in accordance with Veterans Health Administration policy

Concur.

Target date for completion: December 31, 2018

### Director Comments

Based upon the criteria for designation as a Women's Health Primary Care Provider (WH-PCP) per VHA Handbook 1330.01 (1), *Health Care Services for Women Veterans*, dated February 15, 2017, amended September 8, 2017, the Atlanta VA Health Care System currently has 21 designated WH-PCPs, with 15 (71%) who have at least 100 Women Veterans assigned to their respective panels.

An onsite Women's Health Mini-Residency (WHMR) for primary care providers was conducted in May 2018 with additional mini-residency training sessions scheduled for July 2018 and September 2018. After completion of the May 2018 WHMR, the Atlanta VA Health Care System had 5394 Women Veterans who were assigned to 21 designated WH-PCPs. After completion of the next two training sessions, 28 additional primary care providers will have completed the training requirements to be designated as WH-PCPs to help meet the national FY2018 goal of 85 percent of enrolled women Veterans assigned in accordance with VHA Handbook 1101.01 *Patient Aligned Care Team (PACT) Handbook.*

The Women Veterans Program Manager (WVPM) monitors the number of trained WH-PCPs and reports this information through the Women Veterans Health Committee to the Executive Committee of the Medical Staff (ECMS). The Primary Care Management Module (PCMM) Coordinators who are responsible for assigning Veterans to PCPs ensure that newly enrolled Women Veterans are offered assignment to a designated WH-PCP.

## Recommendation 7

The Atlanta VA Health Care System Director provides executive level oversight of the Women Veterans Program to ensure that service level functions are coordinated, processes are streamlined, and identified actions are tracked to resolution.

Concur.

Target date for completion: October 31, 2018

### Director Comments

The Women Veterans Program and the Women's Health Program Manager were realigned under the Chief of Staff on June 27, 2017. A new Clinical Director of Women's Health was also designated effective March 4, 2018, with reporting to the Chief of Staff. The Atlanta VA Health Care System Director provides executive-level oversight of the Women Veterans Program through the Executive Committee of the Medical Staff (ECMS), chaired by the Chief of Staff. The Women Veterans Program Committee minutes are reviewed by the ECMS Committee monthly to ensure service-level functions are coordinated, processes are streamlined, and identified actions are tracked to resolution.

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# OIG Contact and Staff Acknowledgments

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