Department of Veterans Affairs

Office of Inspector General

Evaluation of Medical Care Cost Recovery Program VA Medical Center Brockton/West Roxbury, MA

Report No.: 8R1-G01-008
Date: October 3, 1997

Office of Inspector General
Washington DC 20420

Department of Veterans Affairs

Memorandum

Date: October 3, 1997

From: Director, Bedford Audit Operations Division (52BN)

Subj: Report: Evaluation of Medical Care Cost Recovery Program, VA Medical Center Brockton/West Roxbury, MA (Report No. 8R1-G01-008)

To: Director VA Medical Center Brockton/West Roxbury, MA (525/00)

1. SUMMARY

The Office of Inspector General evaluated the Medical Care Cost Recovery (MCCR) program at the Department of Veterans Affairs Medical Center (VAMC) Brockton/West Roxbury, MA, as part of our nationwide audit of MCCR. The purpose of our nationwide audit is to assess the MCCR billing practices and collection results by Veterans Integrated Service Network (VISN) and identify best practices of Veterans Health Administration (VHA) facilities to identify opportunities to enhance revenues.

We evaluated the MCCR program at VAMC Brockton/West Roxbury in an effort to review billing practices and collection results of a successful MCCR operation and identify opportunities to further enhance revenues. During Fiscal Year (FY) 1996 VAMC Brockton/West Roxbury collected totaling $7,975,781, or 187 percent of their minimum goal. During FY 1997, through August 1997, VAMC Brockton collected $5,186,637 or 81 percent of their minimum goal.

To evaluate VAMC Brockton's billing and collection practices, we conducted a statistical sample of 246 of 7,684 hospital discharges that occurred during FY 1996. We found that (1) insurance carriers were billed for 20 (8.1 percent) of the 246 FY 1996 episodes reviewed, and (2) the VAMC had collected $29,017 (10 percent) of the $291,595 total billings for the 20 cases billed. We identified opportunities to enhance MCCR billings and collections through use of collection tools developed by the MCCR Program Office and we have made observations in the following areas of the MCCR program:

- Obtaining Insurance Data
- Billing Inpatient Care
- Managing Accounts Receivable

The evaluation was conducted in accordance with government auditing standards for qualifications, independence, and due professional care; fieldwork standards for planning, supervision, and evidence; and reporting standards for performance audits.

2. OBSERVATIONS

This report provides details of our observations made regarding the MCCR program at your facility. We identified opportunities in the following areas in the MCCR program that the facility can focus on to further enhance revenues:

Obtaining Insurance Data

MCCR staff rely on Medical Administration Service clerical staff to obtain accurate insurance and employment information from veterans during intake interviews when VA form 10-10 Application for Medical Benefits is completed.

A review of 246 veterans' VISTA administrative records showed only 48 (19 percent) had "yes" indicators for insurance coverage. A February 1997 VHA study, "Use of VHA Care by Veterans with Private Health Insurance", concluded that 51 percent of veterans under age 65 who use VHA facilities carry health insurance while 84 percent of veterans aged 65 and over have health insurance. Applying the VHA study results to our population, the number of veterans with insurance coverage should have been 158. Therefore, VAMC staff could have missed identifying 110 veterans with insurance policies, including 62 veterans with Medigap insurance.

We project that the 7,684 FY 1996 cases had 3,436 unidentified insurance policies of which 1,374 were billable. We also project that 775 of those 1,374 billable policies were Medigap policies.

Preregistration is a process developed by the MCCR Program Office and installed in June 1997 that assists the medical center in updating the patient demographics database to include identifying health insurance coverage. Current staffing constraints have prevented implementation of Preregistration. Implementation of Preregistration could identify additional veterans with insurance coverage.

Billing Inpatient Care

We identified six episodes of care totaling $14,080 were unbilled or underbilled. We identified three patients who had billable insurance; however, the insurance carriers were not billed amounts totaling $11,797. We found three inpatient episodes that were billed as outpatient visits and should have been billed as inpatient care resulting in underbilled inpatient care of $2,283.

Based on our sample results, we project that the universe of 7,684 FY 1996 patient discharges contained $440,000 in unbilled or underbilled care for 187 patients. (Based on the FY 1996 collection rate of 49.7 percent FY 1996 collections would have increased $218,680 to $8,194,461 from these episodes).

The MCCR Coordinator stated that the Auto Biller function in the Integrated Billing software program has been used since May 1997 and has been effective in identifying unbilled care. If utilized after initial receipt in May 1996, the Auto Biller could have prevented these unbilled and underbilled episodes of care.

Managing Accounts Receivable

VA Manual MP-4, Part VIII provides that MCCR staff follow up on unpaid reimbursable cases after the release of the initial claim document. A second notice is sent 45 days after issuance of the initial claim and, if no response is received, a third notice is sent 30 days later. At the time the third notice is sent, telephone followup should be made with the third-party payer. The telephone followup should be documented to include at a minimum, the name and telephone number of person contacted, date of contact, and a brief summary of the conversation. If there is no response from the third-party payer within 30 days after the second followup, the case is to be referred to Regional Counsel with a recommendation for suspension, write off, enforced collection or a request for guidance.

We found that in 10 cases with bills totaling $249,796, MCCR staff were not initiating telephone contact at the time the third notice was sent to insurance carriers.

> -A patient was admitted on January 14, 1996, and discharged on February 13, 1996. The insurance carrier was billed on March 22, 1996 for 29 days for a total of $13,282 and follow-up letters were sent on May 6, and June 5, 1996. We found no documentation of MCCR personnel following up with the insurance carrier for approximately one year until June 20, 1997 when MCCR staff contacted the insurance company. Based on discussions with the insurance company MCCR staff now expect to collect $5,954, the amount the insurance company agreed to pay based on their assessment that only 13 days of stay were required.

We also found that in four cases with billings totaling $208,883, when insurance carriers denied or made partial payments, MCCR staff were not reviewing cases to determine potential collectibility or appealing decisions and submitting additional information to carriers for periods exceeding one year.

> -An insurance carrier was billed $12,617 on March 30, 1996. The medical center received partial payment of $403 on May 14, 1996, leaving a remaining balance of $12,214. MCCR staff did not review the case until April 2, 1997, nearly 11 months after partial payment was received. MCCR staff determined additional payments were possible if additional clinical evidence was furnished the insurance carrier. However, as of July 31, 1997, no information or contacts with the insurance carrier had occurred.

In July 1997, MCCR staff took steps to improve their management of accounts receivable by greater use of software developed by the MCCR Program Office. Collection clerks have increased their use of claims tracking menus. This software tracks admissions, contacts with insurance carriers, and appeals developed from denial of claims. The MCCR Coordinator began using the Insurance Trend Report on a bi-weekly basis to monitor and assess the status of accounts receivable.

Reassignment of UR Nurses and Utilization of Collection Tools Has Increased Revenues

VAMC Brockton/West Roxbury's FY 1997 collections through June totaled $3,951,129 or an average of $439,014 per month. Recent management actions to reassign utilization review nurses to the MCCR Program and utilization of Program Office collection tools have positively impacted FY 1997 collections. Collections in July increased to $487,957, while collections in August increased significantly to $747,551. FY 1997 collections through August totaled $5,186,637 or 81 percent of their minimum goal.

3. CONCLUSION

By focusing on the opportunities in the areas of obtaining insurance data, billing care, and managing accounts receivable and by using MCCR Program Office tools, the VAMC Brockton/West Roxbury can further enhance MCCR revenues.

4. COMMENTS

The results of our review were discussed with you and your staff. Since we are not making any formal recommendations, you are not required to comment on this memorandum. However, we would appreciate receiving any comments you desire to make. If we can assist you further, please contact me at 781-687-3132.

For The Assistant Inspector General For Auditing

(Original Signed By:)
THOMAS L. CARGILL, JR.
Director, Bedford Audit Operations Division

FINAL REPORT DISTRIBUTION

VA Distribution

Under Secretary for Health (105E)

Director, Medical Care Cost Recovery Program (174)

Director, Veterans Integrated System Network (10N1)

Director, VAMC Brockton/West Roxbury (525)

Director, Office of Management Controls (004B)