Department of Veterans Affairs

Office of Inspector General

Audit of Fee Basis Claim Payments
Alaska VA Health Care System
and
Regional Office
Anchorage, Alaska

Overall, the fee program was operating satisfactorily. Some improvements related to insurance billings, authorizations, and coding will help avoid overpayments.

Report No. 9900180-53
Date: April 3, 2000

Office of Inspector General
Washington DC 20420

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

Memorandum to the Director, Alaska Department of Veterans Affairs (VA) Health Care System and Regional Office, Anchorage, Alaska

Audit of Fee Basis Claim Payments

1. The Office of Inspector General audited the VA Fiscal Year (FY) 1998 Fee Basis Claim Payments at the Alaska VA Health Care System and Regional Office, Anchorage, Alaska. The purpose of the audit was to determine whether fee payments for outpatient and inpatient medical care were appropriate. Specifically, the audit objectives were to determine whether (i) veterans receiving fee care were eligible for fee care, (ii) amounts paid for fee care were appropriate, and (iii) fee care was the best alternative for providing medical services. Our universe of FY 1998 fee payments at Anchorage totaled $26,434,527.

2. Overall, the fee program at the Alaska VA Health Care System and Regional Office was operating satisfactorily. Veterans who received fee care were eligible. Some payment errors occurred due to authorization, coding, and pricing issues; however, these were not material when compared to the size and complexity of the fee program at Anchorage. Alternatives to fee care had been implemented to help reduce costs.

3. We identified areas in need of improvement regarding insurance billings, authorizations, coding, and payments for fee care. Based on our sample results, we estimated that a total of $476,330 in Fiscal Year 1998 payments was not properly documented or could have been avoided.

4. We previously discussed these areas with you and your staff and you agreed with the findings and agreed to take corrective action. We believe that improvements made by your fee program staff, the planned changeover to the Medicare rate structure, and the corrective action and training planned in response to our findings will help ensure future payments are accurate and properly documented. As a result, we are not making any

formal recommendations. However, we may follow up on the implementation of planned actions during future reviews. We appreciate the assistance of you and your staff.

For the Assistant Inspector General for Auditing,

(Original signed by:)

WILLIAM H. WITHROW
Director, Kansas City Audit Operations Division

Enclosure

cc: Director, Health Administration Service (10C3)
Director, Veterans Integrated Service Network (10N20)
Director, Management Review and Administration Service (105E)

Enclosure

OBSERVATIONS

Eligibility

Our review of 100 fee payments found that the veterans involved were all eligible for fee care. In five cases, the veterans had insurance coverage, but the insurance companies were not billed. According to VA staff, this occurred primarily because the insurance coverage was not identified until after the episode of care. In our view, once insurance coverage is identified, billings should be sent at that time. The Director agreed to review the five cases and bill as appropriate.

Fee Payments

To review fee care payments, we selected two samples of 50 payments each. One sample was for inpatient fee care (I/P), and the other sample combined outpatient and ancillary fee care (O/P). The review of these samples consisted of analyses to answer the following questions:

- Was data in the Central Fee Database (Database) supported by source documents?
- Were authorizing and payment duties properly separated?
- Were authorizations for fee care proper?
- Did medical documentation support the care coded?
- Was the payment amount proper?

Data Validation

In verifying the Database information to source documents (invoices) for our sample episodes of care, we found several minor discrepancies. However, none of these discrepancies had any affect on the fee payments that were made.

Separation of Duties

We found that duties were properly segregated. Our review of the sample episodes of care found that the authorizing official was different than the payment official in all cases.

Authorizations

In three of the sample cases we reviewed, the episode of care was not authorized or the authorization was not appropriate as discussed below. As a result, $72 of the sample fee

care dollars reviewed was paid improperly. If this error rate continued throughout the universe, we estimate that $276,721 of the Fiscal Year (FY) 1998 payments was not authorized or the authorization was not appropriate. Additionally, costs totaling at least $4,795 that were outside of our sample were also paid improperly.

- In one case, the veteran received a chest x-ray as an outpatient. We paid for this x-ray even though there was no authorization on file. The Nurse Manager for Coordinated Care reviewed this case and agreed that there was no authorization on file and the payment of $21 should not have been made.
- In another case, the veteran was authorized 26 mental health visits for a 1-year period. The visit in our sample was his 110th visit during this period, and, thus, the $30 payment for this visit was not authorized. We also found that this veteran made at least 177 other visits during this period, so the costs related to those visits (at least $4,795) were also not authorized.
- In the third case, the Nurse Manager for Coordinated Care agreed that the veteran received fee basis lab work that could have been provided at the Anchorage outpatient clinic. Thus, the $21 payment for this care was not appropriate.

Nonemergent outpatient care should be properly authorized in advance and should only include services that cannot feasibly be provided by the VA outpatient clinic in Anchorage. Also, the case of the veteran with the multiple mental health visits should be reviewed to assess the appropriateness and effectiveness of the treatment being provided. The Director stated that a complete review of these cases will be performed and overpayments will be pursued.

Coding

In 25 (16 I/P, 8 O/P, 1 Ancillary) of the sample cases reviewed, there was no evidence that the fee care paid for was provided. No Discharge Summary or any other medical documentation of the care provided was available in the facility's computerized medical records (MIMs) or in the veterans' hardcopy medical records. As a result, $91,068 of fee care was paid without proper documentation. After we brought this to facility staff's attention, they contacted the relevant providers and obtained documentation for 7 of the 16 I/P cases.

According to Coordinated Care management, they have emphasized the need for this documentation, and they currently require the vendors to include documentation of the medical care provided with their billing invoices. Since this change had already been made, we did not make a recommendation in this area.

Two other coding issues were noted.

- Related to one of our inpatient sample cases, the veteran had two home visits on the date of admission. According to the Nurse Manager for Coordinated Care, two home visits on the same day are possible and happen frequently. However, we found that the same provider made both of these visits and both were coded as a home visit for a new patient (Common Procedure Terminology (CPT) Code 99341). We further learned that this provider was paid for 31 visits for this same CPT Code for this veteran. The Nurse Manager for Coordinated Care agreed that only the first visit should be coded as a new patient and all subsequent visits should be coded as an established patient. Based on Anchorage's Fee Schedule, the provider was overpaid $2,983 for these visits. Reimbursement for these payments should be sought from the vendor. The Director agreed with the findings and will pursue overpayments.
- Two of the most frequently used codes are no longer valid codes. FY 1998 payments for CPT Codes 99353 and 99352 totaled $675,000. According to the 1998 CPT Code Book, CPT Codes 99353 and 99352 have been deleted and should be replaced by CPT Codes 99349 and 99348 respectively. The usefulness of the Fee Schedule control is compromised if current codes are not used. Also, comparisons with other facilities are not meaningful if different facilities use different codes for the same care. Coding clerks should stay current with and use the latest approved codes. The Director stated that the clerks are now taking classes that will assist with identifying coding errors on invoices. Also, new support materials, i.e. CPT 2000 books, have been obtained and are being used.

Pricing/Payments

In our review of the sample and related cases we identified six issues which resulted in overpayments to the vendor. The six pricing/payment issues are discussed in the following paragraphs.

The amount paid for outpatient services exceeded the Fee Schedule in four of the sample cases reviewed. The overpayment in these 4 cases totaled $25. If this error rate continued throughout the universe, we estimate that $90,024 of FY 1998 payments exceeded the fee schedule. Fee clerks should limit payments to VA's fee schedule.

In one inpatient case sampled, there was a related ancillary payment. The veteran was admitted on April 10, 1998 and discharged on April 24, 1998 with a primary diagnosis of salmonella gastroenteritis. VA made payment for Diagnostic Related Group (DRG) 182 (Esophagitis, gastroenteritis, and miscellaneous digestive disorders, age 18 or older, with Complications and Comorbidities (CC)) for this admission. However, VA also paid $350 for a cystourethroscopy (CPT Code 52000) performed on April 15, 1998. This should

have been included with the DRG payment. Reimbursement for this payment should be sought from the vendor. The Director agreed to review the overpayment and pursue appropriate reimbursement.

In another inpatient case, there were several related outpatient payments. The veteran was admitted on September 17, 1999 and discharged on September 23, 1999. VA paid the community hospital $5,942 for DRG 223 (Major shoulder/elbow procedures, or other upper extremity procedures with CC) for this admission. However, VA also paid for the following three office visits, eight medical and surgical supply charges, and a pathology procedure that occurred during this admission. Several questions/issues were raised by these payments.

- All three office visits were to the community hospital on the day of discharge. Why were there three visits in one day? Why is a hospital receiving payments for office visits on the day of discharge?
- All three office visits were coded as a new patient. Why were they not coded as an established patient?
- Why were there eight charges for medical and surgical supplies on the day of discharge? Weren't these included in the DRG payment?
- Wasn't the pathology procedure included in the DRG payment?

The Director agreed to review this case and seek appropriate reimbursement from the vendor.

In another case (this was not a sample case, but was related to one of the sample cases), VA overpaid the vendor. The admission was for psychiatric treatment, and VA was billed $13,640. According to VA policy, 72 percent of this amount should have been paid. However, VA only paid 50 percent ($6,820). The vendor subsequently requested the other 22 percent ($3,001). However, instead of paying this amount, VA staff mistakenly paid 72 percent of the amount billed ($9,821). Thus, the vendor was overpaid by $6,820 ($9,821 - $3,001). The Director agreed to review the overpayment and pursue appropriate reimbursement.

In another case, VA overpaid the vendor. The veteran received a MRI (CPT Code 70553) on December 15, 1997. On February 2, 1998, VA received a bill with a charge of $1,078 and paid $472. On April 14, 1998, VA received a second bill for the MRI. This billing indicated that $722 more was needed per the contract agreement, and VA paid this additional amount. However, these two payments total $1,194 and exceed the original amount charged ($1,078) by $116. Also, the two payments total more than the fee schedule amount of $1,132. The Director agreed to review the overpayment and pursue appropriate reimbursement.

One veteran had two admissions in which VA paid the DRG Pricer amount even though the private hospital did not provide all of the care needed. For the first admission, the veteran had a 4-day stay at a private hospital with a primary diagnosis of unspecified hypertensive renal disease with renal failure. The private hospital billed VA $3,770 for this admission. VA paid $9,521 for a DRG of 316. However, according to the medical records, the patient left the private hospital three times during this admission to receive hemodialysis treatment at home. This occurred because the hospital did not have the necessary equipment. The same scenario occurred on the second admission. The private hospital billed VA $3,078 for the admission and VA paid $5,575 for a DRG of 182. In our view, since the private hospital did not provide complete care in either admission, it is not entitled to the complete DRG payments. We believe that VA should have paid the amount billed or the DRG Pricer amount, whichever was less for both admissions and should now seek reimbursement from the vendor for the overpayments. The Director agreed to review the overpayment and pursue appropriate reimbursement.

Alternatives to Fee Care

Facility management had taken several initiatives to reduce fee costs. They had established contracts with several providers in the Anchorage area, giving VA discounts off the DRG and CPT rates. They also established emergency care at Elmendorf Air Force Base. Fee costs for emergency care had already started to decline at the time of our audit. As more veterans are informed of this arrangement, fee costs should decline even more.

Summary of Cost Efficiencies

Based on the sample cases, in which we identified erroneous authorizations, coding, and pricing/payments, we estimated that FY 1998 payments totaling $476,330 were not properly documented or could have been avoided. Facility management agreed with the findings and agreed to take corrective action, so we are not making any formal recommendations. We believe that improvements made by the fee program staff, the planned changeover to the Medicare rate structure, and the corrective action and training planned in response to our findings will help ensure future payments are accurate and properly documented.