Department of Veterans Affairs

Office of Inspector General

Audit of Fee Basis Claim Payments Department of Veterans Affairs Medical Center Long Beach, California

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

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Office of Inspector General
Washington DC 20420

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

Memorandum to the Director, Department of Veterans Affairs (VA) Medical Center, Long Beach, California

Audit of Fee Basis Claim Payments

1. The Office of Inspector General audited VA Fee Basis Claim Payments for Fiscal Year (FY) 1998 at VA Medical Center (VAMC) Long Beach, California. We performed the audit as part of a national audit of Fee Basis Claim Payments. The purpose of the audit was to determine whether fee payments made 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. We also evaluated whether third party billings were made when appropriate. Our universe of FY 1998 fee payments at VAMC Long Beach totaled $2,091,269.

2. Overall, the fee program at VAMC Long Beach was operating satisfactorily. Veterans who received fee care were eligible. While some payment errors occurred due to pricing issues; these errors were not material when compared to the size of the fee program. Alternatives to fee care had been and continue to be explored to help reduce costs.

3. We identified areas in need of improvement regarding third party billings, authorizations, coding, and pricing for fee care. Based on our sample results, we estimated that FY 1998 billing and payment efficiencies totaling $153,931 could have been achieved.

4. We previously discussed these areas with you and your staff, and you agreed with the findings and agreed to take corrective action. 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 (10N22)
Director, Management Review and Administration Service (105E)

Enclosure

OBSERVATIONS

Eligibility

Our review found that the veterans involved in 49 sample cases (24 inpatient and 25 outpatient) were administratively eligible (honorable discharge).

Billings

In regard to third party billings, we found four cases in which the veteran had insurance coverage and was treated for a nonservice-connected (NSC) condition, but his insurance company was not billed. We also found one Category C veteran (veteran subject to copayment for NSC care) who received fee care, but was not billed for the copayment. These conditions occurred because the Fee Basis staff had no process in place to identify veterans with insurance or Category C veterans. The Business Office management stated that they will bill the insurance companies and the Category C veteran in the cases identified. Also, the Fee Basis clerks will identify fee patients with NSC conditions who have other insurance or are Category C veterans and notify the billing staff. We estimated that the billings for the five cases will total $4,887. If this error rate continued throughout the universe, we estimate that a total of $141,896 should have been billed for Fiscal Year (FY) 1998.

Fee Payments

Our review of the 49 sample cases 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

We reviewed the sample fee payments to validate key fields to the source documents (invoices and Pricer Reports). All data for which VAMC Long Beach staff was responsible for inputting was validated as correct.

Separation of Duties

We reviewed the sample episodes of care and found that the duties of the authorizing and payment officials were properly separated in all cases.

Authorizations

In nine cases we reviewed, the episode of care was not properly authorized. All of these cases involved documentation issues, and there were no apparent inappropriate payments.

- In three cases, the veteran was transferred from VAMC Long Beach to a private hospital for an endoscopic retrograde cholangiopancreatography (ERCP). However, there was no documentation showing that any attempts were made to place the veteran at another VAMC, such as West Los Angeles. According to the Chief of Staff, attempts were made, and there were no beds or staff available at the time. Facility management immediately established procedures to document attempts to place veterans at other VAMCs prior to authorizing fee care and to monitor the success of making placements.
- In six cases, VA staff did not monitor, or adequately monitor, VA patients at non-VA facilities to ensure that they were transferred to VA as soon as possible after becoming stabilized. In May 1998, management had taken action to improve the monitoring of VA inpatients at non-VA facilities. None of our sample cases had admission dates after May 1998; however, based on interviews with the nursing staff, we concluded that monitoring procedures had been established.

Coding

We reviewed the sample payments and related data to validate the coding and identified the following two issues.

- First, in 19 of our sample inpatient (I/P) fee payments, there was no medical documentation to verify that the fee care was provided. The amount paid for these I/P stays was $126,300. According to fee staff, it was common practice to destroy the medical documents once the fee payment had been processed. Hospital and fee management were not aware of this practice and took immediate corrective action when we brought it to their attention.
- Second, Common Procedure Terminology (CPT) coding for home health visits for Spinal Cord Injury veterans was not accurate. Fee staff coded all home health visits using CPT Code 99351. However this is an Evaluation and Management (E&M) Code for physician services. Currently they are using 99343, which is another E&M Code for physician services. We discussed this issue with VA Central Office staff, and they will be issuing guidance on how

to code these cases. Business Office management stated that they will follow the guidance when it is received.

Pricing/Payments

Our review of the pricing for the 49 sample fee invoices found 4 errors (related to 3 admissions) with improper payments totaling $9,628 as described below.

- In three cases, the fee clerk paid the Diagnostic Related Group (DRG) Pricer amount instead of the required per diem rate. In each case, the veteran was treated at a non-VA facility and then transferred to a VA facility to complete his inpatient episode of care. VA policy states that for this type of case, VA will pay a per diem amount or the DRG amount, whichever is less. In all three cases, the per diem amount was less than the DRG amount. The overpayments for these three cases totaled $9,365. Business Office management agreed to seek reimbursements for these overpayments and instruct fee staff on VA policy concerning when to pay the DRG Pricer amount versus a per diem rate.
- In one case, fee staff did not include all of the diagnostic codes when submitting the case to the Austin Automation Center for a DRG Pricer Report. When the clerk submitted the claim, she entered four diagnostic codes, and the resulting Pricer amount was $4,319. However, the invoice listed five diagnostic codes. When all five codes are used, the Pricer amount is $4,056. Thus, VA overpaid the vendor by $263. Business Office management agreed to seek reimbursement from the vendor. Since this was an isolated oversight, we did not make any recommendations concerning the payment process.

If this error rate continued throughout the universe, we estimate that FY 1998 payments totaling $12,035 were not proper.

Alternatives to Fee Care

Our analysis of the FY 1998 fee costs shows that the majority of the fee costs (81 percent) was for home health visits. A Fee Basis Committee has been reviewing the process for authorizing these visits. There have been changes made in an effort to reduce costs, such as reducing the allotted time for certain activities or eliminating certain activities altogether. We did not identify additional opportunities.

Summary of Cost Efficiencies

Based on the sample cases, in which we identified third party billing needs and erroneous payments, we estimated that FY 1998 billing and payment efficiencies totaling $153,931 could have been achieved. The Director agreed with the findings and agreed to take corrective action, so we are not making any formal recommendations.