Department of Veterans Affairs

Office of Inspector General

Audit of Fee Basis Claim Payments
South Texas Veterans Health Care System
Audie L. Murphy Division
San Antonio, Texas

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

Report No. 99-00180-91
Date: June 28, 2000

Office of Inspector General
Washington DC 20420

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

Memorandum to the Director, South Texas Veterans Health Care System
Audie L. Murphy Division, San Antonio, Texas

Audit of Fee Basis Claim Payments

1. The Office of Inspector General audited the Department of Veterans Affairs (VA) Fiscal Year (FY) 1998 Fee Basis Claim Payments at the South Texas Veterans Health Care System, Audie L. Murphy Division, San Antonio, Texas. We performed the audit as part of a national audit of Fee Basis Claim Payments. The Fee Basis program enables eligible veterans to obtain health care at VA expense from non-VA providers. 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. We also evaluated whether third party billings were made when appropriate. Our universe of FY 1998 fee payments at the Audie L. Murphy Division totaled $5,053,741.

2. Overall, the fee program at the Audie L. Murphy Division was operating satisfactorily. Veterans who received fee care were eligible. Fee basis program management was very knowledgeable about federal, state, and local laws that were relative to fee basis claims and had streamlined workload processes and controls. Some payment errors occurred due to authorization and pricing issues; however, these were not material when compared to the size of the fee program. Alternatives to fee care had been considered for high-cost/high-use services.

3. We identified areas in need of improvement regarding veterans placed in state centers under warrant (a legal process for family members or friends to commit potentially dangerous psychiatric patients for evaluation and care), appropriateness of admissions and length of stay, and coding of fee care. Based on our sample results, we estimated that a total of $73,542 in FY 1998 payments 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. 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 (10N17)
Director, Management Review and Administration Service (105E)

Enclosure

OBSERVATIONS

Eligibility

Our review of 50 fee payments made for care received by veterans determined that all 50 met the administrative eligibility (honorable discharge) criteria. For 38 of the 50 payments, we verified that the administrative eligibility was determined prior to authorizing the claim. For the remaining 12 veterans, we were unable to verify that the administrative eligibility was determined prior to authorizing the claim. However, based on information from staff at the VA Regional Office in Houston, Texas, and other sources, we found that these 12 veterans also met the administrative eligibility criteria.

In regard to third party billings for medical care provided to fee basis veterans, we found that the Audie L. Murphy Division had procedures in place to identify veterans with medical insurance coverage. Through our sample review, we determined that these procedures were working appropriately. The Medical Care Cost Fund Service had recently relocated to the fee basis program area, and monthly meetings were planned to identify potential cost recoveries and enhance the collection processes.

Fee Payments

We reviewed 25 invoices for inpatient (I/P) care and 25 invoices for outpatient (O/P) and ancillary care. The review of these samples consisted of analyses to answer the following questions:

- Was data in the Central Fee 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?
- Were the providers properly licensed?

<u>Data Validation</u>

We reviewed the fee payment source documents (invoices or vendor payment histories and pricer reports) for the sample invoices to validate key fields. We identified one I/P case that did not have all diagnostic codes included in the pricer calculation. However, we initiated a new pricer calculation to include all diagnostic codes and determined that there was no effect. Since there was no effect and this was an isolated incident, we did not make a recommendation regarding this issue.

Separation of Duties

Although the authorization and payment duties were not separated because of staffing limitations, adequate compensating control was present. We found documentation indicating that supervisors reviewed each case prior to processing for payment, and they documented their decisions to approve/disapprove payments for each sample case reviewed. We believe this provided an adequate level of control.

Authorizations

We determined that all of the sample O/P authorizations reviewed were appropriate. However, we found that for three of the I/P cases reviewed, the lengths of stay at the private facilities were excessive, and medical determinations to identify the appropriateness of admissions and lengths of stay should have been accomplished during the monitoring process. VA Policy M-1, Part 1, Chapter 21.10 requires that authorization for payments be limited to the point in time when the veterans can be transferred to VA facilities. A medical determination is to be made to establish when the veteran is stable for transfer. For these cases, a medical determination was not accomplished.

- For two of these cases, we believe that the veterans should have been transferred to a VA facility following the required medical determination. These veterans were remanded to a state psychiatric center under warrant for emergency detention. In these situations, the fee basis program managers believed that they did not have any alternatives to paying the costs associated with these contract hospitalizations and did not attempt to monitor the treatment and obtain a medical determination. We found that psychiatric services were available at the Audie L. Murphy Division, and it would have been a viable alternative to the state centers, according to the Chief of Staff. As a result, we determined that payments of $4,525 could have been avoided for these two cases. The Fee Basis Section Chief agreed that closer monitoring of the State commitments should have been accomplished. Following our review, procedures were revised to include coordination among Fee Basis and Psychiatry services to determine when veterans are deemed stable for transfer based on their medical condition.

- For the third case, we determined that a medical review was accomplished to determine that the veteran required emergency treatment. However, we found that a decision as to when the veteran was stable for transfer was not accomplished. According to the Chief of Staff, the medical records indicate that this veteran was stable for transfer to the Audie L. Murphy Division at least 1 day prior to the actual discharge. As a result, we determined that payment of $5,467 could have been avoided.

  We found that the non-VA facility providing this veteran's care was 1.5 miles from the VA facility. Because of this, the Fee Basis Section Chief agreed that additional questions need to be answered when determining the medical appropriateness of a fee basis admission. These questions should include:

  - Is this a medical emergency?
  - Is a VA facility available?
  - When is the veteran stable enough for transfer to a VA facility to complete treatment?

  In addition, the Fee Basis Section Chief agreed that, in the event of differences of opinion between fee basis and medical staff as to whether fee care should be provided, the case will be referred to the Chief of Staff's office for resolution.

Coding

We reviewed the sample payments and related data to validate the coding. We identified two invoices that contained inaccurate home health care Common Procedure Terminology (CPT) codes. However, we determined that the coding did not affect the amounts paid, since the home health care visit costs were prearranged through written agreements. Both invoices contained several entries for multiple days from the same vendor that utilized home health care codes for a *new* patient. The correct codes should have indicated that the home health care was provided for an *established* patient. The Fee Basis Section Chief agreed that the skilled nursing CPT codes for new and established patients would be correctly applied to accurately reflect the care provided. In addition, the facility had requested clarification from VA Central Office program management about which codes should be used for home health aides and family members.

Pricing/Payments

We also reviewed the pricing for the sample invoices. We identified one invoice that contained two payments for the same CPT code on the same treatment day. The two payments, totaling $35.45, were equal to the amount that was billed. However, the Fee

Basis Section Chief stated that VA should have only paid $14.89 in accordance with the established Medicare rates. She did not know why VA paid twice for this particular treatment date. However, she plans to offset any future payment to this vendor in order to collect the $20.56 overpayment and will make her staff aware of the overpayment. Since this appeared to be an isolated error, we did not project the error rate to the entire universe for FY 1998.

Provider Licensing

We were unable to verify whether one provider was licensed during the time that treatment was provided. We requested that staff follow up on this issue, and the Fee Basis Section Chief determined that the physician was properly licensed with the State Optometry Board when the treatment occurred.

Alternatives to Fee Care

We found that VA staff were effectively monitoring fee costs, and facility management had taken several initiatives to reduce fee costs. These included establishing contracts with local providers that allow VA discounts from the Diagnostic Related Group (DRG) and CPT rates and establishing agreements with home health care providers.

Office personnel in the Chief of Staff's office monitor fee costs on an ongoing basis to identify trends and decide on alternatives. At the time of our review, alternatives to providing dialysis treatments to veterans at community treatment centers were being studied. However, no readily identifiable solution was deemed effective at decreasing current costs and providing a viable alternative for a significant number of veterans.

Summary of Cost Efficiencies

The three cases in which we identified erroneous authorizations totaled $9,992 in costs that could have been avoided. If this error rate continued throughout the universe, we estimated that FY 1998 payments totaling $73,542 could have been avoided. Facility management agreed to take corrective action, so we are not making any formal recommendations.