Department of Veterans Affairs

Office of Inspector General

Audit of Fee Basis Claim Payments
VA Medical Center
Little Rock, Arkansas

Overall, the fee program was operating satisfactorily. Some improvements related to separation of duties, 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 Medical Center, Little Rock, Arkansas

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 VA Medical Center (VAMC) Little Rock, Arkansas. 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 VAMC Little Rock totaled $5,537,173.

2. Overall, the fee program at VAMC Little Rock 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 of the fee program. Alternatives to fee care had been implemented to help reduce costs.

3. We identified areas in need of improvement regarding separation of duties, authorizations, coding, and pricing for fee care. Based on our sample results, we estimated that FY 1998 payments totaling $316,016 were 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. 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 (10N16)
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 veterans met the administrative eligibility (honorable discharge) criteria. In regard to third party billings for medical care provided to fee basis veterans, we found that VAMC Little Rock had procedures in place to identify veterans with medical insurance coverage. Through our sample review, we determined that these procedures were working appropriately.

Fee Payments

We reviewed 25 invoices for inpatient care and 25 invoices for outpatient 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?

Data Validation

We reviewed the fee payment source documents (invoices and pricer reports) for the sample invoices to validate key fields. We identified two invoices that contained inaccurate data. For the first invoice, the pricer amount was incorrectly input. For the second invoice, a diagnosis code was incorrectly input. We found that these were only reporting issues, and there was no monetary effect. Since there was no significant effect and the Fee Basis Section Chief agreed to ensure that staff are aware of the importance of verifying data input for accurate reporting, we did not make a recommendation regarding this issue.

Separation of Duties

We found that the authorization and payment duties were properly separated for 2 of 50 invoices. The duties were not properly separated for 4 other invoices; and, for the remaining 44 invoices, we could not determine who authorized the fee care or whether the authorization and payment duties were properly separated. The Fee Basis Section Chief stated that limited staffing resources have not allowed for adequate separation of

duties in the past. However, she agreed that the fee basis procedures would be changed to ensure that the authorization and payment duties would be properly separated.

Authorizations

During FY 1998, facility management had initiated changes to the authorization procedures for patients requiring cardiac surgery services from a private facility. However, the procedures for paying fee card authorized claims and issuing and renewing fee cards needed to be improved.

We found that four sample cardiac surgery referrals totaling $7,441 were not properly authorized. The length of time authorized for the treatments was longer than necessary because the transfer of those patients to the private facilities was not properly coordinated, and the patients were not always monitored following transfer to the private facility. According to the Fee Basis Section Chief, the problems associated with the authorizations for these heart surgery patients occurred because policies and procedures were not established when the medical center's cardiac surgery department was initially eliminated. At this same time, there were several patients in the VA cardiac program who were in urgent need of cardiac surgery. VA clinical staff referred these patients to private facilities for cardiac surgery without coordination with the Fee Basis Service Staff. Therefore, the referrals were not properly authorized in the Fee Basis program. Since the time that these problems were identified, a contract has been established with a private facility for cardiac surgeries, along with implementation of procedures for coordinating and managing the authorization of the fee basis care for these patients.

We also found that the procedures for authorizing the issue and renewal of fee cards needed to be improved. We identified three cases that exceeded the authorized fee card limitation of $125 per month by $67, without the required supporting documentation to justify exceeding the limitation. However, these were only documentation errors, since they would have been approved anyway. The Fee Basis Section Chief agreed to ensure that appropriate supporting documentation is obtained for payments that exceed the monthly fee basis limitation.

In addition, we identified two veterans who were improperly authorized fee cards. In both examples, the veterans were issued fee cards, but had several clinic visits scheduled at the VAMC. Thus, since the veterans had access to the VA facility, the fee card authorizations were not warranted. The Fee Basis Section Chief agreed to review the justification for the issuance of these fee cards and the procedures for authorizing future fee cards.

If these cardiac surgery referral and fee card authorization error rates continued throughout the universe, we estimate that FY 1998 payments totaling $92,038 were not proper.

Coding

We reviewed the sample payments and related data to validate the coding and found that for 12 of the inpatient fee payments, totaling $201,421, there was no medical documentation to verify that the fee care was provided. Most of these cases involved patients who were referred for cardiac care following the closure of the cardiac surgery program. We found that the medical documentation was contained in the medical records, but Fee Basis Service staff did not review this information prior to paying the invoice. Current procedures now require that the medical documentation be presented prior to processing an invoice for payment. In addition, Fee Basis and Cardiology Service staff now meet daily to discuss the status of the patients referred for cardiac care under contract and projected fee basis costs. Since the procedures have been improved, we did not make a recommendation regarding this issue.

Pricing/Payments

We reviewed the payment amounts disbursed and found that one invoice was overpaid by $1,825. The fee clerk did not calculate a per diem amount and paid the Diagnostic Related Group (DRG) amount. The veteran was treated at the non-VA facility for 1 day and then transferred to the VAMC to complete his inpatient episode of care. VA policy states that for this type of case, VA will pay a per diem amount. The fee clerk agreed that this payment was in error, and the per diem amount should have been calculated and paid. The Fee Basis Section Chief agreed to request reimbursement from the vendor for the overpayment and instruct fee staff on VA policy concerning when to pay the per diem amount versus the DRG amount. If this error rate continued throughout the universe, we estimate that FY 1998 payments totaling $22,557 were not proper.

We also identified an error that resulted in an underpayment of $6,487. The fee clerk paid the billed amount instead of the required DRG amount. The veteran was treated at the VAMC and then transferred to a non-VA facility for surgery to complete his inpatient episode of care. VA policy states that for this type of case, VA will pay the DRG amount. The Fee Basis Section Chief agreed to reimburse the vendor for the underpayment and instruct fee staff on VA policy concerning when to pay the DRG amount versus the billed amount. Since the fee clerk had obtained the DRG report and inadvertently input the incorrect amount, we did not project this error to the universe.

Alternatives to Fee Care

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 DRG and Common Procedure Terminology rates and establishing community based outpatient clinics throughout the primary service area. We did not identify any additional opportunities for reducing fee basis costs.

Summary of Cost Efficiencies

Based on the sample cases, in which we identified erroneous authorizations, coding, and pricing, we estimated that FY 1998 payments totaling $316,016 ($92,038 + $201,421 + $22,557) were not properly documented or could have been avoided.