



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Review of Allegations of Coding and Billing Irregularities, VA Medical Center, Kansas City, Missouri

To Report Suspected Wrongdoing in VA Programs and Operations

**Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time,
Monday through Friday, excluding Federal holidays**

E-Mail: yaoighotline@va.gov

Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections investigated allegations regarding a pattern of inappropriate medical coding and billing to increase third party insurance reimbursements at the Kansas City VA Medical Center. The allegation included two specific incidents: (1) the Medical Care Collection Fund Billing Department inappropriately added a Current Procedural Terminology “modifier 59” to the billing records for a patient receiving “Epoetin” injections, (2) and the Billing Department inappropriately billed for complications attributable to the patient’s participation in a voluntary research study.

We were unable to substantiate the allegations and make no recommendations.



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

TO: Veterans Integrated Service Network 15 Director

SUBJECT: Healthcare Inspection – Review of Alleged Coding and Billing Irregularities, VAMC, Kansas City, Missouri

Purpose

The Department of Veterans Affairs (VA) Office of Inspector General (OIG), Office of Healthcare Inspections reviewed allegations that the billing department at the Kansas City, Missouri VA Medical Center (KCVAMC) had engaged in a pattern of inappropriate activity to obtain greater reimbursement from private insurance companies. The allegation included two specific incidents: (1) the Medical Care Collection Fund (MCCF) Billing Department inappropriately added a Current Procedural Terminology (CPT) “modifier 59” to the billing records for a patient receiving “Epoetin” injections, (2) and the Billing Department inappropriately billed for complications attributable to the patient’s participation in a voluntary research study.

Background

KCVAMC is one of eight medical centers in Veterans Integrated Service Network (VISN) 15, and provides acute medical surgical, neurological, psychiatric, and rehabilitation medicine for the veterans of the Kansas City area. Specialty services include audiology, cardiac catheterization, sine-angiography, neurosurgery, orthopedic surgery, renal transplants, vascular laboratory services, and specialized low vision care. KCVAMC’s primary service area includes over 200,000 veterans, some 25 percent of whom are over 60. KCVAMC served over 42,000 veterans and had over 426,000 outpatient visits in FY 2008.

Medical Care Collection Fund (MCCF)

The Consolidated Omnibus Budget Reconciliation Act, dated April 7, 1986, Public Law 99-272, authorized the VA to seek reimbursement from third-party health insurers for the cost of medical care furnished to insured non-service connected veterans treated at VA facilities and to create the means test co-payment. The Budget Reconciliation Act of 1990, dated November 5, 1990, Public Law 101-508, established the *Medical Care Cost Recovery (MCCR) revolving fund*, allowing MCCR funds

to be used to supplement medical care facility operational expenses and further established that certain veterans would be charged applicable per diem and co-payments for medical services, hospitalization, nursing home care, and medications. The Veterans Reconciliation Act of 1997, dated August 6, 1997, Public Law 105-33, established MCCF and further extended billing to insurance carriers for non-service connected care for service-connected veterans.

Medical Record Coding

Accuracy in code assignment is essential in health care management. The Veterans Health Administration (VHA) policy ¹ and guidelines ² provide guidance for managing the VHA facility-wide clinical coding program. The International Classification of Diseases, 9th Revision, Clinical Modification (ICD9-CM) Official Coding Guidelines, published by the Cooperating Parties (American Hospital Association, American Health Information Management Association, Centers for Medicare and Medicaid Service, and the National Center for Health Statistics), are followed by all VHA facilities regardless of payment source.

From VHA Policy:

Coding is an art and science requiring specialized skills, training, and education. Industry-established and VHA-specific guidelines and criteria must be followed to ensure accuracy and consistency of code assignment, proper code sequence, and valid data reporting. Coding serves two primary purposes: to create secondary records for the retrieval of diagnosis or procedures, and to create details for reimbursement. Accuracy in code assignment is essential in health care management. Codes are used for a variety of purposes, such as: clinical studies, performance measurement, workload capture, cost determination, Veterans Equitable Resource Allocation (VERA), classifying morbidity and mortality, indexing of hospital records by disease and operations, data storage and retrieval, and reimbursement.

VHA guidelines also require employees performing coding activities, ranging from supervision to code assignment to coding education, must be qualified and preferably credentialed (e.g., Registered Health Information Administrator (RHIA), Registered Health Information Technician (RHIT), Certified Coding Specialist (CCS), Certified Coding Specialist-Physician-based (CCS-P), Certified Professional Coder (CPC), and/or Certified Professional Coder-Hospital (CPC-H)).

All coding must be completed through the national encoder software, QuadraMed. The software provides every coder with web-based copies of all required coding books,

¹ VHA Handbook 1907.03 Health Information Management Clinical Coding Program Procedures, November 2, 2007

² VHA Coding Guidelines Version 9.2 November 2009

including ICD9-CM, CPT, and Healthcare Common Procedure Coding System (HCPCS), as well as a number of references and support tools. Quadramed has an audit function that tracks responsibility for coding changes to the medical record.

Minimum core responsibilities of the coding staff are Inpatient Facility Coding, Inpatient Professional Fees, Surgical Case Coding, and Outpatient Encounters.

CPT Modifiers

A modifier provides the means by which the reporting provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. VHA provides general guidance on how to use the CPT system's 32 different modifiers.

In the case involving the use of *CPT modifier 59*, *VHA guidance* is as follows:

Modifier –59 allows the physician to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier –59 is appropriate for procedures or services that are not normally reported together, but are appropriate under the circumstances. CPT states that modifier –59 may represent a different session or patient encounter, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same date by the same physician.

Insurance companies customarily request copies of supporting documentation from the medical record for the separate and distinct procedure before payment of a claim that includes a modifier 59. This usually will result in higher reimbursements, if approved.

Medical Billing

Medical billing is the process of collecting fees for medical services. A medical bill is called a claim. The purpose of medical billing is to ensure that the provider, VA, receives fair payment for services rendered. Payment should reflect the services performed and should be received in a timely manner.

Each billable encounter is processed through Quadramed. Billers will verify insurance, check coverage limits, and coordinate benefits. Quadramed introduced an automatic billing function called Auto Biller with Integrated Billing (IB) Version 2.0. Once a bill has been set up, the auto biller continues and attempts to gather as much information as is available. For inpatients, diagnosis and procedures are gathered from the PTF record. Procedures are added for outpatient visits. When Auto Biller creates a claim, all coding information that populates the claim is not updated if the encounter's ICD-9, CPT, or

HCPCS codes are edited after the claim is auto-generated. Therefore, staff must always “de-select” these auto-biller selected codes and then “re-select” the appropriate codes when processing an auto-generated claim to ensure the most appropriate codes are being reported on the claim(s).

There are a number of edit checks that the bill goes through before being authorized. Quadramed has a claims scrubbing function that checks the claim against the National Integrated Billing Edits. These edits were established to check common errors. Any instance of overriding these edits checks needs to be properly authorized.

Bundled services represent separate procedures that are normally performed together as part of provider services and are generally considered not separately reportable. The claims scrubber edits function in Quadramed is set to identify bundled/unbundled services. Some services are frequently “bundled” into one CPT code to describe all components of a procedure or service.

Appropriate MCCF Billing staff must have the Quadramed Integrated Billing package, IB AUTHORIZE key assigned to them in order to authorize claims processing. Claims that are not authorized cannot be printed, transmitted, or audited.

CBIO Coding and Billing Oversight

Responsibilities of the Compliance and Business Integrity Officer (CBIO) include evaluating and assessing policies, procedures, systems, and control environments established by the VHA Chief Business Office, the Health Informatics and Data Program, VISNs, and VA medical center business and health information operational units.

Evaluation and assessment include audits, which measure accuracy and quality of business and health information output and management reports, review of policies and procedures against laws, regulations, VA and VHA policy documents, evaluations of organizational responses to detected errors and deficiencies.

The CBIO performs monthly audits on coding and billing accuracy rates, and tracks and reports trending information.

Scope and Methodology

The scope of this investigation was limited to determining whether there was a pattern of activity to inappropriately modify CPT codes in an effort to obtain greater reimbursement from private insurance companies and to investigate the two cases cited in the complaint. A site visit was conducted on October 20–21, 2009, where we interviewed KCVAMC staff including the complainant, billers, coders, medical records technician, accounts receivable technician and the following KCVAMC supervisory or management personnel:

- MCCF Billing Supervisor
- Chief of Health Information Management (HIM)/Coding Supervisor
- Chief of MCCF
- Chief of Health Administration and Management Revenue (HAMR)
- CBIO

We reviewed documentation including coding, billing, and patient records for the two patients addressed in the complaint, VHA policies and directives, CBI Billing/Coding Accuracy Audit Reports, and other relevant guidance. We reviewed the results of CBI coding and billing audits and claims rejection rates reported in the “eDenial” 3rd party insurance rejection reports.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President’s Council on Integrity and Efficiency.

Findings

Issue 1: Pattern of Inappropriate use of the CPT Modifier 59

We did not substantiate that there was a pattern of inappropriate activity to increase reimbursements by adding modifier 59 on 3rd party insurance claims. We found no evidence to support that allegation. We did substantiate that some 3rd party claims for the patient identified in the complaint contained 59 modifiers. However, the differences in the reimbursement rates in the instances that the modifier 59 was included on the claim was the same or less than one percent more than reimbursements for claims for the same procedure without modifier 59.

We reviewed Quadramed coding records and related authorized insurance claims for the period July 29, 2008, through June 23, 2009, for the patient identified in the complaint. We found that the modifier 59 was inconsistently applied. When the modifier 59 was applied the Quadramed encoder histories did not document the responsible coding staff. A Quadramed software discrepancy was found and reported on November 24, 2009, by the Billing Supervisor, which affected audit tracking for all CPT modifiers. This discrepancy was reported as being in the process of being resolved.

We could not find any evidence to support a pattern of coding or billing irregularities or that there was undue pressure to change coding or billing records to obtain unjustified reimbursements from third party payers. The coders and billers acknowledged that there were occasions where there were discussions over coding and billing matters that required additional clarification or counsel. We found no evidence from the interviews with the coding and billing staff that inappropriate coding or pressure was taking place.

We reviewed the results of CBIO coding and billing audits and claims rejection rates reported in the ‘eDenials’ reports and found no conclusive evidence of significant error rates or billing rejection rates for miscoding indicative of a pattern of coding or billing irregularities.

Issue 2: Inappropriate Billing Related to Complications from Participation in a Voluntary Research Study

We did not substantiate the allegation that complications from a research study procedure were improperly billed to a private insurance company. We found that the incident described in the complaint was billed appropriately.

A chronology of the events showed that the patient was not enrolled in the research protocol when the alleged complications occurred. It was determined that the patient had a documented history dating back to 2004 of the condition that caused the emergency room visit and was unrelated to the procedure performed in July 2009. We found that the billing was appropriate and not related to the voluntary research study.

Conclusions

We did not substantiate the allegations and make no recommendations.

Comments

The VISN and system Directors concurred with the inspection results (see pages 7–8 for the full text of their comments).

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

**Department of
Veterans Affairs**

Memorandum

Date: December 30, 2009

From: Network Director, VA Heartland Network, Kansas City, MO (10N15)

**Subject: Healthcare Inspection – Healthcare Inspection – Review of
Alleged Coding and Billing Irregularities, VAMC, Kansas City,
MO**

To: John D. Daigh, Jr. M.D. Assistant Inspector General for
Healthcare Inspections
Director, Management Review Service (10B5)

I concur with the findings and recommendations.

(original signed by:)

James R. Floyd

Director, VA Heartland Network

**Department of
Veterans Affairs**

Memorandum

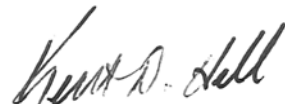
Date: December 22, 2009

From: Kent D. Hill, Director Kansas City VA Medical Center

Subject: **Healthcare Inspection – Review of Alleged Coding and Billing Irregularities, VAMC, Kansas City, MO**

To: John D. Daigh, Jr. M.D. Assistant Inspector General for Healthcare Inspections

We have reviewed the results of your inspection regarding allegations of coding and billing irregularities at the Kansas City VA Medical Center. We appreciate the time and effort you put into this review. We concur with your report. We were confident that our current practices were within appropriate standards for coding and billing and are pleased that you did not substantiate the allegations and have no recommendations.


KENT D. HILL

OIG Contact and Staff Acknowledgments

OIG Contact	Anthony Murray Leigh, CPA CFE (410) 637-4723
Acknowledgments	Thomas I. Seluzicki, CPA CFE Stephanie Hills, RN MSN Reba Ransom, RN MSN

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