Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Review of Inappropriate Copayment Billing for Treatment Related to Military Sexual Trauma

Report No. 09-01110-81

February 4, 2010

VA Office of Inspector General
Washington, DC 20420

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

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Executive Summary

Introduction

At the request of Senate Veterans' Affairs Committee Chairman Daniel K. Akaka, the VA Office of Inspector General (OIG) investigated allegations of charging veterans for treatment as a result of military sexual trauma (MST) at the Austin Outpatient Clinic, which is part of Central Texas Veterans Health Care System (CTVHCS). The OIG referred the allegations to the Director of CTVHCS for investigation and response. Concerned with the information provided in the response from CTVHCS, the OIG decided to conduct a VA-wide evaluation of copayment billing practices for care rendered for MST-related conditions.

Results

Based on the Veterans Health Administration's (VHA's) fiscal year (FY) 2009 Medical SAS Outpatient data file (generated on October 20, 2009), 5,340,754 patients sought outpatient care for a total number of 92,892,834 encounters in FY 2009. Among the 5,340,754 patients, 65,264 (1.2 percent) received at least one outpatient care encounter for MST-related conditions at VHA facilities during FY 2009. Sixty percent of the patients who sought at least one outpatient care encounter for MST-related conditions in FY 2009 were woman veterans. We found that use of the clinic stop code specifically designated for MST-related care is inconsistently implemented at VHA medical facilities. As a result, MST treatment data are not readily accessible across the VA system based on the clinic stop code.

We conducted a pilot review for information gathering. Based on the pilot review's results, we concluded that a VA-wide evaluation of inappropriate copayment billing practices was not warranted and confined our evaluation to CTVHCS.

It appears that suppressing the copayment trigger for MST-related service in the Integrated Billing Package works appropriately except possibly in certain instances related to timing. The billing system may not automatically cancel copayment charges if MST designation takes place after the encounter date. CTVHCS has cancelled all erroneous charges and refunded any payments that were received.

We found that erroneous copayments for MST-related care have resulted from staff changing patients' copayment status from "not required to make a copayment" to "copayment required." When manual edits are made to create a copayment bill, proper controls must be in place to ensure that the manual changes consider MST and any other conditions that entitle veterans to cost free care. CTVHCS has cancelled all erroneously added charges and refunded any payments received. However, it is a concern that

manually added copayment billing may exist at other VHA facilities and for other cost free care conditions mandated under special authority.

Recommendations

We recommended that:

- The Acting Under Secretary for Health ensure the use and implementation of a method specifically designated to track MST-related care at all VHA medical facilities so that MST treatment data are readily accessible across the VA system.

- The Veterans Integrated Service Network (VISN) 17 Director ensure that the CTVHCS Director determines whether a delay of more than 1 day between the dates of care and note signing creates an erroneous copayment bill and/or accounting for MST-related care.

- The VISN 17 Director ensure that the CTVHCS Director includes in the facility's standard operating procedure the requirement that business staff review for MST designation (or for any other conditions that entitle veterans to cost free care or medications) prior to adding copayment charges.

Comments

The Acting Under Secretary for Health, VISN 17 Director, and CTVHCS Director concurred with the findings and recommendations and provided implementation plans. (See Appendixes C–D, pages 18–24, for the full text of the comments.) The Acting Under Secretary for Health will revise VHA policy to enable tracking of MST-related outpatient care. The revised policy will be implemented, and education will be provided. The VISN 17 and CTVHCS Directors have filed a work order along with a request to have specific copayment charges reviewed. Once the work order is processed and closed, they will be able to determine whether corrections need to be made to the Integrated Billing Package. Also, the VISN 17 and CTVHCS Directors have instructed CTVHCS staff who add copayment charges to review appropriate documentation prior to adding charges. Quarterly documentation reviews will be conducted to determine compliance. The implementation plans are acceptable, and we will follow up until all actions are complete.

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

Introduction

Purpose

The VA Office of Inspector General (OIG) received a request from Senate Veterans' Affairs Committee Chairman Daniel K. Akaka to investigate allegations of charging veterans for treatment as a result of military sexual trauma (MST) at the Austin Outpatient Clinic (OPC), which is part of Central Texas Veterans Health Care System (CTVHCS). In accordance with VA Directive 0701, *Office of Inspector General Hotline Complaint Referrals*, January 15, 2009, the OIG referred the allegations to the Director of CTVHCS for investigation and response (Appendix A).

Concerned with the information provided in the response from CTVHCS (Appendix B), the OIG decided to conduct a VA-wide evaluation of copayment billing practices for care rendered for MST-related conditions. The purpose of this review was to assess the extent of inappropriate copayment charges for treating MST.

Background

Basic Eligibility for VA Health Care Benefits.

Service members are eligible for some VA health care benefits if they served on active duty in the uniformed services for the minimum amount of time specified by law and were discharged or released under conditions other than dishonorable. Reservists and National Guard members also qualify for VA health care benefits if they were called to active duty (other than for training only) by a Federal order and completed the full period for which they were called to duty.

In order to be eligible, veterans who enlisted after September 7, 1980, or who entered active duty after October 16, 1981, must have served 24 continuous months or the full period for which they were called to active duty. This minimum duty requirement may not apply to veterans discharged for hardship, early out, or a disability incurred or aggravated in the line of duty (Department of Veterans Affairs; *Federal Benefits for Veterans, Dependents and Survivors*; 2009 Edition).

VA Health Care Enrollment and Priority Groups.

The Veterans' Health Care Eligibility Reform Act of 1996 (Public Law 104-262) requires VA to establish and operate a system of annual patient enrollment and created seven priority groups for managing demand within available resources. The Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (Public Law 107-135) subsequently expanded the seven priority groups to eight with Priority Group 8 having the lowest priority.

In general, veterans are required to apply for enrollment into the VA health care system to receive care (Department of Veterans Affairs; *Federal Benefits for Veterans, Dependents and Survivors*; 2009 Edition).

Veterans do not have to be enrolled if they:

- Have a service-connected (SC) disability of 50 percent or more;[1]
- Seek care for a disability the military determined was incurred or aggravated in the line of duty—but which VA has not yet rated—within 12 months of discharge;
- Seek care for a SC disability only; or
- Seek registry examinations (Ionizing Radiation, Agent Orange, Gulf War/Operation Iraqi Freedom, and Depleted Uranium).

Unenrolled veterans will be automatically enrolled by VA the first time they seek VA care. During enrollment, each veteran is assigned to one of the following eight priority groups:

Priority Group 1:
- Veterans with SC disabilities rated 50 percent or more, or
- Veterans determined by VA to be unemployable due to SC conditions.

Priority Group 2:
- Veterans with SC disabilities rated 30 or 40 percent.

Priority Group 3:
- Veterans with SC disabilities rated 10 or 20 percent;
- Veterans who are former prisoners of war (POWs) or were awarded a Purple Heart medal;
- Veterans awarded special eligibility for disabilities incurred in treatment or participation in a VA vocational rehabilitation program; or
- Veterans whose discharge was for a disability incurred or aggravated in the line of duty.

Priority Group 4:
- Veterans receiving aid and attendance or housebound benefits, or
- Veterans who were determined by VA to be catastrophically disabled.

Priority Group 5:
- Veterans receiving VA pension benefits;
- Veterans who are eligible for Medicaid programs; or

[1]VA assigns disability ratings to compensate veterans for physical or mental conditions incurred or aggravated during military service. These ratings are assigned in increments of 10, ranging from zero to 100 percent.

- Non-SC veterans and non-compensable, zero percent SC veterans whose gross annual household income and net worth are below the established VA means test thresholds.

Priority Group 6:

- Veterans of World War I or the Mexican Border War;
- Veterans seeking care solely for conditions associated with exposure to toxins or environmental hazards while in service;
- Veterans with zero percent SC disabilities who are receiving disability compensation benefits; or
- Veterans who served in a theater of combat operations after November 11, 1998, as follows:
    - Veterans discharged/released from active duty on or after January 28, 2003, who were enrolled as of January 28, 2008, and veterans who apply for enrollment after January 28, 2008, for 5 years post discharge.
    - Veterans discharged/released from active duty before January 28, 2003, who applied for enrollment after January 28, 2008, or who apply by January 27, 2011.

Priority Group 7:

- Veterans with income and/or net worth above the VA national income threshold but below the geographic income threshold who agree to pay copayments.

Priority Group 8:

- Veterans with income and/or net worth above the VA national income threshold and the geographic income threshold who agree to pay copayments.

Copayment Requirement for VA Health Care and Medication.

VA provides cost free care and medication for the treatment of SC conditions and to veterans with SC disabilities rated 50 percent or more, former POWs, and VA pensioners. VA also provides cost free care and medication for veterans under special authorities (for example, medications for conditions that place the veterans in Priority Group 6) and for the treatment for MST-related conditions.

Other veterans must make copayments in order to receive VA health care and/or medications (Department of Veterans Affairs; *Federal Benefits for Veterans, Dependents and Survivors*; 2009 Edition). Specifically,

Inpatient Care:

- Copayment for Priority Group 7 and certain other veterans is 20 percent or $213.60 for the first 90 days of inpatient hospital care during any 365-day period. For each additional 90 days, the copayment is $106.80. In addition, there is a $2 per diem charge.

- Copayment for Priority Group 8 and certain other veterans is $1,068 for the first 90 days of care during any 365-day period. For each additional 90 days, the copayment is $534. In addition, there is a $10 per diem charge.

Outpatient Care:

The copayment is $15 for a primary care visit and $50 for some specialized care. Copayments are exempted for outpatient visits solely for preventive screening and/or immunizations; laboratory, flat film radiology, electrocardiograms, and hospice care; and publicly announced VA health fairs.

Medication:

Medication copayments do not apply to the following groups of veterans:

- Veterans with a SC disability of 50 percent or more;
- Veterans receiving medication for SC conditions;
- Veterans whose annual income does not exceed the maximum annual rate of the VA pension;
- Veterans enrolled in Priority Group 6 who receive medication under their special authority;
- Veterans receiving medication for conditions related to MST;
- Certain veterans receiving medication for treatment of cancer of the head or neck;
- Veterans receiving medication for a VA-approved research project; or
- Former POWs.

For other veterans whose conditions are not SC, the copayment is $8 for each 30-day or less supply of medication provided by VA. For veterans enrolled in Priority Groups 2 through 6, the maximum copayment for medications in calendar year 2009 was $960.

Extended Care:

The copayment amount is based on each veteran's financial situation and is determined upon application for extended care services. Copayments range from $0 to $97 a day.

Military Sexual Trauma.

VA refers to MST as the experiences of sexual harassment and/or sexual assault that occurred while the veteran was in the military. Both males and females can experience MST. The perpetrator can be of the same or of the opposite gender. Like other types of trauma, MST can negatively impact a person's mental and physical health, even many years later.

The Veterans Health Care Act of 1992 (Public Law 102-585) was signed into law after a series of hearings on women veterans' issues by the Senate Veterans' Affairs Committee in July 1992. The Veterans Health Care Act of 1992 authorized VA to provide outreach and establish MST counseling and treatment programs for women veterans who experienced incidents of sexual trauma while on active duty. The Veterans Health Care Extension Act of 1994 (Public Law 103-452) authorized VA to provide MST counseling and treatment to men as well as women. The Veterans Millennium Health Care Act (Public Law 106-117) expanded the focus on MST programs to include outreach and extended VA's authority to provide MST programs until December 2004. The Veterans Health Program Improvement Act of 2004 (Public Law 108-422) extended VA's authority permanently and extended MST counseling and related treatment to veterans whose MST occurred while serving on active duty or active duty for training (as defined under Title 38 United States Code §101(22)) if service was in the National Guard or Reserves.

Following the passage of these public laws, Veterans Health Administration (VHA) Directive 2005-015, *Military Sexual Trauma Counseling*, March 25, 2005, mandated universal screening of all enrolled veterans for a history of MST and mandated that each VA medical facility appoint an MST Coordinator to oversee the screening and treatment referral process. The directive recommended the use of clinic stop code 524 so that collection of MST treatment data is accessible and consistent across the VA system. Stop codes are identifiers used in VHA's managerial cost accounting system, the Decision Support System (DSS), to indicate the primary clinical group providing the services. DSS is a congressionally-mandated resource management tool. Implementation began throughout VHA in 1994.

VA provides free, confidential counseling and treatment for veterans' mental and physical health conditions resulting from MST that occurred while serving on active duty or active duty for training if service was in the National Guard or Reserves. Veterans do not need to have reported the incident(s) when they happened or have other documentation that they occurred. Appropriate services are provided for any injury, illness, or psychological condition resulting from MST. Veterans do not need to be SC and may be able to receive this benefit even if they are not otherwise eligible for VA health care benefits. Although veterans receiving MST-related counseling and treatment are not billed for inpatient, outpatient, or medication copayments, applicable copayments may be charged for services not related to MST or for other non-SC conditions.

Designation of Military Sexual Trauma Related Care.

According to the VA *Automated Service Connected Designation Technical Manual* of September 2007, the SC designation has been automated for outpatient encounters within the Patient Care Encounter and Scheduling packages. The automation of SC designation utilizes the mapped *International Classification of Diseases, Clinical Modification, 9th Revision* (ICD-CM-9) with rated disability codes at the time the provider actually picks the ICD-9 code for the encounter. When a provider chooses the ICD-9 diagnosis code for the encounter, the software will automatically determine if the diagnosis is related to the veteran's established SC conditions to make the proper SC or non-SC designation for that encounter. These encounters are then displayed for editing incorrectly designated encounters.

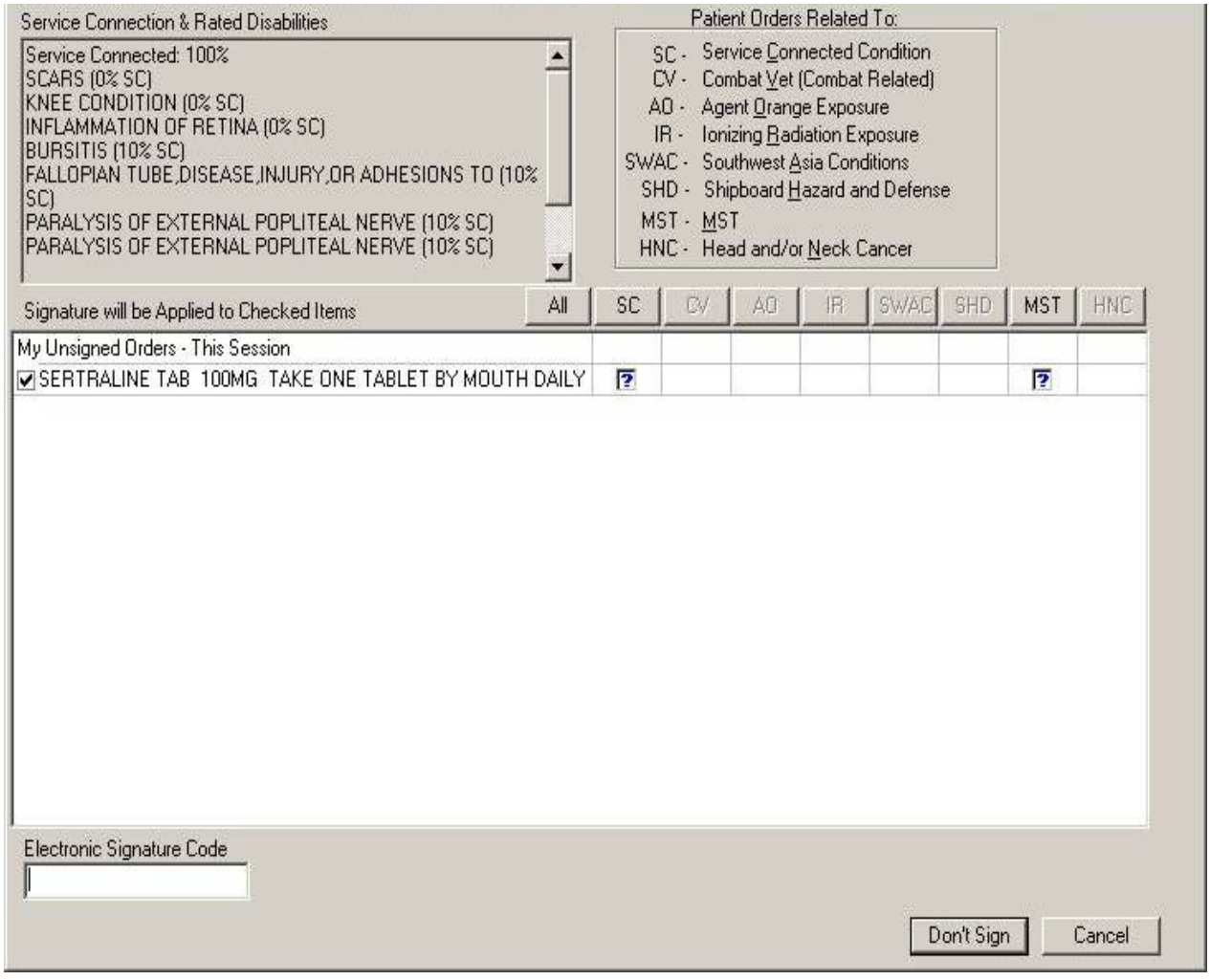

Figure 1. Screen for medication order. The provider needs to designate if the medication order is related to MST (or related to other conditions that entitle veterans to cost free care) before he or she can sign the order.

Designation of MST encounters, however, requires care providers to check the corresponding MST box before they can sign the notes. This same process also applies to all medication orders. Figure 1 gives an example of the screen display for a medication order. The provider needs to designate if the medication order is related to MST (or related to other conditions that entitle veterans to cost free care) by resolving the question marks to suppress or not suppress the copayment billing charges before he or she can sign the order.

Because one prescription order may include multiple medications, some of which may not be for MST-related treatment, each medication needs to be designated individually as MST related or not.

Central Texas Veterans Health Care System.

CTVHCS is one of the three health care systems in the VA Heart of Texas Health Care Network (Veterans Integrated Service Network (VISN) 17). The other two systems in VISN 17 are South Texas Veterans Health Care System and VA North Texas Health Care System (http://www.heartoftexas.va.gov/. Last accessed on November 15, 2009).

CTVHCS serves over 230,000 veterans from 39 counties in central Texas. It covers 35,243 square miles and eight congressional districts. CTVHCS consists of two main medical centers located in Temple and Waco; an outpatient clinic located in Austin; and four community based outpatient clinics located in Brownwood, College Station, Cedar Park, and Palestine (http://www.centraltexas.va.gov/about/index.asp. Last accessed on November 15, 2009). CTVHCS offers treatment for MST on an outpatient basis for both male and female veterans. MST treatment is available at the Austin, Temple, and Waco facilities (http://www.centraltexas.va.gov/services/index.asp. Last accessed on November 15, 2009).

Alleged Inappropriate Billing for Military Sexual Trauma Care at the Austin Outpatient Clinic.

Senate Veterans' Affairs Committee Chairman Daniel K. Akaka received allegations that veterans at CTVHCS's Austin OPC were charged for treatment that was related to MST. In accordance with VA Directive 0701, *Office of Inspector General Hotline Complaint Referrals*, January 15, 2009, the OIG referred the allegations to the Director of CTVHCS for investigation and response (Appendix A).

The CTVHCS Director's response indicated that the Austin OPC treated 250 veterans for MST in calendar year 2008 and that 86 rendered services flagged as related to MST were billed, including 91 prescriptions and six visits (Appendix B). Concerned with the information provided in the response, the OIG decided to conduct this review to assess the extent of inappropriate copayment charges for treating MST.

Scope and Methodology

We reviewed applicable regulations, policies, procedures, and guidelines. VHA's fiscal year (FY) 2009 Medical SAS Outpatient data file (generated on October 20, 2009) was used to describe VA MST patient demographics and characteristics.

Veterans who seek care for MST may or may not be associated with SC disabilities. Veterans receive cost free counseling and treatment (including medication) for mental and physical health conditions related to experiences of MST even though they may not otherwise be eligible for VA health care. For veterans with less than 50 percent SC disabilities and high income, copayment may be required for counseling and treatment of conditions that are not SC. Although veterans receiving MST-related counseling and treatment are not billed for inpatient, outpatient, or medication copayments, applicable copayments may be charged for services not related to MST and for non-SC conditions. In order to suppress the copayment trigger in the VA billing system—the Integrated Billing Package (IB)—for MST-related counseling, encounters, and medications, the provider needs to check the MST box to designate that the service provided is MST related.

Staff then review the patient visit information, make necessary edits, and release them for first party (copayment) and/or third party (reimbursable health insurance) billing where appropriate. We limited our review to copayment only.

Logically, only MST patients who meet copayment requirements and who have not reached their applicable maximum copayment may be mistakenly billed for MST-related services. Patients who do not meet copayment requirements (for example, 50 percent or more SC or low income) are automatically suppressed for billing for any treatment. We thus limited our review to only patients who met copayment requirements, were billed for care, and had been diagnosed with MST.

Furthermore, inappropriate copayment billing for MST-related treatment may occur if:

1. The suppressing copayment trigger for MST-related service in the IB is not set up appropriately, and/or

2. MST designated service encounters were inappropriately edited for billing.

Situation 1 would reflect a system-wide issue.

We conducted a pilot review for information gathering. We first requested from CTVHCS the 2008 Austin OPC MST data that were originally used in the Director's response letter to the OIG inquiry. The pilot review focused on only those MST patients who met copayment requirements and were billed copayments for care designated as MST related.

Based on the pilot evaluation results, we concluded that a VA system-wide evaluation of inappropriate copayment billing practices was not warranted. Thus, we confined our evaluation to CTVHCS.

We then requested and analyzed CTVHCS copayment data that covered all Central Texas MST patients who met copayment requirements and for whom at least one copayment bill was generated by the IB for outpatient visits from October 1, 2006 to June 1, 2009. Medical record reviews were conducted when necessary to verify pertinent information.

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

Results and Conclusions

Issue 1: Demographics and Characteristics of Patients Who Sought Military Sexual Trauma Designated Care at VHA Facilities in Fiscal Year 2009

According to VHA's FY 2009 Medical SAS Outpatient data file (generated on October 20, 2009), 5,340,754 patients sought outpatient care for a total number of 92,892,834 encounters in FY 2009.

Table 1 shows that 65,264 (1.2 percent of 5,340,754) patients received at least one outpatient care encounter for MST-related conditions at VHA facilities during FY 2009. A total of 754 (1.2 percent of 65,264) MST patients had all their outpatient episodes designated as MST related (data not shown). Austin OPC treated 454 MST patients, and one of them had all outpatient care designated as MST related (data not shown).

Austin OPC treated a higher percentage of female MST patients (72 percent) than VHA as a whole (60 percent). At all VHA facilities, female MST patients were more likely to have had at least one of their designated MST episodes of care also designated as SC than their male counterparts (62.8 percent for females versus 51.1 percent for males). This is in contrast to Austin OPC where females were less likely (59.0 percent for females versus 63.2 percent for males) to have had at least one of their designated MST episodes of care also designated as SC. Overall, female MST patients were younger than male MST patients (male patient median age was 57 for all of VHA versus 54 for those at Austin OPC) with half of them age 47 or under at the time of their first outpatient episode of care for MST-related conditions in FY 2009.

Table 1. Demographics of patients who sought MST designated care at VHA facilities in FY 2009.

	All VHA Facilities [65,264]		**Austin OPC** [454]	
	Female	**Male**	**Female**	**Male**
Number of MST patients (percent)	38,895 *(59.6%)*	26,369 *(40.4%)*	329 *(72.5%)*	125 *(27.5%)*
Number of patients with any MST visit also marked as service-connected visit	24,436 (62.8%)	13,483 (51.1%)	194 (59.0%)	79 (63.2%)
Median age (years) at time of first MST visit in FY 2009	47	57	47	54
Number of patients with any MST visit recorded at clinic stop code 524	376 (0.97%)	129 (0.49%)	0	0

VHA Directive 2005-015, *Military Sexual Trauma Counseling*, March 25, 2005, recommended the use of clinic stop code 524 specifically for MST-related care. VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*,

September 11, 2008, repeated the same recommendation. However, the recommendation has not been fully implemented after 4 years as evidenced by the meager use of the 524 code for care designated for MST-related conditions (Table 1). As a result, MST treatment data are not readily accessible across the VA system. For example, in the absence of the indicator for MST-designated care in the VHA FY 2009 Medical SAS Inpatient data file, inpatient treatment data for MST-related conditions are not readily accessible because of inconsistent use of the specific MST clinic stop code.

Issue 2: Copayment Billing for Military Sexual Trauma Designated Care at Austin Outpatient Clinic in 2008

The Austin OPC billing data file includes all claims for copayment and reimbursable health insurance for clinic visits and/or disbursed medication for all MST patients treated there in 2008. These charges may or may not relate to treatment for MST conditions (as designated by checked MST boxes) because these MST patients met copayment requirements for care rendered for non-SC conditions. There were a total of 97 MST patients (39 percent of the 250 MST patients reported in the VISN Director's response letter) with at least one bill generated by the IB for copayment or for third party reimbursement. For these 97 patients, the total number of generated claims was 2,132. The number of claims among individuals varied from 1 to 161.

After receiving the OIG's referral letter, VISN staff generated the data file and reviewed the claims in an attempt to determine whether patients were billed inappropriately for MST-related care. According to their review, claims for care provided to 17 patients were considered MST related. According to the Director's response letter (Appendix B), the claims billed included 91 prescriptions and six visits. To ensure no inappropriate billings, these charges were cancelled and any payments received were refunded to the patients.

The primary goal of our pilot evaluation concerned whether the IB trigger for suppressing copayment for MST-related services was set up appropriately. Thus, we asked VISN staff to further investigate the Austin claim bills. We focused on reviewing each copayment billed for MST designated treatment as MST patients might have received care for their non-SC conditions that were unrelated to MST.

Based on further investigation, it was determined that all copayment charges for 16 out of the 17 patients were in fact billed correctly for non-MST designated services. One copayment charge for one MST-related visit was billed in error. In this case, the clinic appointment was checked out with an unsigned provider note, which resulted in the visit not being designated as related to MST. Thus, the IB created the charge for the visit on the appointment date. When the provider signed the note 1 week later, the encounter was marked as related to MST; however, the patient had already been billed for the copayment.

Based on the pilot evaluation results, we abandoned the original plan of conducting a VA system-wide review and limited our review to CTVHCS instead.

Issue 3: Copayment Billing for Military Sexual Trauma Designated Care at Central Texas Veterans Health Care System from October 1, 2006, to June 1, 2009

CTVHCS data included all generated bills for outpatient encounter copayments for MST patients who met copayment requirements from October 1, 2006 to June 1, 2009. The data contained 158 charges from 62 MST patients (Figure 2). The number of encounters for each individual varied from 1 to 22. The majority (82 percent = 51/62) of the patients had none of their visits designated for MST-related conditions.

Sixteen (10 percent) out of the 158 encounters from 11 patients were designated as related to MST conditions and had a charge generated by the IB for copayment. This included the patient who was erroneously billed for the MST-related encounter copayment in 2008 at the Austin OPC.

Ten (62.5 percent) of the 16 billed MST-related encounters were automatically generated by the IB at the time the patients checked out—prior to providers signing their notes—so that the 10 encounters were not designated as MST related. Later on the same days, when five encounters were designated as MST related once providers signed their notes, the IB package (correctly) automatically cancelled these charges. The other five encounters (including the 2008 Austin OPC case) had the same situation as the Austin case—the providers' notes were signed after the dates of the patients' visits.

The other six copayments were manually added as a result of an Income Verification Match review, which changed the patients' status from "not required to make a copayment" to "copayment required." These charges were added by staff without any review for an MST designation. All erroneous charges have been cancelled, and any payments received were refunded to the patients. Staff have been instructed to review for MST designation prior to adding charges.

It appears that the IB would automatically cancel copayment bills generated when services not designated as MST related were changed to MST related later on the same day as the encounter. For example, if an encounter was checked out when the service was not designated as MST related but the service was re-designated as MST related later on that same date, the copayment bill would be automatically cancelled by the IB. However, if the designation was modified after the check out date, there were instances when the copayment was not automatically cancelled by the IB. This resulted in erroneous copayment bills for MST-related care.

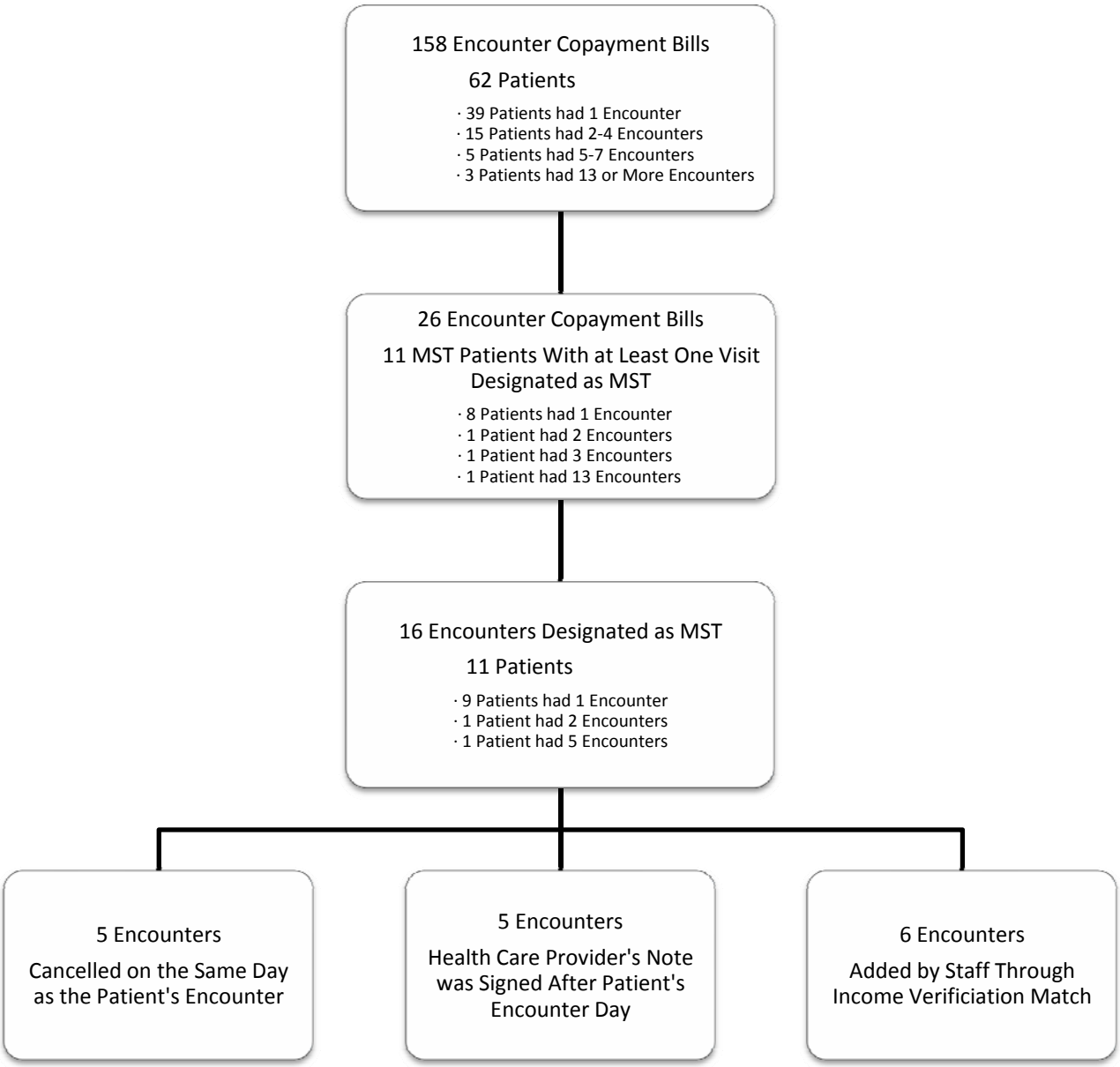

Figure 2. Erroneous copayment billing for MST designated encounters: ALL MST patients treated at CTVHCS who met VA copayment requirement and were billed at least once from October 1, 2006 to June 1, 2009.

Conclusions

1. The recommended use of the clinic stop code specifically designated for MST-related care by VHA Directive 2005-015, *Military Sexual Trauma Counseling*, March 25, 2005, and VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, is inconsistently implemented at VHA medical facilities. As a result, MST treatment data are not readily accessible across the VA system.

2. It appears that suppressing the copayment trigger for MST-related service in the Integrated Billing Package works appropriately except possibly for instances of timing issues between appointment check out and change of "related to MST" designation. It seems that the billing system may not automatically cancel copayment charges if MST designation takes place after the encounter date. VHA must determine whether this condition which permits erroneous bills to be issued exists.

CTVHCS has cancelled all erroneous charges and refunded any payments that were received to the patients.

3. Erroneous copayments for MST-related care have resulted from staff changing patients' copayment status from "not required to make a copayment" to "copayment required." When manual edits are made to create a copayment bill, proper controls must be in place to ensure that the manual changes consider MST and any other conditions that entitle veterans to cost free care.

CTVHCS has cancelled all erroneously added charges and refunded any payments received to the patients. It also has educated staff on the process for reviewing for MST status prior to adding charges.

It is a concern that manually added copayment billing may exist at other VHA facilities and for other cost free care conditions mandated under special authority.

Recommendations

Recommendation 1: We recommended that the Acting Under Secretary for Health ensure the use and implementation of a method specifically designated to track MST-related care at all VHA medical facilities so that MST treatment data are readily accessible across the VA system.

Recommendation 2: We recommended that the VISN 17 Director ensure that the Director for Central Texas Veterans Health Care System determine, by a review of source code for the Integrated Billing Package or other appropriate approach, whether a delay of more than 1 day between the dates of care and note signing creates an erroneous copayment bill and/or accounting for MST-related care.

Recommendation 3: We recommended that the VISN 17 Director ensure that the Director for Central Texas Veterans Health Care System include in the facility's standard operating procedure the requirement that business staff review for MST designation (or for any other conditions that entitle veterans to cost free care or medications) prior to adding copayment charges.

Appendix A

OIG Referral Memorandum to Central Texas Veterans Health Care System

Department of Veterans Affairs

Memorandum

Date: February 3, 2009

From: Congressional Relations Officer (50B)

Subj: Hotline Case Number 2009-1110-CR-40

To: Director, Central Texas VA Health Care System

OFFICE OF INSPECTOR GENERAL REFERRAL

1. **Response Due Date: March 20, 2009**

2. The allegations described in the attachments were reported to the Office of Inspector General and are referred to your office for review in accordance with VA Directive 0701, dated March 5, 2003.

3. Please determine the merit of each complaint or allegation. Your response should include the OIG control number above and describe how the allegations were reviewed, whether they were substantiated, what corrective action you have taken to address any substantiated allegation(s), and when you initiated or completed that action. **Please provide the documentation that supports your finding on each allegation. You should also include a point of contact and a telephone number or e-mail address in case we have follow-up questions.** You should make every effort to protect the identity of the complainant during your review.

4. When the review is complete, you may send your response by mail [VA OIG 50B/CG), P.O. Box 50410, Washington, DC 20091–0410] or by fax [202–565–8667]. If you send the response by fax, you do not need to mail the original. **TO MAINTAIN SECURITY, DO NOT USE E-MAIL TO SEND US YOUR RESPONSE.**

5. For your information, all or part of your report to the Inspector General may be available to the complainant under the Freedom of Information Act.

6. If you have any questions, please call me (202-461-4527) or Ms. Joanne Moffett (202-461-4720).

(original signed by:)
CATHERINE A. GROMEK

Attachment
cc: 10B5, VISN 17

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REPORT OF CONTACT

Date: February 3, 2009 HOTLINE CASE NO.: 2009-1110-CR-40

ISSUES OR ALLEGATIONS TO BE ADDRESSED: Central Texas Veterans Health Care System - Austin Outpatient Clinic

DETAILS OF ALLEGATIONS OR COMPLAINT:

The Office of Inspector General received allegations from the Chairman, Senate Veterans' Affairs Committee, that the Austin Outpatient Clinic may be charging veterans, specifically, women veterans, for treatment as a result of military sexual trauma (MST). As you know, VHA Directive 2005-015 (March 25, 2005) sets out the policy that veterans receiving MST-related counseling and treatment are not to be billed for inpatient, outpatient, or pharmaceutical copayments.

Please provide the number of veterans treated for MST during calendar year 2008. Please review each veteran's record to determine whether the veteran was charged for treatment or pharmaceuticals related to MST, and whether VA has received any payments for such treatment or pharmaceuticals. If a veteran was charged for care related to the MST, provide the justification. If the charges were in error, provide the OIG with a corrective action plan for these veterans. Also, provide information on what you will do to ensure that other community outpatient clinics (CBOCs) attached to the Central Texas Veterans Health Care System follow the VHA Directive with regards to MST as well as any actions planned to review the records of veterans that sought MST care at those CBOCs.

Appendix B

Director, Central Texas Veterans Health Care System, Response to OIG Referral Memorandum

Department of Veterans Affairs

Memorandum

Date: April 21, 2009

From: Director (00), Central Texas Veterans Health Care System, Temple, TX

Subj: Hotline Case Number OIG 2009 – 1110-CR-40, VAMC Temple, TX(674)

To: Director, (50B/CG), Hotline Division, Office of Inspector General (OIG), Washington, DC
Catherine A. Gromek
Director, (10N17), Heart of Texas Veterans Health Care Network, Arlington, TX
Deborah Antai-Otong/Michael Kuchyak

1. Thank you for the opportunity to respond to Case Number 2009 1110-CR4-40, dated February 3, 2009, regarding allegations of charging veterans, specifically, women veterans, for treatment as a result of military sexual trauma (MST).

2. There were 250 unique veterans treated for MST at the Austin Outpatient Clinic during calendar year 2008. The records of these veterans were reviewed, and there were 86 bills which included 91 prescriptions and 6 visits for services related to care flagged as related to MST. The same review has been initiated for all CTVHCS including Community Based Outpatient Clinics (CBOCs).

3. While documentation in the medical record may not indicate treatment for MST, if the "related to MST" box was checked by the provider, bill cancellations or refunds will be processed for these visits or medications prescribed at these visits. Visits from any CTVHCS site including CBOCs with the "related to MST" box checked will not be billed. In addition, to ensure accurate documentation, the Health Information Management section, in conjunction with the Chief of Staff's Office at CTVHCS will develop an educational program for providers. This program will provide information related to appropriate MST designations and documentation to support counseling and treatment.

4. If you have any questions regarding this information, please contact Janet Lesikar at 254-743-0233.

/s/
Thomas C. Smith, III, FACHE

Appendix C

Acting Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: December 30, 2009

From: Acting Under Secretary for Health (10)

Subject: **OIG Draft Report, *Healthcare Inspection, Review of Inappropriate Copayment Billing for Treatment Related to Military Sexual Trauma, Central Texas Veterans Health Care System, Temple, Texas***

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and I concur with the recommendations. As an organization, VHA strives to ensure that Veterans receive the health care that they are entitled to and are not erroneously billed for services. Your report suggests that there may be limited situations in which the opportunity for inappropriately billing Veterans for treatment related to Military Sexual Trauma (MST) exists. I will ensure that VHA conducts a review of the circumstances that may lead to inappropriate copayment billing for MST-related treatments and make the changes necessary to prevent such errors in the future.

2. Your report also states that VHA is inconsistent in tracking MST-related care at medical facilities, and as a result, MST treatment data is not readily accessible across the VA system. I agree that we need to improve our process for tracking this information consistently throughout the system. VHA staff has already recognized that the current policy, which recommends the use of a stop code specifically designated for MST-related care to track MST treatment data, is not optimal. We are currently in the process of revising this policy to recommend use of the encounter-level identifier available in the Medical SAS Data sets (the MST check box) to track MST-related outpatient care. I believe that the encounter level identifier is the most effective means for tracking care because, unlike clinic stop codes, this identifier is linked to the Integrated Billing package.

The designation of MST-related care in this manner is the best way for providers to ensure that patients are not billed for MST-related services. By using the encounter-level identifier, information on MST-related treatment will be readily accessible across the VA system.

3. As for the availability of MST treatment data across the VA system, I must point out that by using the encounter-level identifier as described earlier, the VHA Office of Mental Health Services MST Support Team has been effective in making this information readily available. The MST Support Team compiles and distributes reports on MST-related care throughout VHA annually.

For example, in FY 2008, the MST Support Team produced the following reports: MST Screening; MST-Related Outpatient Care; MST Screening and Outpatient Care among Operation Enduring Freedom/Operation Iraqi Freedom Veterans; MST-related Screening at VHA Community Based Outpatient Clinics (CBOCs); and MST-related Outpatient Care at VHA CBOCs. Furthermore, the MST Support Team conducts system-wide education on these issues and provides technical support regarding MST-related screening and treatment.

4. Thank you for the opportunity to review the report. Attached is VHA's plan of corrective action for the one recommendation in the report that is directed to me for a response. The Director of the Central Texas Veterans Health Care System has directly responded to the other two recommendations in the report that are specifically provided to him. If you have any questions, please contact Margaret Seleski, Director, Management Review Service (10B5) at (202) 461-7245.

(original signed by:)
Gerald M. Cross, MD, FAAFP

Attachment

VETERANS HEALTH ADMINISTRATION
Action Plan
OIG Draft Report, Healthcare Inspection, Review of Inappropriate Copayment Billing for Treatment Related to Military Sexual Trauma
Central Texas Veterans Health Care System, Temple, Texas

Recommendations/ Actions	Status	Completion Date

Recommendation 1: We recommended that the Acting Under Secretary for Health ensure the use and implementation of a method specifically designated to track MST-related care at all VHA medical facilities so that MST treatment data are readily accessible across the VA system.

Concur

VHA's Office of Patient Care Services, Office of Mental Health will revise VHA Directive 2005-015, *Military Sexual Trauma Counseling* (issued March 25, 2005) and VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, (issued September 11, 2008) to recommend use of the encounter-level identifier available in the Medical SAS Data sets (the MST check box) to track MST-related outpatient care. Subsequently, VHA's Office of the Deputy Under Secretary for Health for Operations and Management, in conjunction with VHA's Office of Patient Care Services, will disseminate and ensure implementation of the revised policy. VHA's Office of Mental Health MST Support Team will conduct system-wide education to support effective implementation of the revised policy.

In Process 03/31/10

Appendix D

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 17, 2009

From: Network Director, VA Heart of Texas Health Care Network, Arlington, TX (10N17)

Subject: **Review of Inappropriate Copayment Billing for Treatment Related to Military Sexual Trauma**

To: Acting Under Secretary for Health (10N)

I have reviewed and concur with the attached response from the Central Texas Veterans Health Care System regarding the above referenced health care inspection. Thank you.

(original signed by:)
Timothy P. Shea, FACHE

Appendix E

Central Texas Veterans Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 17, 2009

From: Director, Central Texas Veterans Health Care System

Subject: **Review of Inappropriate Copayment Billing for Treatment Related to Military Sexual Trauma**

To: Director, VA Heart of Texas Health Care Network (10N17)

I concur with the findings and recommendations in the draft report. The following corrective actions will be taken in response to the recommendations.

(original signed by:)
Thomas C. Smith, III, FACHE

Central Texas Veterans Health Care System Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 2: We recommended that the VISN 17 Director ensure that the Director for Central Texas Veterans Health Care System determine, by a review of source code for the Integrated Billing Package or other appropriate approach, whether a delay of more than 1 day between the dates of care and note signing creates an erroneous copayment bill and/or accounting for MST-related care.

Concur **Target Completion Date:** Ongoing

During the reviews, instances were identified when copayment charges were initially created for a bill that was not annotated as related to MST. At a later time, the appointment status was changed to be related to MST. In some cases, the Integrated Billing (IB) Package appropriately cancelled the copayment charges. In a few, the charges were not automatically cancelled as expected. A Remedy Ticket was filed, November 25, 2009, with CO IT Ticket # 0000000365558 along with a request that these specific copayment charges are reviewed to determine if the appointment that appears to be linked to the copayment charges is the correct appointment, and if so why the IB package did not automatically cancel these charges, when the appointment status was changed. Until the Remedy Ticket is processed and closed we are unable to determine and correct circumstances surrounding the above recommendations.

Recommendation 3: We recommended that the VISN 17 Director ensure that the Director for Central Texas Veterans Health Care System include in the facility's standard operating procedure the requirement that business staff review for MST designation (or for any other conditions that entitle veterans to cost free care or medications) prior to adding copayment charges.

Concur **Target Completion Date:** August 25, 2009

When the process for manually adding copayment charges was reviewed, it was determined that staff were not reviewing the medical documentation to

determine if the visit status was related to MST. All Central Texas Veterans Health Care System staff, with access to add copayment charges, have been instructed to review the appropriate documentation to identify those encounters for MST related care, and exempt from copayments, prior to charge creation. The MCCF Coordinator will conduct quarterly documentation reviews to determine compliance with revised billing guidelines.

Appendix F

OIG Contact and Staff Acknowledgments

OIG Contact	Limin X. Clegg, Ph.D., Director Biostatistics, Program Evaluation and Consultation 202-461-4664
Acknowledgments	Elizabeth A. Bullock Patricia Christ Nathan McClafferty Patrick Smith

Appendix G

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