VA Office of Inspector General

OFFICE OF AUDITS & EVALUATIONS

Veterans Health Administration

Review of Outpatient Fee Payments at the VA Pacific Islands Health Care System

March 17, 2010
09-02088-106

ACRONYMS AND ABBREVIATIONS

MQAS	Management Quality Assurance Service
PIHCS	Pacific Islands Health Care System
VHA	Veterans Health Administration
VistA	Veterans Health Information System and Technology Architecture

REPORT HIGHLIGHTS: Review of Outpatient Fee Payments at the VA Pacific Islands Health Care System

Why We Did This Audit

We conducted this review at the VA Pacific Islands Health Care System (PIHCS) at the request of Senator Daniel Akaka, Chairman of the Senate Veterans' Affairs Committee. The objective of our review was to determine the extent and causes of improper payments for PIHCS' outpatient fee care program.

What We Found

Our review found that PIHCS improperly made duplicate payments for 13 percent of outpatient fee claims, which resulted in overpayments of $49,571 (or less than 1 percent of total outpatient fee expenditures). The error rate at PIHCS was significantly lower than the national error rate identified in a previous VA Office of Inspector General (OIG) audit.

VA's Management Quality Assurance Service (MQAS) had previously identified the duplicate payment issue at PIHCS during a financial management review, and our results support that PIHCS managers have been taking appropriate steps to prevent further duplicate payments. Since June 2008, PIHCS managers have provided training for fee staff on avoiding duplicate payments and notified local providers of proper billing requirements.

What We Recommended

We recommended that the Acting Under Secretary for Health ensure that PIHCS management initiates recovery of the duplicate overpayments identified by this review.

Agency Comments

The Under Secretary for Health agreed with the recommendation and monetary benefits in the report and reported that VHA plans to recover the duplicate overpayments identified by this review by April 30, 2010. We consider VHA's corrective actions acceptable and will follow up on their implementation.

(original signed by:)
BELINDA J. FINN
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Objective

We conducted this review at the request of Senator Daniel Akaka, Chairman of the Senate Veterans' Affairs Committee. The objective was to determine the extent and causes of improper payments for PIHCS' outpatient fee care program.

VA's Outpatient Fee Program

The Veterans Health Administration (VHA) uses the Non-VA Fee Program to provide medical care to eligible veterans. Title 38 of the United States Code, Sections 1703, 1725, and 1728, authorizes VA to pay non-VA providers for veterans' care when certain medical services are unavailable, cannot be economically provided due to geographical inaccessibility, or in emergencies when delays are hazardous to life or health. With the exception of some emergencies, outpatient fee care must generally be authorized prior to veterans receiving services from non-VA providers—VHA refers to this type of care as "pre-authorized" fee care. In Hawaii, veterans may also receive outpatient fee care if the care prevents the need for hospital admission.

PIHCS' Fee Program

PIHCS provides outpatient medical services to about 128,000 veterans living in a large and diverse region that includes Hawaii, Guam, and American Samoa. When timely medical services are not available to VA patients at its facilities, PIHCS staff arrange for their treatment at Department of Defense medical centers through interagency agreements or at community medical facilities through the fee program. In FY 2008, PIHCS' fee staff processed about 172,500 outpatient claims costing $18.7 million for fee services provided by non-VA medical providers.

Prior Reviews

In FY 2009, the OIG completed the *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program* (Report 08-02901-185, dated August 3, 2009). Although the audit was a nationwide review of VA's Fee Program, it did not include Hawaii and Alaska due to unique features of their fee programs. The audit found that VA facilities improperly paid about 37 percent of outpatient fee claims by making duplicate payments, paying incorrect rates, and making other minor payment errors, such as paying for the wrong quantity of services. As a result, we estimated that in FY 2008, VHA overpaid $225 million and underpaid $52 million to fee providers, or about $1.1 billion in overpayments and $260 million in underpayments over 5 years.

RESULTS AND RECOMMENDATION

Finding PIHCS Strengthened Fee Processing Controls To Prevent Duplicate Payments

Our review found that PIHCS made duplicate payments for 13 percent of its outpatient fee claims, resulting in overpayments of $49,571. The duplicate payments occurred because fee staff did not review payment histories when processing fee payments. In June 2008, VA's MQAS also identified this issue at PIHCS. As a result, PIHCS provided additional training to fee staff and has been strengthening its fee payment processing controls to prevent further duplicate payments.

Duplicate Payments

During the 12-month period April 1, 2008–March 31, 2009, PIHCS processed about 124,000 outpatient fee claims totaling $14.3 million. Our review of 100 sample claims found that PIHCS had generally strong controls to ensure that fee services were properly pre-authorized. However, we identified 19 claims with payment errors. For 13 of the 19 claims, fee staff either paid for the same services twice or paid the professional component of a service twice. The remaining six payment errors were not significant—four errors resulted from using outdated Medicare rates, which is a system programming issue that the National Fee Program Office is addressing, and two errors were minor computation errors.

The most significant error made at PIHCS was duplicate payments. Similar to what we found during our national outpatient fee audit, PIHCS made two types of duplicate payments—straight duplicate payments in which they paid an invoice or a service twice and duplicate payments in which they paid the professional component of a billed service twice. Straight duplicate payments affected about 2 percent of the claims. Professional component duplicate payments affected about 11 percent of the claims. Fee staff made these duplicate payments primarily because they did not review Veterans Health Information Systems and Technology Architecture (VistA) Fee payment histories prior to paying the invoices. By reviewing payment histories, fee staff can determine if PIHCS already paid for a service or components of a service.

Corrective Actions Already Initiated

MQAS, which is aligned under VA's Chief Financial Officer, identified the problem of duplicate payments during a financial management review at PIHCS in June 2008. MQAS recommended that PIHCS provide training to fee staff on Medicare global rates and require fee staff to review payment histories when processing payments.

In response to MQAS' recommendations, PIHCS immediately initiated corrective actions. The Acting Chief of the Non-VA Care Unit required fee clerks to ensure provider claims had correct procedure code modifiers and to review payment histories to avoid duplicate payments. The Acting Chief also began conducting training during weekly staff conferences. In July 2008, the Acting Chief of Financial Resources Management notified area hospitals that PIHCS would deny invoices that did not have appropriate procedure codes. Furthermore, in January 2009, managers again reminded fee staff to follow processing procedures required to avoid duplicate payments.

Conclusion

Our review identified only one significant type of fee payment error—duplicate payments. However, the monetary impact of the duplicate payments is minimal (representing less than 1 percent of total outpatient fee expenditures), and PIHCS is taking appropriate steps to prevent future duplicate payments. In addition, the error rate at PIHCS was significantly lower than the error rate identified in our national *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program*.

Recommendation

1. We recommended that the Acting Under Secretary for Health ensure that PIHCS management initiates recovery of the duplicate payments identified by this review.

VHA Comments

The Under Secretary for Health agreed with the recommendation and monetary benefits in the report and provided an acceptable implementation plan. (See Appendix D for the full text of his comments.) He reported that he will ensure PIHCS management promptly initiates recovery of the duplicate payments identified by this review. The target date for recovery of those overpayments is April 30, 2010. He added that VHA has established a process for generating post-payment reports to identify possible duplicate payments and has provided training and guidance to field-based staff on how to use these reports to identify duplicate payments. In addition, VHA plans to implement a new software product, Fee Basis Claims System (FBCS), which will also help reduce duplicate payments. FBCS software is tentatively scheduled to be implemented at PIHCS in May 2010.

Appendix A Scope and Methodology

To address the objective, we reviewed a statistical sample of 100 claims valued at $124,668 paid during the 12-month period, April 1, 2008 through March 31, 2009, the most recent 12-month period for which complete payment data was available. (Appendix B provides more detail on our sample design and results.) For our review, we used data from the VistA Fee Outpatient Menu. We excluded claims for services provided under other contracting authorities such as sharing agreements or home health contracts properly executed under Title 38 of the United States Code, Section 1720.

Reliability of Computer-Processed Data

To test the reliability of claims information in the VistA Fee system, we compared the VistA information with selected veteran and vendor data shown on the original invoices. We found no significant errors between the VistA Fee system data and the original invoice data. We concluded the data from the VistA Fee system was sufficiently reliable to meet our objective.

Fraud Indicator Testing

We also performed tests for indications of possible fraud for outpatient claims paid during the period October 1, 2007–June 30, 2009. Using data mining techniques, we identified invoices with the following characteristics: (1) large numbers of claims paid for care of the same patient; (2) invoices containing two or more identical charges for the same patient on the same treatment date; and (3) claims with different invoice numbers for charges for the same patient, provider, and treatment date. We then used claims and medical documentation from VistA Fee and the Computerized Patient Records System to review a sample of these invoices and obtained additional documentation from PIHCS staff when appropriate. In all, we reviewed 68 claims for possible fraud indicators (in addition to our 100-claim sample).

Our analysis identified two duplicate payments and one payment for a service not received. However, we did not find evidence that the billings or payments were fraudulent; they appeared to be oversight errors, and PIHCS initiated recovery of the overcharges. The types of errors and error rates we identified during the fraud indicator testing were generally consistent with the errors identified by our 100-claim sample review discussed in this report.

Compliance with Government Audit Standards

We conducted our review work from April 2009 through September 2009. Our assessment of internal controls focused on those controls relating to our review objective. We did not review the appropriateness or the quality of the care provided. We conducted this review under the *Quality Standards for Inspections* (dated January 2005) issued by the President's Council on Integrity and Efficiency.

Appendix B Statistical Sampling Methodology

Approach

To evaluate the accuracy of outpatient fee payments, we selected a representative sample of outpatient fee invoice payments for review. We reviewed each sample claim to determine if the beneficiary was eligible for outpatient fee care, if appropriate authorization for the fee service was obtained, and if payments were accurate.

Population

The population consisted of 123,625 non-VA outpatient fee claims valued at approximately $14.3 million and paid during the 12-month period April 1, 2008 through March 31, 2009.

Sampling Design

We conducted a single-stage random sample of all claims identified in our population. Each sample item consisted of a single outpatient fee claim.

We considered payment of an outpatient fee claim to be improper if one or more of the following conditions was met:

- The veteran was ineligible for the service.
- The payment was to an ineligible or incorrect vendor.
- The payment was for an ineligible service.
- The payment was for a service not received.
- The payment included a duplicate payment.
- The payment amount was incorrect.

Projections and Margins of Error

Our review of 100 outpatient fee claims at PIHCS valued at $124,668 identified 13 claims with projectable payment errors valued at $2,251. Extrapolating the errors to the population of payments at a 90 percent confidence level projected dollar value errors valued at $258,966, with an upper limit of $468,362 and a lower limit of $49,571. We projected cost savings at the lower limit to address the lack of precision in the projection. We are being conservative by choosing to use the lower limit of the 90% confidence interval and believe the cost savings are likely to be at least this amount.

Appendix C Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefits	Questioned Costs
1	Strengthened controls to prevent duplicate payments of outpatient fee claims.	$49,571
	Total	**$49,571**

Appendix D Agency Comments

Department of Veterans Affairs

Memorandum

Date: March 1, 2010

From: Under Secretary for Health (10)

Subj: OIG Draft Report, *Review of Outpatient Fee Payments at the Department of Veterans Affairs Pacific Islands Health Care System* (WebCIMS 449796)

To: Assistant Inspector General for Auditing (52)

1. I have reviewed the draft report, and I concur with the recommendation and the associated monetary benefit. As an organization, the Veterans Health Administration (VHA) is working diligently to ensure that processes and procedures are in place to avoid improper duplicate payments for outpatient fee claims. I am encouraged that the error rate for improper outpatient fee payments at the Department of Veterans Affairs' Pacific Islands Health Care System (PIHCS) was significantly lower than the National error rate. PIHCS managers have proactively taken the necessary steps to prevent further duplicate payments by providing additional training for fee staff and notifying local providers of proper billing requirements. I will ensure PIHCS management promptly acts to initiate recovery of the duplicate over-payments identified by this review.

2. To address improper payments throughout VHA, the National Fee Program Office (NFPO) within VHA's Chief Business Office (CBO), in conjunction with Austin Central Fee Program (ACFP), has established a mechanism to generate post-payment reports from ACFP to identify possible duplicate payments. These post-payment reports enable facility fee programs to identify possible duplicate payments based on established algorithms. NFPO has provided training and guidance to field-based staff on how to utilize these post-payment reports to identify duplicate payments and to subsequently generate collection actions for duplicate payments. NFPO will work with fee staff at PIHCS to gain access to these post-payment reports and use them to identify and act upon any duplicate payments.

3. In addition to the post-payment reports, VHA CBO has sponsored implementation of a new software product, Fee Basis Claims System (FBCS), which will assist in the reduction and elimination of duplicate payments. FBCS accomplishes this by prompting claims examiners of the possible existence of a duplicate claim prior to making a payment on a similar claim. The program also allows users to view potential duplicate claims at various stages of the claim processing lifecycle. Moreover, FBCS reports tool allows managers to perform quality control measures, including searching for duplicate claims, to ensure the highest claims quality processing possible. FBCS software is tentatively scheduled to be implemented at PIHCS in May 2010.

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OIG Draft Report, *Review of Outpatient Fee Payments at the Department of Veterans Affairs Pacific Islands Health Care System* (WebCIMS 449796)

4. Thank you for the opportunity to review the report. Attached is VHA's plan of corrective action for the report's recommendation as well as our concurrence to your associated monetary benefits. If you have any questions, please have a member of your staff contact Linda Lutes, Director, Management Review Service (10B5) at (202) 461-7245.

Robert A. Petzel, MD

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report, Review of Outpatient Fee Payments at the Department of Veterans Affairs Pacific Islands Health Care System (WebCIMS 449796)

Date of Report: January 27, 2010

Recommendations/ Actions	Status	Completion Date

Recommendation 1. We recommend that the Under Secretary for Health ensure that the Department of Veterans Affairs Pacific Islands Health Care System's (PIHCS) management initiate recovery of the duplicate over-payments identified by this review.

VHA Comments

Concur

VHA Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) will work with the Director, PIHCS, to ensure PIHCS management initiate recovery of duplicate over-payments identified by this review. DUSHOM will follow-up with the Director, PIHCS, to obtain notification once all duplicate over-payments identified by this review have been recovered. The National Fee Program Office within VHA's Chief Business Office will work with fee staff at PIHCS to gain access and utilize post-payment reports to identify and correct any duplicate payments.

Planned April 30, 2010

Associated Monetary Benefits

Recommendation	Explanation of Benefits	Questioned Costs
1	Strengthened controls to prevent duplicate payments of outpatient fee claims.	$49,571
	Total	$49,571

VHA Comments

VHA concurs with the associated monetary benefits.

Veterans Health Administration
February 2010

Appendix E OIG Contact and Staff Acknowledgments

OIG Contact	Gary Abe, 206-220-6651
Acknowledgments	Ron Stucky Randy Alley Kevin Day Todd Groothuis Barry Johnson Matt Rutter Sherry Ware

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