VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Audit of Alleged Improper Payments to Providers After Veterans' Reported Deaths

March 27, 2017
16-00252-137

ACRONYMS

CBO	Chief Business Office
DMF	Death Master File
FY	Fiscal Year
HCS	Health Care System
HEC	Health Eligibility Center
NCA	National Cemetery Administration
NVC	Non-VA Care
OIG	Office of Inspector General
SSA	Social Security Administration
VA	Department of Veterans Affairs
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VistA	Veterans Health Information Systems and Technology Architecture

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Highlights: Audit of VHA's Alleged Improper Payments to Providers After Veterans' Reported Deaths

Why We Did This Audit

In September 2015, the VA Office of Inspector General received a Hotline complaint alleging that the Veterans Health Administration (VHA) paid non-VA care (NVC) providers for services that could not have been rendered because the veterans had already died. To investigate the allegation, we reviewed payment records documenting outpatient and inpatient claims worth about $15.5 million to determine whether, and to what extent, improper payments were made from FYs 2011 to 2015 for roughly 4,200 deceased veterans.

What We Found

We substantiated the allegation and found that VHA improperly paid 12 of 25 reviewed billed NVC outpatient services valued at just over $3,200. As a result, VHA made about $810 in improper payments. Based on the small amount of improper payments identified in our universe of approximately $1.5 million billed outpatient services, we estimated that VHA annually makes about $101,000 in improper payments to NVC providers for outpatient services not rendered to deceased veterans. These improper payments occurred because NVC authorization clerks at VA medical facilities failed to revise, as required by VHA policy, the end dates on NVC authorizations to reflect the veterans' dates of death.

However, we did not substantiate that VHA made improper payments for inpatient services. We found that VHA properly paid all 60 of the billed NVC inpatient services we reviewed, totaling about $890,000, on behalf of 44 deceased veterans. We found that these inpatient services had been rendered before the veterans' dates of death. Thus, we estimated that VHA properly paid NVC providers about $14.0 million for inpatient services, representing about 90 percent of the approximate $15.5 million in total payments.

We found no evidence that the improper payments identified were a systemic problem. However, if VHA does not take corrective action to ensure that NVC authorizations are updated in accordance with VHA policy, we estimated that VHA will improperly pay NVC providers around $505,000 for outpatient services over the next 5 years.

What We Recommended

We recommended that the Under Secretary for Health recover the improper payments identified in this report and ensure that VA medical facilities follow VHA policy, which requires end dates on NVC authorizations to be updated upon notification of the veterans' deaths.

Agency Comments

The Under Secretary for Health concurred with our report and provided an acceptable action plan. We will follow up on the implementation of the corrective actions.

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Objective

To determine whether the Veterans Health Administration (VHA) improperly authorized non-VA care (NVC) payments for deceased veterans.

Allegation

The VA Office of Inspector General (OIG) received a Hotline complaint in September 2015 alleging that VHA had improperly paid NVC providers for services that could not have been rendered to deceased veterans. Based on information provided by the complainant, we obtained NVC payments made in FYs 2011–2015 from VA's Fee Basis Payment data files and compared the treatment dates with veterans' dates of death reported in the Social Security Administration's (SSA) Death Master File (DMF).[1] We identified about 4,200 veterans linked to approximately $15.5 million in potential improper payments for whom the treatment dates indicated the care was provided after the date of the veterans' reported deaths. Of the approximate $15.5 million NVC payments, about $1.5 million (10 percent) and about $14.0 million (90 percent) were for billed outpatient and inpatient services, respectively.

Improper Payments Definition

The Improper Payments and Recovery Act of 2010, Public Law 111-204, defines improper payments as any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. The definition of improper payments includes any payment to an ineligible recipient or for an ineligible good or service.

Non-VA Care Claims

VA issues patients individual authorizations for care so that they may obtain services from non-VA providers for a specified time period. According to VHA guidance in "Working with the Veterans Health Administration: A Guide for Providers," providers may submit claims for payment in electronic or paper form but these claims must contain veteran and provider information, and appropriate medical coding information showing the procedures, dates of service, and corresponding charges. VA uses the Fee Basis Claims System and Veterans Health Information Systems and Technology Architecture (VistA) Fee software package (electronic payment systems) to electronically pay NVC claims. Electronic payment records are generated when claims are paid and associated with individual authorizations.

[1] NVC payment data included FY 2015 outpatient claims paid up to May 30, 2015 and FY 2015 inpatient claims paid up to June 29, 2015. These were the most recent claims available at the time we obtained the data.

RESULTS AND RECOMMENDATIONS

Finding VHA Improperly Paid a Small Number of Outpatient Non-VA Care Claims for Services Purportedly Provided after Veterans' Deaths

We found that VHA improperly paid a small number of outpatient NVC claims for services purportedly provided after veterans' deaths. We also found that no improper payments were made for inpatient services after veterans' dates of death. Overall, we reviewed a statistical sample of 85 billed NVC services (25 outpatient services and 60 inpatient services) paid for 60 deceased veterans and valued at just under $893,000.

We substantiated the complainant's allegation and found from our review of 25 NVC outpatient services, valued at just over $3,200, that 12 of the billed services were improperly paid. These 12 billed services totaling about $810 were for outpatient services that could not have been provided to 8 veterans after their deaths. These improper payments occurred because NVC authorizations for outpatient care were not updated to end on the veterans' dates of death as required by VHA Procedure Guide 1601F.02.

Thus, the NVC claims payment staff paid the erroneous claims after the veterans' dates of death because the authorizations were still valid for the treatment dates billed by the providers. Although we confirmed that VHA made improper payments, we concluded that the issue was not systemic. We did not find any instances of fraud after conducting tests, such as reviewing and examining additional billed services from the audit universe to ensure providers did not repeatedly bill for care purportedly provided after a veteran's date of death.

We did not substantiate the allegation that VHA made improper payments for inpatient services. We found that VHA properly paid all 60 of the billed NVC inpatient services totaling about $890,000 for 44 deceased veterans since the services were rendered before the veterans' dates of death. These inpatient service billings appeared to be improper payments to the complainant because he did not realize that the "treatment dates" in the electronic payment file reflected the patients' authorization dates for NVC care, not the dates the care was provided.[2]

In addition, the dates of death in the SSA DMF that the complainant relied on when he made the allegations were not always correct. Based on our review of the 60 billed inpatient services, we estimated that VHA correctly paid the inpatient services valued at about $14.0 million (90 percent) in our

[2] Information obtained during OIG's interview with complainant held on October 15, 2015.

universe of approximately $15.5 million, which also included just over $1.5 million (10 percent) in outpatient services.

Based on the small amount of improper payments identified among the approximately $1.5 million (10 percent) billed outpatient services in our universe, we estimated that VHA annually makes about $101,000 in improper payments to NVC providers for outpatient services that could not be rendered to deceased veterans.[3] VHA could reduce improper payments made to NVC providers by about $505,000 over 5 years if VHA ensured that NVC authorizations for deceased veterans were properly updated.

Improper Payments for Outpatient Services

VHA made a small number of improper payments for outpatient NVC services that could not have been rendered after veterans' dates of death. We found from our review of 25 billed NVC outpatient services, valued at just over $3,200, that 12 billed services were improperly paid for 8 veterans. As a result, VHA made about $810 in improper payments. Although we did not find any indication of fraud, these payments were improper because the services could not have been rendered to deceased veterans. The types of services billed were for recurring authorized outpatient services, such as homemaker/home health aide, home hospice, and home infusion.

Authorization End Dates Not Updated

NVC claims payment staff rely on authorization dates in VistA and the Fee Basis Claims System, to ensure that providers are rendering services during the authorized period of care, before they pay providers' bills. Of the 25 billed outpatient services we tested, NVC providers erroneously billed VA medical facilities for 12 billed services totaling about $810 as the services could not have been rendered to the 8 veterans[4] who were deceased. Moreover, VA medical facilities made these improper payments because NVC authorization clerks had not updated the dates on the NVC authorizations to reflect the veterans' dates of death, as required by VHA Procedure Guide 1601F.02.

VHA Procedure Guide 1601F.02 states that VHA will only pay for outpatient services rendered up to a veteran's date of death and requires authorizations to be updated accordingly. NVC authorization clerks are responsible for properly updating the end dates on the authorizations and can be notified of a veteran's death by an email from facility staff or a medical record alert. NVC claims payment staff review the dates of service on the submitted claims and compare them with the dates on the authorizations to ensure VHA only pays for services provided during the authorized time period. Thus, updating the end dates on NVC authorizations to reflect the

[3] We did not consider the annual improper payments to be systemic when compared to overall NVC expenditures during the same period. NVC expenditures increased from about $4.6 billion in FY 2011 to about $6.6 billion in FY 2015.
[4] There were veterans with more than one improperly paid service.

veterans' dates of death is critical to ensuring VHA does not pay bills issued in error or fraudulent billings after the veteran's death.

We found that the corresponding authorizations for the 12 improperly paid services were not updated in accordance with VHA Procedure Guide 1601F.02. The NVC providers submitted erroneous claims for services purportedly rendered after the veterans' deaths and the NVC payment clerks paid these claims because the end dates on the authorizations had not been updated to reflect the veterans' dates of death.

These two examples show how improper payments occurred after NVC authorization clerks did not update authorizations in accordance with VHA policy.[5]

Example 1

A VA medical facility had authorized a veteran to receive NVC services until November 30, 2014. However, the veteran passed away on May 27, 2014, based on the information in the veteran's electronic health record, the Veterans Benefits Administration (VBA's) Beneficiary Identification and Records Locator System, as well as a public obituary. Subsequently, the NVC homemaker/home health aide provider billed the VA medical facility for about $8,117 in services purportedly provided in May, June, and July 2014, after the veteran's death. According to the Geriatrics and Extended Care Section Chief, the program coordinator was on extended medical leave at the time. As a result, authorization staff were not notified of the death and did not update the end date on the NVC authorization to signal the veteran's date of death, as required. The VA medical facility improperly paid for these services. We learned that the vendor had begun repaying the VA medical facility for these erroneous billings before our review.

Example 2

A veteran passed away on January 18, 2014, according to information in his electronic health record, VBA's Beneficiary Identification and Records Locator System, and National Cemetery Administration (NCA) records. The electronic health record also indicated that the veteran's family notified the VA medical facility of the veteran's death on January 21, 2014. Subsequently, the NVC provider billed the VA medical facility $880 for homemaker/home health aide services purportedly provided in January, February, and March 2014, after the veteran's death. The VA medical facility paid for these services because the NVC authorization clerk had not

[5]The sampled services for the two examples totaled about $120 and $160, respectively. However, the payments presented in the report reflect all services in our universe billed by the providers after the veterans' dates of death. We only projected on the sampled services.

updated the authorization's end date of September 30, 2014, to reflect the veteran's date of death.

NVC staff at the two VA medical facilities confirmed with these vendors that they submitted the claims in error. At the time of publication, one vendor had completed repaying the erroneous billings while the other was still in the process. We concluded that these vendors were not attempting to defraud VA because we did not identify other improperly billed services or other material payments that warranted additional review. In addition, the NVC authorization staff at these VA medical facilities were aware that the end dates of authorizations needed to be updated to reflect the veterans' dates of death. However, in one case, the Geriatrics and Extended Care Section Chief stated that there was no backup staff then to receive the notifications from vendors. Now, additional staff, besides the program coordinator, receive the vendors' notifications and send the death notification emails to the authorization staff so the authorizations can be adjusted. In the other case, the Chief of Non-VA Care Coordination stated that there was a process to alert authorization staff of a veteran's death using the veteran's medical record. However, he acknowledged that the authorization staff were not notified of this veteran's death.

VA medical facilities improperly paid NVC providers approximately $810 for outpatient services that could not have been rendered to 8 deceased veterans. We did not refer these cases to the Office of Investigations because we did not identify any fraud indicators and the payments made were for a small number of veterans for nominal amounts. Furthermore, we did not detect any suspicious payment patterns, such as providers repeatedly billing for services after a veteran's date of death and confirmed that these providers were not under criminal investigation.

Although the improper payments identified totaled a small amount, they still met the Office of Management and Budget's definition of improper payments. We estimated that updating authorizations in accordance with VHA policy could help VHA reduce improper payments made to NVC providers for deceased veterans by approximately $101,000 annually. We further estimated that VHA could avoid making improper payments to providers by about $505,000 ($101,000 x 5 years) over the next 5 years if NVC authorization clerks updated authorizations as required by VHA policy.

Inpatient Services Were Properly Paid

We did not identify any cases in which VHA improperly paid for inpatient services provided to veterans after their dates of death. For 30 of the 60 services reviewed, we determined that the treatment dates for the billed NVC inpatient services in the VA's electronic payment records were related to the authorization dates for the veterans' care rather than the veterans' actual treatment dates. Thus, the information in the electronic payment records made it appear that the VA medical facilities had improperly paid for inpatient medical services provided after the veterans' deaths even though

they had not. Example 3 illustrates how VA's electronic payment record data created the appearance of improper payments.

Example 3

A VistA electronic payment record indicated that May 31, 2012 was a veteran's last treatment date for an episode of care, but the veteran's electronic health record showed he passed away on May 12, 2012 in a community nursing home. Despite the last treatment date shown in the VistA electronic payment record, NVC payment staff correctly paid the NVC provider for the days of care up to the veteran's date of death instead of the treatment date reported in the VistA electronic payment record. Thus, the VA medical facility paid the NVC provider the correct amount, $2,575.10, for the equivalent of 11 days[6] of service in May 2012, at the per diem rate of $234.10.

According to NVC managers and staff, VA's electronic payment system establishes the last treatment date in a payment record as the last day of the month or the last day of the authorization, whichever is earlier. However, NVC staff indicated that episodes of care could end before the end of the month or the last day of the authorization, such as in the case of a veteran's death. For these 30 billed inpatient services, the NVC payment clerks followed VHA Procedure Guide 1601F.02 and only paid NVC providers for services up to the date of death, or before, and not the last treatment date recorded in the payment record.

For 27 of the 60 NVC billed inpatient services, our analysis of the veterans' reported dates of death disclosed that the SSA DMF contained inaccurate information. The dates of death reported in the SSA DMF were unreliable based on our examination of information from sources such as:

- VHA's electronic medical records
- Data from VBA's Beneficiary Identification and Records Locator System and Corporate Database
- NCA's First Notice of Death and Gravesite Locator
- Public obituaries found on the internet

Example 4 illustrates how incorrect date of death information reported in the SSA DMF made it appear that VA medical facilities paid for inpatient services provided after the veterans' dates of death.

[6] The NVC authorization stated that VA pays either the first or the last day of the episode of care, but not both.

Example 4

According to the SSA DMF, a veteran passed away on March 3, 2005. The VA medical facility paid for nine services totaling about $26,300 for community nursing home and non-VA inpatient hospital services. However, the treatment dates for these services ranged from December 2011 to November 2012. Reviews of VHA, VBA, NCA records and of a public obituary showed that the veteran actually passed away on May 14, 2013. Thus, the date of death reported in the SSA DMF was incorrect by more than 8 years and the VA medical facility did not pay for services provided after the veteran's death.

Finally, our review of the last three billed inpatient services disclosed that both the reported treatment dates and the SSA DMF dates of death were incorrect and that the billed services were provided before the veterans' deaths. As a result, we found that VA medical facilities had properly paid all 60 of the reviewed inpatient services totaling about $890,000, and that the 44 veterans had received the billed services before their deaths. Therefore, we estimated that VHA correctly paid all billed inpatient NVC services valued at approximately $14.0 million (90 percent) from our universe of about $15.5 million.

Conclusion

We substantiated the allegation that VHA made improper payments for services allegedly rendered after veterans' reported deaths because we found a number of improper NVC payments for outpatient care. We found that VHA improperly paid 12 of 25 billed outpatient NVC services (valued at just over $3,200) because the authorization clerks did not update the authorizations to end on the veterans' dates of death as required by VHA policy. Consequently, VHA improperly paid about $810 for outpatient services. From the $1.5 million billed outpatient NVC services in our universe, we estimated that VHA annually makes about $101,000 in improper payments to NVC providers for outpatient services that are erroneously billed for deceased veterans. Over the next 5 years, we estimated that VA will improperly pay about $505,000 to NVC providers if NVC authorizations are not updated to end on veterans' dates of death, as required by VHA Procedure Guide 1601F.02.

In addition, we found that VHA properly paid all 60 of the billed inpatient services reviewed, totaling about $890,000 for 44 deceased veterans, because the services were rendered before the veterans' dates of death. As a result, we estimated that VHA correctly paid all of the billed inpatient NVC services, valued at approximately $14.0 million from our universe of about $15.5 million; this finding was in direct contradiction to that part of the allegation as the complainant relied on incorrect last treatment dates in the electronic payment records and/or incorrect dates of death in the SSA DMF.

Recommendations

1. We recommended the Under Secretary for Health recover the reported improper payments for outpatient services that could not have been rendered to deceased veterans.

2. We recommended the Under Secretary for Health ensure medical facilities adhere to VHA Procedure Guide 1601F.02 and update non-VA care authorization end dates for deceased veterans.

Management Comments

The Under Secretary for Health concurred with our findings and recommendations and provided an acceptable corrective action plan to implement the recommendations. Specifically, the Under Secretary for Health communicated that the Office of Community Care, in collaboration with Geriatrics and Extended Care, will recover the improper payments for outpatient services identified. In addition, the Under Secretary for Health agreed that authorization end dates should be updated to reflect the veterans' dates of death to avoid improper payments. The Office of Community Care will provide guidance and process training for updating authorization end dates to all staff who work with authorizations.

OIG Response

The Under Secretary for Health's planned corrective actions are responsive. We wish to clarify that we identified $810 in improper payments from our review of 25 billed outpatient services valued at just over $3,200 and that based on these results, we estimated there were $101,000 in improper payments in the $1.5 million NVC outpatient services billings in our universe. We will monitor implementation of the recommendations until all proposed actions are completed by the Office of Community Care in collaboration with Geriatrics and Extended Care. Appendix E provides the full text of the Under Secretary for Health's comments.

Appendix A Background

Non-VA Care

Section 1703, Title 38, United States Code, permits VA to purchase health care services when services are unavailable at VA medical facilities. According to sections 17.52 and 17.53, Title 38, Code of Federal Regulations (38 CFR §17.52 and §17.53), VA medical facilities should be the first option for providing veterans medical care. NVC should be used when the facility cannot provide services due to geographic inaccessibility or in emergencies when delays may be hazardous to a veteran's life or health. In addition, 38 CFR §17.54 requires the preauthorization of NVC treatment except for emergency care.

Chief Business Office

VHA's Chief Business Office (CBO) oversees the development of administrative processes and policy for the delivery of VA health care benefits programs to veterans. The CBO Purchased Care Office is responsible for programs such as NVC, which authorize veterans and their dependents to receive health care services external to VA.

VHA's Valid Sources for Dates of Death

According to VHA Directive 1906, valid sources to establish a veteran's date of death include:

- A VHA facility, if the person died in the facility or while under VA auspices
- A death certificate
- NCA, if the veteran received NCA benefits

On September 18, 2015, the Under Secretary for Health issued a memo clarifying guidance in VHA Directive 1906 and informing VHA staff that other types of evidence listed in 38 CFR §3.211 and §3.212 could also be used to establish a veteran's death. These regulations listed types of evidence, such as State and community public records and coroners' reports, clinical summaries signed by medical officers in U.S. controlled hospitals, and affidavits of persons with personal knowledge of the fact of the veteran's death.

Health Eligibility Center

The Health Eligibility Center (HEC) is VHA's primary source of enrollment and eligibility information and supports the delivery of VA health care benefits. Enrollment updates, including date of death information, can be made at VA medical facilities through VistA and/or the Enrollment System. The HEC is currently finalizing a sharing agreement with SSA to automatically process the DMF and feed date of death data to the VHA systems that require the information.

Appendix B Scope and Methodology

Scope

We conducted our audit work from January through December 2016. The audit universe was composed of billed NVC outpatient and inpatient services paid between FY 2011 and FY 2015 for which veterans had treatment dates in VA's Fee Basis Inpatient Payment and Fee Basis Outpatient Payment data files after the dates of death reported in SSA's DMF. This resulted in a universe of about 17,600 services billed in approximately 7,000 claims for about 4,200 veterans totaling approximately $15.5 million. To perform research and plan the scope of the audit, we visited the CBO program office in Denver, CO; the VA San Diego, CA Healthcare System (HCS); and the HEC in Atlanta, GA. In addition, we performed desk reviews of 85 statistically selected services from these VA medical facilities:

- C.W. Bill Young VA Medical Center; Bay Pines, FL
- Southeast Louisiana Veterans HCS; New Orleans, LA
- VA Boston HCS – Jamaica Plain Campus; Boston, MA
- VA Pittsburgh HCS – University Drive Campus; Pittsburgh, PA
- VA Texas Valley Coastal Bend HCS; Harlingen, TX
- Mann-Grandstaff VA Medical Center; Spokane, WA

Methodology

To accomplish our objectives, we interviewed CBO and HEC managers to obtain information about NVC payments for deceased veterans and to gain an understanding of management's role in maintaining dates of death data in VHA systems. We performed a detailed review of the 85 sampled billed services by obtaining access to the electronic payment systems and health care records at 6 VA medical facilities.

We confirmed NVC inpatient and outpatient claim information by reviewing VistA's Fee Payment modules, the Computerized Patient Record System, providers' original claims when available, and dates of death from VHA, VBA and NCA records, as well as obituaries found on the internet. We then determined whether services were rendered and improperly paid after the dates of death by reviewing claims information from the payment systems.

Lastly, we interviewed local NVC management and staff regarding date of death records, payments of NVC claims for deceased veterans, and relevant procedures to update NVC authorizations.

Fraud Assessment

The audit team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this audit. The audit team exercised due diligence in staying alert to any fraud indicators by taking actions such as:

- Reviewing and testing additional billed services from the audit universe to ensure providers did not repeatedly bill for services after a veteran's date of death
- Reviewing the number of veterans affected to determine if the providers in question improperly billed VA for many veterans
- Sending the list of NVC providers who erroneously billed for outpatient services to the OIG's Office of Investigations for review to ensure none of the providers were currently under investigation or had been investigated for fraudulent activity

We did not identify any instances of fraud during this audit.

Data Reliability

Our initial review of 884 NVC billed services identified a computer-processed data universe of potential improper payments requiring further analysis to validate whether VHA had made improper payments. Therefore, we designed audit steps to test the reliability of the entire computer-processed data universe. Our audit steps required us to perform a data reliability check for each statistical sample since we traced back the main data values of each sample to the systems where the values originated or resided. Our testing of the data values for 85 sampled services disclosed that the values were sufficiently reliable for our audit objectives and for the conclusions in this report.

Government Standards

Our assessment of internal controls focused on those controls relating to our audit objectives. We conducted this performance audit in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

Appendix C Statistical Sampling Methodology

To determine whether VHA had improperly authorized NVC payments for deceased veterans, we used statistical sampling to test billed NVC inpatient and outpatient services paid in FYs 2011–2015.

Population

We performed a review to identify NVC paid claims with treatment dates that occurred after veterans' dates of death reported in the SSA DMF. The review captured NVC claims that billed for services in separate line items depending on the date when the service took place and claims that billed for services in a lump-sum amount for a period. For example, home infusion or home health aide claims may include several billed services in each claim listed by service date while community nursing home claims bill one lump-sum amount for a month worth of services. We identified roughly 7,000 claims totaling approximately $15.5 million representing nearly 17,600 of billed services believed to have been provided to about 4,200 veterans after they had died.

Sampling Design

We developed a two-stage stratified sampling design. In the first stage, we grouped the population of billed NVC services into two strata based on total dollar amount per VA medical facility. In the second stage of the sample, we used stratified random sampling to select billed services. This sampling methodology resulted in the random selection of 85 billed outpatient and inpatient services from 81 claims totaling approximately $893,000 paid for 60 veterans at 6 statistically selected VA medical facilities. We used this method to ensure that all of the billed services had a chance of being selected; we had a representative sample; and the projections described the entire population.

Weights

We calculated estimates in this report using weighted sample data. The OIG statistician computed sampling weights by taking the product of the inverse of the probabilities of selection at each stage of sampling. Since each VA medical facility had a different number of billed services, the sampling weights varied in size. This accounts for the percentages calculated from the raw sample numbers being different from the percentages calculated from the weighted projections.

Projections and Margins of Error

The margins of error and confidence intervals are indicators of the precision of the estimates. If we repeated this audit with multiple samples, the confidence intervals would differ for each sample, but would include the true population value 90 percent of the time.

Using the point estimate of the 90 percent confidence interval, we estimated that on average VHA improperly paid about $101,000 yearly to NVC providers for outpatient services. We performed a combined 5-year statistical projection and averaged it to present a yearly estimate.

Updating NVC authorizations to properly reflect the date when veterans can no longer receive care could help VHA reduce improper payments by about $505,000 over the next 5 years. This table summarizes our projections.

Table. Yearly Estimated Number and Value of Billed Services Presumably Rendered to Deceased Veterans

VHA Paid for Outpatient Services Rendered After the Veterans' Dates of Death	Lower Limit*	Estimate	Upper Limit*	Margin of Error*
Number of Billed Services	844	1,384	1,925	541
Amount of Billed Services	$34,958	$100,822	$166,685	$65,864

Source: OIG statistical analysis performed in consultation with the Office of Audits and Evaluations statistician
Note: Rounded numbers were used for reporting purposes

**Projected using a 90 percent confidence interval*

Appendix D Potential Monetary Benefits in Accordance With Inspector General Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
2	Update authorizations in accordance with VHA Procedure Guide 1601F.02 to reduce improper payments to non-VA care providers over the next 5 years	$0	$505,000
	Total	**$0**	**$505,000**

Appendix E Management Comments

Department of Veterans Affairs Memorandum

Date: January 06, 2017

From: Under Secretary for Health (10)

Subj: OIG Draft Report, Audit of Alleged Improper Payments to Providers After Veterans' Reported Deaths (7760475)

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review the Office of Inspector General (OIG) draft report Audit of Alleged Improper Payments to Providers After Veterans' Reported Deaths. I concur with the findings in the report and provide the attached action plan to address recommendations 1 and 2.
2. We appreciate the OIG's work on this review finding approximately $810 in improper payments out of $15.5M in outpatient and inpatient claims for 4,200 Veterans. OIG further concluded that these erroneous payments do not indicate a systemic issue.
3. Similarly, we are pleased that the investigators found no instances of fraudulent billing. We take our financial processes and procedures seriously taking every precaution to safeguard the federal dollar.
4. Community Care providers are required to notify the VA Medical Center (VAMC) within one business day upon notification of a Veteran death, if care was provided under a VA authorization. The VAMC is responsible for validating date of death and updating the Master Veterans Index (MVI). The MVI populates several VA internal and external systems with this information.
5. VHA Procedure Guide 1601F.02 gives guidance that VHA will only pay for outpatient services rendered up to a Veteran's date of death and requires authorizations to be updated accordingly. Community Care authorization clerks are responsible for properly updating the end dates on the authorizations.
6. We are dedicated to sustained improvement in the GAO high risk areas. The recommendations in this report apply to high risk area 2 (inadequate oversight and accountability). VHA's Office of Community Care will collaborate with affected program offices to reinforce existing policy through national communication channels to ensure all staff working with authorizations are aware of the proper process to change an authorization end-date upon notification of a Veteran's death.
7. If you have any questions, please email Karen Rasmussen, M.D., Director, Management Review Service at VHA10E1DMRSAction@va.gov.

(original signed by:)

David J. Shulkin, M.D.

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report: *Audit of Alleged Improper Payments to Providers After Veterans' Reported Deaths*

Date of Draft Report: December 7, 2016

Recommendations/ Actions	Status	Completion Date

Recommendation 1: We recommended the Under Secretary for Health recover the reported improper payments for outpatient services that could not have been rendered to deceased veterans.

VHA Comments: Concur

VHA received the list of reported improper payments valued at $808.25. Of the 12 identified claims, OIG reports that seven payments valued at $438.87 have already been recovered. The VHA Office of Community Care (10D) in collaboration with Geriatric and Extended Care (GEC) will work with the identified facilities to recover the remaining payments valued at $369.38.

Upon completion of this action, VHA will provide recovery information for all 12 reported improper payments, to include bill of collection date, amount, and bill number.

	Status	Target Completion Date
	In process	May 2017

Recommendation 2: We recommended the Under Secretary for Health ensure medical facilities adhere to VHA Procedure Guide 1601F.02 and update non-VA care authorization end dates for deceased veterans.

VHA Comments: Concur

This recommendation is related to GAO High Risk Area 2 (inadequate oversight and accountability). VHA's actions will ensure that all medical facilities are properly following and implementing VHA policy on non-VA care authorizations.

Community Care providers are required to notify the VAMC within one business day upon receipt of a Veteran death, if care was provided under a VA authorization. The VAMC is responsible for validating the date of death and updating the Master Veterans Index (MVI). The MVI populates several VA internal and external systems with this information. VHA agrees that authorization end dates must be updated to reflect a Veteran's date of death in order to avoid improper payments and that VHA Procedure Guide 1601F.02 provides this guidance. The VHA Office of Community Care will provide updated training to all staff that work with Veteran authorizations. This training will include guidance and processes for updating the authorization end date to reflect a Veteran's date of death.

At completion of this action, VHA will provide the following documentation:

1) Slide deck containing reminder announcements for the Community Care Operations Program Office National Monthly Call and affected program offices.
2) Publications and/or communications released on this topic.

	Status	Target Completion Date
	In process	May 2017

For accessibility, the format of the documents presented in this appendix was modified to fit in this document.

Appendix F OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Appendix G Report Distribution

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