VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Review of Alleged Overpayments for Non-VA Care Made by Florida VA Facilities

June 5, 2017
15-01080-208

ACRONYMS

CBO	Chief Business Office
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
FBCS	Fee Basis Claims System
NVC	Non-VA Care
OIG	Office of Inspector General
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Website: www.va.gov/oig/hotline

Email: vaoighotline@va.gov

Telephone: 1-800-488-8244

Highlights: Review of Alleged Overpayments for Non-VA Care Made by Florida VA Facilities

Why We Did This Review

The OIG Hotline received an allegation in October 2014 that VA was paying full price for physician services to a non-VA care provider rather than paying lower contract rates, resulting in overpayments of provider claims for non-VA care.

What We Found

We substantiated the allegation that, contrary to Government regulations, Veterans Health Administration's (VHA) Florida claims processing centers did not reimburse a non-VA care provider based on the applicable Medicare rates, when appropriate. We determined that VHA payments exceeded Medicare rates in 52 of the 55 examples provided by the complainant, of which 44 (with a value of $27,010) were related to specific physician-administered drugs. The associated overpayments totaled $28,295. Based on these results, we expanded our review to all payments made by Florida VA facilities from October 1, 2012 through March 31, 2016 for these types of services.

Our review of 73,124 payments to non-VA care providers for physician-administered drugs from October 1, 2012 through March 31, 2016 identified 26,178 overpayments (35.8 percent), totaling approximately $17.2 million, ranging from $.01 to $47,943.40. Of this $17.2 million, VHA overpaid approximately $6.9 million (40.2 percent) to the provider identified in the allegation.

These overpayments occurred because VHA did not use Medicare rates for physician-administered drugs, as published by the Centers for Medicare & Medicaid Services. These funds could have been more effectively spent on veteran care.

What We Recommended

We recommended the Under Secretary for Health ensure that all payments for non-VA physician-administered drugs are made in accordance with the Code of Federal Regulations for all Veterans Integrated Service Networks. We also recommended the Under Secretary develop a plan for uploading Medicare rates into the Fee Basis Claims System (to enable the proper payment of physician-administered drug claims) and issue Bills of Collection for overpayments to non-VA care providers.

Agency Comments

VHA concurred with our recommendations and provided an action plan to address those recommendations. VHA also stated that they would provide the OIG with documentation to support completion of the action plans.

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Objective

The VA Office of Inspector General (OIG) received an allegation in October 2014 that VA was paying full price for physician services to a non-VA care provider rather than paying lower contract rates, resulting in overpayments of provider claims for non-VA care. During a subsequent discussion, the complainant stated that VA did not have a contract with this provider and, therefore, VA should have reimbursed the provider based on allowable Medicare rates because no contract or lower VA payment rate was available. The overpayments allegedly occurred in Florida, within the Veterans Integrated Service Networks (VISN) 8, potentially resulting in hundreds of VA claims payments exceeding Medicare rates.

Our initial review determined that Veterans Health Administration's (VHA) Florida claims processing centers did not reimburse a non-VA care provider in accordance with applicable Medicare rates, when appropriate. As a result, we adjusted our review to determine if Florida VA facilities overpaid other non-VA care providers for physician-administered drugs.

Non-VA Medical Care Program

The majority of veterans enrolled in the VA health care system receive care in VA-operated medical facilities, such as VA medical centers and community-based outpatient clinics. To ensure timely and accessible care for veterans, VA also has statutory authority[1] to obtain health care services from non-VA care providers. VA created the Non-VA Medical Care Program to purchase medical services from community health care providers when services are not readily available from a VA medical facility. The Code of Federal Regulations (CFR) in Title 38 §17.56, *Payment for Inpatient and Outpatient Health Care Professional Services at Non-Departmental Facilities*, allows for VA reimbursement of physician-administered drugs in accordance with Medicare pricing schedules. Effective October 1, 2014, the VA Secretary transferred the authority to pay non-VA care claims from the Veterans Integrated Service Networks to the Chief Business Office for Purchased Care. Consequently, claims processing personnel report to the Chief Business Office (CBO).

Payment Processing

The CBO uses the Fee Basis Claims System (FBCS) to process and pay non-VA medical care claims. FBCS enables the CBO to upload various pricing schedules, including Medicare rates, for use in determining the claims payment amount. CBO claims processors use this system to determine the amount payable for non-VA care claims. When Medicare pricing is not available in FBCS, VA typically pays billed or VA fee schedule amounts.

[1] Title 38 United States Code 1703; Title 38 CFR §17.52-17.56

RESULTS AND RECOMMENDATIONS

Finding VA Overpaid for Physician-Administered Drugs Related to Non-VA Medical Care

We substantiated the allegation that the VHA's Florida claims processing centers did not reimburse a non-VA care provider in accordance with applicable Medicare rates, when appropriate. We found that VHA payments exceeded Medicare rates in 52 of the 55 examples provided by the complainant, of which 44 (approximately $27,010) were for specific physician-administered drugs. Overpayments totaled $28,295. Based on these results, we expanded our review to all payments made by Florida VA facilities for these physician-administered drugs occurring from October 1, 2012 through March 31, 2016.

Our review of 73,124 payments to non-VA care providers for physician-administered drugs from October 1, 2012 through March 31, 2016 identified 26,178 overpayments (35.8 percent), totaling approximately $17.2 million, with individual overpayments up to $47,943. The median overpayment amount was $37.28. Of this $17.2 million, VHA overpaid approximately $6.9 million (40.2 percent) to the provider identified in the allegation.

These overpayments occurred because VHA did not utilize Medicare payment rates for physician-administered drugs. Medicare rates for physician-administered drugs, as published by the Centers for Medicare & Medicaid Services (CMS), are not uploaded by CBO into VHA's FBCS. As a result, VHA overpaid claims by approximately $17.2 million to non-VA care providers.

Payment Criteria for Outpatient Non-VA Care

Title 38 CFR §17.52, *Hospital Care and Medical Services in Non-VA Facilities,* authorizes VA to pay for non-VA care when VA facilities are not capable of economically furnishing medical services, when VA care is geographically inaccessible, or when VA is not capable of furnishing the care. Title 38 CFR §17.56 describes the requirement for VA to reimburse providers for health care professional services using, in the absence of a contract or negotiated agreement, the lower of: 1) published Medicare rate; 2) non-VA provider's billed charge; or 3) local VA fee schedule amount. This regulation does not specifically mention an exception or waiver that exempts paying Medicare rates for physician-administered drugs.

VA addressed this payment methodology in a memo issued by the Deputy Under Secretary for Health for Operations and Management on May 16, 2011. The memo announced VHA's adoption of the methodology outlined in 38 U.S.C. 1703 and 1728 for outpatient claims; it also provided implementation guidance for VA claims processors.

Analysis of Claims Provided by Complainant

In October 2014, the OIG received a Hotline complaint that VHA overpaid a provider by as much as $100,000 for non-VA care since June 2013. The complainant provided us with 55 examples of alleged VA overpayments that occurred in Florida. In accordance with 38 CFR §17.56, in the absence of a contract or negotiated rate, the proper payment amount would be the lower of: the published Medicare rate, the non-VA provider's billed charge, or a local VA fee schedule amount.

We found that VA payments exceeded Medicare rates in 52 of the 55 examples, totaling $28,295. Forty-four (approximately $27,010) of those 52 overpayments were for physician-administered drugs. Our review of these 55 claims payments included:

- Comparing VA data with actual claims documents, which reflected billed charges as well as amounts paid
- Comparing the actual paid amounts to the published Medicare rates
- Reviewing each step of the payment process in FBCS with Orlando non-VA medical care payment personnel to confirm these overpayments

The finding of a proportionately high occurrence of overpayments led us to consider that this problem might not be limited to the single provider named in the complaint. Therefore, we expanded our scope to payments for physician-administered drugs made by Florida VA facilities to other non-VA care providers. Because these overpayments may have occurred as early as 2013, we obtained data on payments made from October 1, 2012 through March 31, 2016.

Non-VA Care Providers in Florida

Our review of 73,124 payments to non-VA care providers for physician-administered drugs from October 1, 2012 through March 31, 2016 identified 26,178 overpayments (35.8 percent), totaling approximately $17.2 million, with individual overpayments up to $47,943. The median overpayment amount was $37.28. Of this $17.2 million, VHA overpaid approximately $6.9 million (40.2 percent) to the provider identified in the allegation, due to VA not following payment guidelines in accordance with 38 CFR §17.52.

To identify these overpayments, we selected the most frequently billed physician-administered drugs and then obtained payments made by Florida VA facilities to non-VA care providers for those drugs. We compared this payment population against published Medicare rates applicable at the time of payment to identify overpayments.

Examples of calculated overpayments are shown in this table.

Table Example of Overpayment Calculations

Date of Service *(2014)*	CPT Code	Amount Paid by VHA	Medicare Payment Amount	Overpayment
June 4	J9033	$8,050	$3,736	$4,314
June 16	J9035	$24,000	$10,492	$13,508
September 30	J9263	$15,000	$339	$14,661

Source: VA OIG analysis of FBCS claims payments

To confirm our analysis, we provided NVC management with a selection of 20 non-VA claims payments, of which we had determined that 19 were overpayments. We asked NVC management to review our calculations for assessing payment accuracy.

NVC management agreed with our payment calculations for the 19 overpayments, provided Medicare rates were used for payment. The payment accuracy for the remaining claim, billed as J3490,[2] was not determined because there was not a corresponding published Medicare rate for this Current Procedural Terminology (CPT) code; therefore, we excluded this code from our calculations of overpayments. Code J3490 is a non-specific code that should be used only when another J-code does not describe the drug being administered (that is, CMS has not assigned a specific J-code to the drug used). All 13,342 transactions using the billing code J3490 were subsequently excluded from our review because Medicare has not assigned a payment amount for drugs with that code. No J3490 transactions were included in the 73,124 payments reviewed.

CBO Did Not Comply With VA's Adoption of Medicare Payment Methodology

NVC management stated that when CBO took over management of the non-VA health care claims payment process, in October 2014, it provided guidance to claims processors not to pay Medicare rates for physician-administered drugs.

CBO Purchased Care management stated that Medicare rates did not apply to VA payment of physician-administered drugs but were unable to provide us with support for why 38 CFR §17.56 did not apply. However, on May 16, 2011, the Deputy Under Secretary for Health for Operations and Management issued a memo directing all VISN directors to implement the

[2] The Healthcare Common Procedure Coding System (HCPCS) Current Procedural Terminology (CPT) codes associated with physician-administered drugs generally begin with a "J" and are commonly referred to as J-codes. These physician-administered drugs include injectable drugs that ordinarily cannot be self-administered, chemotherapy drugs, immunosuppressive drugs and inhalation solutions, and some orally administered drugs.

Medicare payment methodology for non-VA outpatient care. The memo did not specifically include Medicare schedules for physician-administered drugs. The Deputy Under Secretary further stated that before the full implementation of this guidance, manual pricing of these claims would be required.

We learned that the Orlando NVC claims processing site had a workaround solution using a printed list of physician-administered drugs with corresponding drug prices, prior to aligning under the CBO. This manual pricing process was subsequently abandoned at the direction of CBO management.

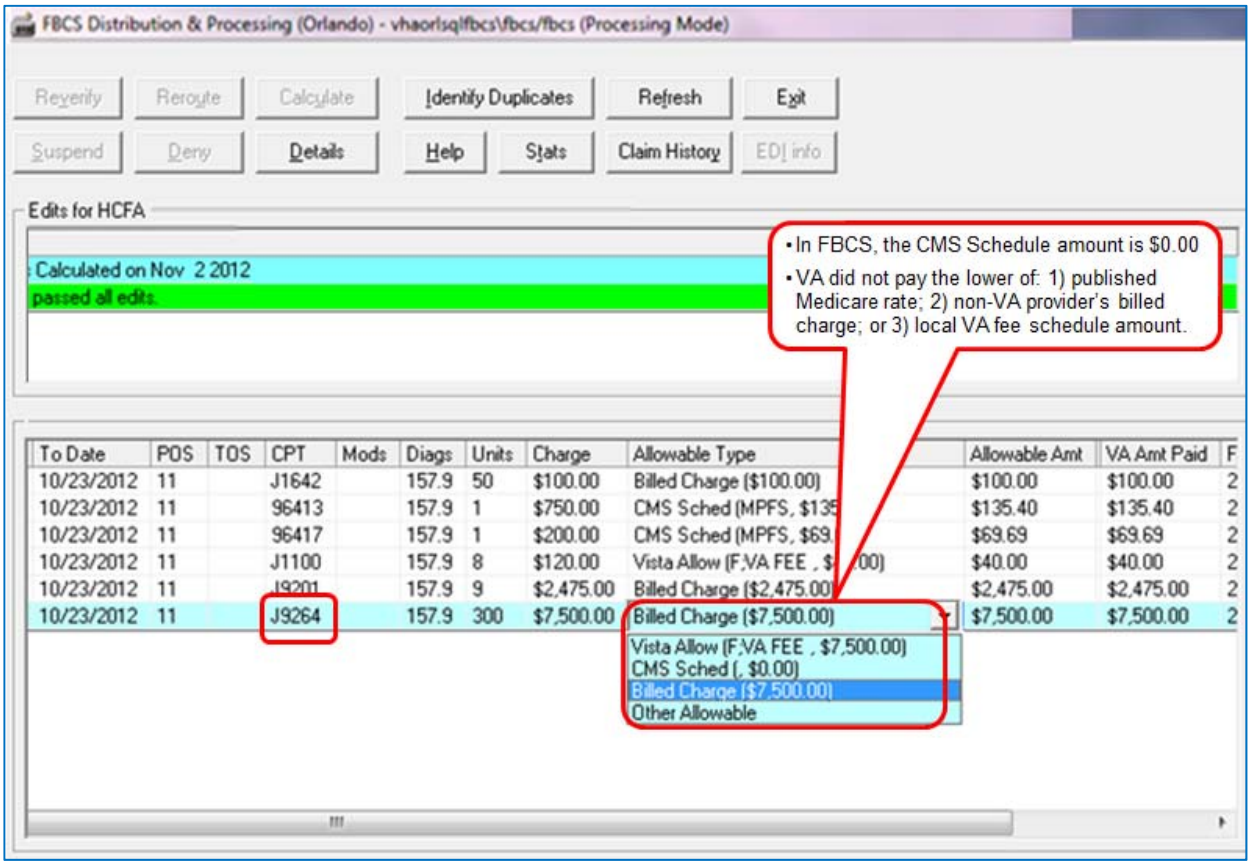
In the absence of a contract or negotiated rate with the non-VA care provider, FBCS provides the claims payer with three reimbursement options when choosing the payment amount. NVC management stated there were no contracts related to physician-administered drugs. The claims payer is expected to choose the lowest amount from these payment options:

- VA fee schedule
- CMS Medicare rates
- Billed charge

Medicare Rates Not Loaded Into FBCS

FBCS allows claims payers to select from a drop-down list of pre-loaded rates for most CPT codes. However, Medicare rates (shown as "CMS Sched") for physician-administered drugs are not pre-loaded into FCBS. Consequently, the CMS schedule amount in FBCS defaults to $0.00. The example below shows that VHA paid the "Billed Charge" of $7,500.00 for a claim for 300 units of the drug coded as J9264. The Medicare rate for this physician-administered drug is $9.59 per unit. This resulted in an overpayment of $4,622.70 because the available payment amount for this service is higher than the published Medicare rate.

Figure. Image of FBCS Claim Payment Options



Source: FBCS screen print of a claim processed on Nov. 2, 2012 and obtained on April 29, 2015

Why This Occurred

The overpayments occurred because VHA did not pay non-VA claims for physician-administered drugs using Medicare rates, which are lower than the billed charges paid. Proper payment could be achieved by uploading appropriate rates to VA's FBCS. Title 38 CFR §17.56 states that, in the absence of a contract or negotiated rate, VA pay no more than the lowest of the published Medicare rates, a VA fee schedule amount, or the billed charges.

Conclusion

We substantiated the allegation that VHA overpaid claims for non-VA care for physician-administered drugs to a non-VA care provider. Our review of claims payments found overpayments totaling approximately $17.2 million to non-VA care providers from October 1, 2012 through March 31, 2016. These VA resources could have been more effectively spent on veteran care. Our review of the VHA claims payments indicated that claims were processed as instructed by management.

Recommendations

1. We recommended the Under Secretary for Health develop and implement a plan to ensure all non-VA physician-administered drugs (other than orally administered) are paid in accordance with the Code of Federal Regulations.

2. We recommended the Under Secretary for Health develop a plan for uploading Medicare rates into the Fee Basis Claims System to enable the proper payment of physician-administered drug claims.

3. We recommended the Under Secretary for Health issue bills of collection, as necessary and in accordance with VA policy, to recover physician-administered drug overpayments made by Florida VA facilities.

Management Comments

VHA agreed with our findings and recommendations. VHA has reached out to the FBCS software contractor, Document Storage Systems, Inc., to obtain the additional software and schedules necessary to price physician-invoiced, physician-administered drugs according to Medicare pricing requirements. Further, VHA will take steps to ensure all payment locations understand the standardized procedures for these payments. Standard operating procedures and other related instructions and trainings will be updated to reflect the utilization of applicable Medicare Drug Schedules and how to properly price physician-invoiced, physician-administered drug charges. VHA stated that they would provide documentation to the OIG upon the completion of its action plan.

Staff will receive refresher training to ensure they understand these updated processes. In addition, VHA will establish and implement appropriate quality measures to ensure voucher examiners adhere to these processes. VHA will alert voucher examiners to the newly added pricing software, provide training, and implement appropriate quality measures to ensure voucher examiners properly price all invoices for non-VA physician-administered drugs. Finally, VA will also develop a remediation plan for overpayments associated with physician-injectable drugs.

OIG Response

VHA's comments and corrective action plans are responsive to the intent of the recommendations. We will monitor implementation of planned actions and will close recommendations when we receive sufficient evidence demonstrating progress in addressing the issues identified.

Appendix A Scope and Methodology

OIG Data Analysis of 55 J-code Claims Provided by the Complainant

Our review, conducted from April 2015 to February 2017, began with an analysis of 55 alleged overpayments identified by the complainant for service dates ranging from April 2012 to January 2014. We determined that VHA payments exceeded Medicare rates in 52 of the 55 examples provided by the complainant, with overpayments totaling $28,295. The 55 examples included 21 unique J-codes. The Healthcare Common Procedure Coding System uses CPT codes associated with physician-administered drugs that generally begin with a "J" and are commonly referred to as J-codes. These services include injectable drugs that ordinarily cannot be self-administered such as chemotherapy drugs, immunosuppressive drugs, inhalation solutions, and some orally administered drugs.

Following this assessment, we identified 20 paid J-codes based on frequency of occurrence and 20 paid J-codes based on amount paid, resulting in a selection of 40 codes. We then added these to the original 21 unique codes provided by the complainant for a total of 61 J-codes. After removing duplicates, 36 unique J-codes out of 532 possible CMS codes were identified for our review. Because we chose not to limit our scope to this particular provider, we reviewed payments for similar CPT codes made by Florida VA facilities to all non-VA care providers to determine if the issue also occurred with other providers.

Having selected all payments made by Florida VA facilities for these J-codes occurring from October 1, 2012 through March 31, 2016, we identified the non-VA care providers based on payment data. We then downloaded applicable quarterly Medicare rates for the 36 J-codes identified. The applicable Medicare rates were matched against 73,124 claims paid by VA. This matching process identified the existence and amount of VA overpayments.

We reviewed applicable criteria including Federal laws and regulations, VA policies and procedures, and other payment guidelines related to physician-administered drugs. We obtained background information from VISN officials on the roles of management and the transition of oversight of the Non-VA Medical Care Program to the CBO. We also conducted a site visit at the Orlando NVC claims processing site to observe, document, and flowchart the claims payment process.

OIG Data Analysis of Non-VA Care Paid Claims

We obtained MedSAS[3] data for the most prevalent and highest dollar-amount CPT codes paid to non-VA care providers from October 1, 2012 through March 31, 2016. These data included

[3] MedSAS, is a collection of datasets containing patient demographics, care utilization, diagnosis, and treatment information. MedSAS is sourced from VistA, VA's system for electronic health records.

699,747 MedSAS records encompassing 87 CPT codes, in seven VA facilities, with payments totaling approximately $105.4 million. We excluded 69,879 records, with payments totaling approximately $7.6 million, for the VA Gulf Coast Veterans Health Care System because they included payments by non–Florida VA facilities.

We also excluded 555,954 records that were not related to J-code services or were for a J-code that did not have a corresponding Medicare rate. Our data contained 790 records totaling $115,814 in payments to one provider with a contract. We asked the CBO to confirm whether other contracts covering physician-administered drugs in Florida existed. We were advised that no other such contracts existed. Consequently, we excluded these records from our review. This reduced the universe of records to 73,124, totaling approximately $46.3 million in payments. We compared the amounts VA paid for these J-codes with the corresponding Medicare rates that are published quarterly.

Data Reliability

We used computer-processed data from MedSAS to address our review objective. We assessed whether our data were complete by comparing the range of the dates of service, place of service, and CPT codes requested to the data provided. We selected 25 claims payments and tested the accuracy of the MedSAS dataset by comparing it to the FBCS screen and the original health insurance outpatient claim form (CMS 1500). We found no differences among these three data sources.

Although we identified and removed the one contractor's payments from our analysis, the data did not contain complete information regarding contract payments. We discussed this issue extensively with CBO management, which again stated that, during our period of review, only one provider contract existed for the payment of physician-administered drugs. Based on our testing of claims data and assertions from CBO management, we concluded the data were appropriate and sufficient for our review purposes.

Fraud Assessment

We assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this review. We exercised due diligence in staying alert to any fraud indicators by soliciting the OIG's Office of Investigations for indicators. Our review of the VHA claims payments indicated that claims were processed as instructed by management.

Government Standards

We conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.*

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

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
1	Estimated overpayments from October 2012 through March 2016	$0	$17.2 million
	Total	**$0**	**$17.2 million**

Appendix C Management Comments

Department of Veterans Affairs Memorandum

Date: May 3, 2017

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report, Review of Alleged Overpayments made by Florida VA Facilities (VAIQ 7781380)

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

1. Thank you for the opportunity to review the Office of Inspector General (OIG) draft report, Review of Alleged Overpayments made by Florida VA Facilties. I concur with OIG recommendations 1 and 2, and concur in principle with recommendation 3. I provide the attached action plan to address these recommendations.

2. VHA validated that VISN 8 facilities made some overpayments for physician injected drugs, but needs to conduct a further detailed review, particularly of invoices from physicians that included physician injected drugs as a professional charge.

3. VHA's Fee Basis Claims System (FBCS) pricing software currently contains Medicare pricing algorithms for non-VA physician-administered drugs (other than orally administered) for charges invoiced by a facility on a facility invoice. VHA has reached out to the FBCS software contractor, Document Storage Systems, Inc, (DSS) to obtain the additional software and schedules necessary to price physician invoiced physician-administered drugs according to Medicare pricing requirements. The purchase of the FBCS Medicare Drug Average Sales Price Schedule will ensure its availability for pricing physician invoiced charges properly.

4. VA has developed a corrective action plan for the issues and resultant overpayments associated with physician injectable drugs.

5. VHA has also established a major new initiative to strengthen VHA's ability to combat fraud, waste and abuse (FWA). The initiative is aligned with the President's pledge to investigate fraudulent activities and root out corruption. VHA Procurement and Logistics has assigned two representatives as part of the FWA team to help combat FWA across VHA.

6. If you have any questions, please email Karen Rasmussen, M.D., Director, Management Review Service at VHA10E1DMRSAction@va.gov.

(original signed by:)

Poonam Alaigh, M.D.

Attachment

For accessibility, the format of the original document in this attachment has been modified to fit in this document.

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report: Review of Alleged Overpayments made by Florida VA Facilities

Date of Draft Report: February 27, 2017

Recommendations/ Actions	Status	Completion Date

Recommendation 1: We recommended the Under Secretary for Health develop and implement a plan to ensure all non-VA physician-administered drugs (other than orally administered) are paid in accordance with the Code of Federal Regulations.

VHA Comments: Concur. This recommendation is related to GAO High Risk Area 1, Ambiguous Policies and Inconsistent Processes.

VHA's Fee Basis Claims System (FBCS) pricing software currently contains Medicare pricing algorithms for non-VA physician-administered drugs (other than orally administered) for charges invoiced by a facility on a facility invoice. However, the FBCS pricing software does not currently have the necessary pricing algorithms to calculate the Medicare rate when charges are billed via a physician's invoice as a professional charge. When the FBCS pricing software does not return a Medicare rate, either because there is not an applicable Medicare rate or because the FBCS pricing software does not have the applicable algorithm for a billed code, Voucher Examiners follow VA's payment regulations and VHA guidance applicable in the absence of a Medicare rate. In the case of physician administered drugs billed on a physician's invoice, this results in payments that exceed the applicable Medicare rate.

VHA has reached out to the FBCS software contractor, Document Storage Systems, Inc, (DSS) to obtain the additional software and schedules necessary to price physician invoiced physician-administered drugs according to Medicare pricing requirements. The purchase of the FBCS Medicare Drug Average Sales Price Schedule will ensure its availability for pricing these types of charges properly.

VHA will take steps to ensure all payment locations understand the standardized procedures for these payments. Standard operating procedures, other related instructions and trainings will be updated to reflect the utilization of applicable Medicare Drug Schedules and how to properly price physician-invoiced physician-administered drug charges. Staff will receive refresher training to ensure they understand these updated processes. In addition, VHA will establish and implement appropriate quality measures to ensure Voucher Examiners adhere to these processes.

At completion, the Office of Community Care will provide the following documentation:

1. 100 percent deployment confirmation of the pricing software associated with the Medicare Drug Average Sales Price Schedule

2. Evidence that Voucher examiners have been made aware of and are properly utilizing the added pricing software.

Status	Target Completion Date
In process	October 2017

Recommendation 2: We recommended the Under Secretary for Health develop a plan for uploading Medicare rates into the Fee Basis Claims System to enable the proper payment of physician-administered drug claims.

VHA Comments: Concur. This recommendation is related to GAO High Risk Area 1, Ambiguous Policies and Inconsistent Processes.

As discussed above, VHA will work with DSS to obtain the pricing software associated with the Medicare Drug Average Sales Price Schedule to price professional charges as invoiced on a physician bill. Once the new software is ready for deployment, VHA will alert Voucher Examiners to the newly added pricing software, provide training, and implement appropriate quality measures to ensure Voucher Examiners properly price all invoices for non-VA physician-administered drugs.

At completion, the Office of Community Care will provide the following documentation:

1. 100 percent deployment of pricing software associated with the Medicare Drug Average Sales Price Schedule

Status	Target Completion Date
In process	October 2017

Recommendation 3: We recommended the Under Secretary for Health issue bills of collection, as necessary and in accordance with VA policy, to recover physician-administered drug overpayments made by Florida VA facilities.

VHA Comments: Concur in principle. This recommendation is not related to a GAO High Risk Area.

VHA's Office of Community Care attempted to validate the OIG findings by conducting a partial review of claims with dates of service in 2012-2016 that contained J-codes billings which capture the physician administered drugs. Our review was conducted from February 28, 2017- March 6, 2017. Our review was high level, matching data points to find obvious overpayments and obvious proper payments. We also supported our review with a detailed, line item spot check of randomly selected claims.

VHA has validated that Region 2, VISN 8 facilities made some overpayments for physician administered and injected drugs but needs to conduct further detailed review, particularly of invoices from physicians that included physician injected drugs as a professional charge. When that review is completed, VHA will provide the results to OIG. VA will also develop a remediation plan for overpayments associated with physician injectable drugs.

At completion, the Office of Community Care will provide the following documentation:

1. Results of VHA review to mitigate and validate findings to ensure OIG and VHA are in agreement regarding claims processing accuracy associated with the scope of this review.

2. Evidence of VHA plan for remediation of overpayments and/or other appropriate actions for recovery of overpayments in accordance with VA Policy.

Status	Target Completion Date
In process	December 2017

Appendix D OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Murray Leigh, Director Tesia Basso Nathan Fong Kimberly Nikravesh D. Stephen Nose Athenia Rosolowski

Appendix E Report Distribution

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This report is available on our website at www.va.gov/oig.