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VETERANS HEALTH ADMINISTRATION

Non-VA Emergency Care
Claims Inappropriately
Denied and Rejected

AUDIT

REPORT #18-00469-150

AUGUST 6, 2019



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Executive Summary

When veterans receive emergency care at non-VA facilities, they can file for reimbursement of non-VA emergency care costs. If claims are denied or rejected, non-VA facilities and providers can bill the veterans for some or all the costs of the emergency care services provided.

A September 2017 request from then Representative Tim Walz (Minnesota) expressed a concern about claims processors denying veterans' non-VA emergency care claims to meet production goals and receive incentives such as high performance ratings and bonuses.¹ The VA Office of Inspector General (OIG) conducted this audit to determine whether processors of non-VA emergency care claims inappropriately denied or rejected the claims, and if so, whether the cause was pressure to meet production standards.

A Significant Number of Denied and Rejected Claims Were Inappropriately Processed, Some Leading to Wrongful Denials and Rejections

VA personnel who process payments of claims for medical care obtained outside VA are from the Claims Adjudication and Reimbursement Directorate (CAR) in the VA's Office of Community Care (OCC). The audit team's nationwide accuracy review found that an estimated 31 percent of denied or rejected non-VA emergency care claims were inappropriately processed by CAR staff.² Denied and rejected claims could shift the financial burden of non-VA care from VA to the veteran. Under regulations, when a claim is "denied" it is because there is not a basis for a payment, but a claim may also be "rejected," which means that it cannot be decided until the claimant provides additional or corrected information.³ When CAR denies a claim, the claimant may have to pay out of pocket for his or her emergency care.

The billed amount of inappropriately processed claims from April 1 through September 30, 2017, that were denied or rejected was large in the aggregate—an estimated \$716 million—and presented potential undue financial risk to an estimated 60,800 veterans. The audit team could not determine whether providers billed veterans for inappropriately processed claims that VA did not reimburse. However, the risk of undue financial burden remained for individuals who could ultimately be billed by the non-VA provider for their episode of emergency care. Although

¹ Throughout this report, claims processors are generally referred to as voucher examiners.

² The audit team assessed 240 denied or rejected non-VA emergency care claims that were scanned or electronically received from April 1 through September 30, 2017, and processed under 38 U.S.C. § 1728 (unauthorized claims) or § 1725 (Millennium Bill claims).

³ A claimant can be the veteran or a non-VA provider or facility.

claimants can appeal denied claims, CAR was not effectively monitoring veterans' appeals of non-VA emergency care claims decisions.

While not all claims-processing errors resulted in inaccurate decisions, the audit revealed that a portion of those denied and rejected claims should have been approved. The OIG estimated that about 17,400 veterans, with bills totaling at least \$53.3 million, were negatively affected during the audit period. The OIG estimated that if corrective actions are not taken, these errors could result in \$533 million in improper underpayments to claimants over five years.⁴

The remaining processing errors are also significant, as claimants did not receive complete and accurate information regarding why their claims were not approved. In other words, the procedural errors created a risk that claimants could not effectively respond with necessary information to obtain claim approval and payment.

OCC's CAR Culture Created Pressure for Timely Production

The audit found that the OCC's CAR placed more emphasis on the number of claims processed than the accuracy of the claims decisions. Prioritizing production over quality stemmed from a backlog of unprocessed claims more than 30 days old, which OCC and CAR leaders tried to reduce. At the start of fiscal year (FY) 2016, the inventory of aged claims was about 482,000 claims out of 1.7 million (28 percent).⁵ The initial goal in 2016 was to process and pay at least 85 percent of authorized non-VA care claims within 30 days (and 45 days for unauthorized non-VA emergency care claims) and reduce the claims backlog to less than 10 percent of the total inventory. By 2017, that goal increased to 98 percent of claims. Even with these goals, Veterans Health Administration (VHA) data showed the inventory of aged claims had increased to 36 percent of all claims by November 2018.

To address the congressional request, the audit team conducted interviews with 182 CAR staff and leaders, reviewed survey responses from 435 CAR staff, assessed 180 denied and 60 rejected non-VA claims that were scanned or electronically received during the audit period, and reviewed relevant email records. Since at least December 2016, OCC and CAR leaders have discussed and developed strategies to process more claims.⁶ Interviews revealed that voucher examiners received a work-production credit when they rejected or denied a claim, or sent the claim for payment, but did not receive credit for researching the claim and then suspending it for clinical review.

⁴ To project the monetary benefit over the next five years, the audit team multiplied the estimated financial impact during the six-month period to obtain a yearly rate.

⁵ Aged claims are authorized claims over 30 days old and unauthorized claims over 45 days old.

⁶ Appendix A provides additional details on instances of concerted claims-processing efforts, and the emphasis on timeliness, to meet goals and reduce backlogs.

Interviews and survey responses showed that some voucher examiners were verbally directed or encouraged to deny non-VA emergency claims to meet production standards. Additionally, some examiners who had not been directly encouraged to reject or deny claims responded that they still felt the CAR culture created “systemic pressure to favor speed over accuracy.” Overall, the responses showed that the claims-processing environment focused on production and prioritized quantity over quality.

Through interviews, the audit team identified factors in CAR’s claims-processing environment that staff considered to be incentives (such as overtime and telework privileges) that were tied to meeting or exceeding production targets. OCC policy instructs supervisors to authorize overtime only to examiners who meet performance standards. Examiners felt that supervisors incentivized overtime opportunities based on production outcomes. Similarly, telework opportunities were tied to the quantity of claims processed. Examiners who did not consistently meet the production numbers were not considered for overtime and had their telework privileges removed. Examiners also earned bonuses when they exceeded performance standards. The FY 2017 annual bonuses awarded to eligible voucher examiners at general schedule-4 (GS-4) through GS-6 pay levels were \$500 for an outstanding rating and \$350 for an excellent rating. Although performance ratings are directly tied to performance bonuses, the OIG did not find that performance bonuses were a driving factor for examiners to inappropriately process claims to meet production standards. While production standards were tied directly to performance evaluations and overtime and telework opportunities, accuracy standards did not hold a similar weight.

CAR Lacked Sufficient Quality Controls

Senior voucher examiners were held to a production standard of processing 13 unauthorized or Millennium Bill (Mill Bill) claims per hour to receive a fully successful performance rating, and 15 of these claims per hour to receive an exceptional rating.⁷ The accuracy performance standard required processing 96.5 percent of claims accurately to receive a fully successful rating and 98.5 percent to receive an exceptional rating. The audit found that standards for accurate claims processing were unofficial and inconsistently monitored from region to region. Even though performance evaluations for voucher examiners included an accuracy standard, CAR did not have an accuracy assessment policy or standardized practice. These accuracy standards were inconsistently applied because they were based on supervisory review and spot checks for potential errors at the local level.

Nearly half the voucher examiners who responded to the audit team’s survey said they were not aware of supervisors reviewing any of their claims for accuracy. Furthermore, voucher

⁷ Unauthorized claims are for reimbursement of unauthorized care for veterans with service-connected disabilities that meet certain administrative and clinical eligibility requirements under 38 U.S.C. § 1728. Millennium Bill claims are for reimbursement of unauthorized care for veterans with nonservice-connected disabilities that meet certain administrative and clinical eligibility requirements under 38 U.S.C. § 1725.

examiners reported that the production and accuracy standards at the fully successful level were too high and did not allow enough time to do a thorough and complete job of assessing claims. Because, according to CAR data, nearly 80 percent of unauthorized and Mill Bill claims are denied or rejected, it is especially important that they be denied or rejected for accurate reasons.

Additional Barriers Affected Claims Processing

Clear communication about claims status is critical for veterans to respond to denials and rejections in a timely manner. However, during the course of the audit, the OIG team found a significant backlog in mail processing that created a risk that veterans would not be informed of a claims decision or would be informed too late to resubmit or appeal. Backlogs at three facilities showed stacks of unsent claims decision letters printed between one and two months prior to the OIG site visits. The outgoing mail typically included claim rejection and denial letters that needed time-sensitive responses, such as updating claim information or appealing a denial.

Finally, since FY 2017 the OCC experienced several leadership changes, including three CAR directors. While the findings in this report cannot be tied directly to the lack of stability in key leadership positions, it provided the context in which problems were allowed to continue without remediation.

VHA's Recent Actions

During this audit, the OIG team provided interim briefings to CAR leaders. In May 2019, VHA officials reported to the audit team that they had implemented process improvements and initiatives that affect claims processing nationwide and the environment in which claims are processed. The changes that VHA reported include standardizing denial and rejection reasons, reviewing denial and rejection reasons on clinical decisions, offering regular training, and developing plans and strategies that focus on quality. The OIG has not verified the implementation of these actions.

What the OIG Recommended

The audit team concluded that there was a significant risk that some of the errors identified resulted from the environmental pressure to meet production targets, insufficient quality assurance of claims-processing accuracy, and incentives that were associated with meeting production targets.

The OIG made 11 recommendations to improve the accuracy of non-VA emergency claims processing, including recommendations to address the culture of prioritizing claims productivity over accuracy, improve performance evaluation standards and review processes, tie incentives to all performance standards rather than just production quantity, reevaluate inappropriately processed claims, and improve internal and external communication about claim status.

Management Comments

The Executive in Charge, Office of the Under Secretary for Health, concurred with recommendations 1–4, 7–9, and 11; concurred in principle with recommendations 5, 6, and 10; and submitted acceptable corrective action plans for all recommendations. The OIG will monitor implementation of planned actions and will close the recommendations when VA provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.



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Contents

Executive Summary	i
Abbreviations	viii
Introduction	1
Results and Recommendations	6
Finding 1: A Significant Number of Denied and Rejected Claims Were Inappropriately Processed, Some Leading to Wrongful Denials and Rejections	6
Impact of Inappropriate Processing	7
Evidence and Examples of Inappropriately Processed Claims and Wrongful Denials	7
Recommendations 1–4	14
Finding 2: OCC’s CAR Culture Created Pressure for Timely Production	17
Recommendations 5–8	24
Finding 3: CAR Lacked Sufficient Quality Controls Over Denied and Rejected Claims	26
Recommendation 9	28
Finding 4: Additional Barriers Affected Claims Processing	30
Recommendations 10–11	33
Appendix A: Timeline of OCC Efforts to Meet Claims-Processing Goals	36
Appendix B: Background	39
Appendix C: Scope and Methodology	45
Appendix D: Statistical Sampling Methodology	47

Appendix E: Potential Monetary Benefits in Accordance with Inspector General Act
Amendments51

Appendix F: Survey Results52

Appendix G: Management Comments.....57

OIG Contact and Staff Acknowledgments69

Report Distribution70

Abbreviations

CAR	Claims Adjudication and Reimbursement
CFR	Code of Federal Regulations
eCAMS	Electronic Claims Adjudication Management System
FBCS	Fee Basis Claims System
FY	fiscal year
GAO	Government Accountability Office
GS	General Schedule
OCC	Office of Community Care
OIG	Office of Inspector General
U.S.C	United States Code
VACC	VA Community Care
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

When a veteran receives emergency care at a non-VA facility, the claimant can file for reimbursement of non-VA emergency care costs. The claimant requesting payment or reimbursement may be the provider of care, the veteran who paid for the treatment, or a person or organization that paid for such treatment on behalf of the veteran. The VA Office of Inspector General (OIG) conducted this audit to determine whether VA medical claims processors in the Veterans Health Administration (VHA), Office of Community Care (OCC), inappropriately denied or rejected non-VA emergency care claims, and if so whether the cause was pressure to meet production standards.

The OIG initiated this audit in 2017 at the request of then Congressman Tim Walz (Minnesota), the former Ranking Member of the U.S. House of Representatives' Committee on Veterans' Affairs. Senator Tammy Baldwin (Wisconsin) and then Senator Claire McCaskill (Missouri) made similar requests. The congressional requests asked the OIG to investigate whether VA OCC's production standards incentivize employees to deny non-VA emergency care claims, and whether employees were directed or encouraged by VA managers to deny veterans' claims in order to meet production standards. Then Congressman Walz was concerned that VA's OCC "has created perverse incentives for its claims processors to deny veterans' emergency care claims to meet production goals and in turn receive high performance appraisal ratings and bonuses."

The OIG concluded that an estimated 31 percent of denials and rejections were inappropriately processed during the review period, and that undue production pressures combined with lack of effective quality assurance measures were the cause. This inappropriate processing led to a significant number of claims being denied or rejected that should have been approved, and occurred because there is no effective quality control process, and leadership has been in constant flux. This audit also identified issues with mail processing, which can cause inappropriate denials and leave veterans in the dark regarding the status of their claims.

Why This Is Important

It is critical that VHA staff process claims for non-VA emergency care in an accurate and timely fashion. When these claims are denied, non-VA facilities and providers can bill veterans for some or all the costs of the emergency care services provided. Therefore, inappropriately denied or rejected non-VA emergency care claims present a risk of substantial, undue financial burden on veterans.

When a claim is denied or rejected, the financial burden could shift to the veteran. The billed amount of inappropriately processed claims from April 1 through September 30, 2017, that were denied or rejected was large in the aggregate—an estimated \$716 million—and presented

potential undue financial risk to an estimated 60,800 veterans. Although the audit team could not determine whether providers billed veterans for inappropriately processed claims that VA did not reimburse, the risk of undue financial burden remained for individuals who may ultimately be billed by the non-VA provider for their episode of emergency care.

Of the inappropriately processed denials and rejections, the audit reveals that a portion of those claims should have been approved. The OIG estimated about 17,400 of the 60,800 veterans—with bills totaling at least \$53.3 million—were negatively impacted during the audit period. The remaining processing errors are also significant, as claimants did not receive complete and accurate information regarding why their claims were not approved. In other words, the procedural errors created a risk that claimants could not effectively respond with necessary information to potentially obtain approval and payment of the claim.

Denial or Rejection of Non-VA Emergency Care Claims

Title 38 of the United States Code (U.S.C.) authorizes payment or reimbursement to a claimant for emergency treatment provided to veterans meeting specific eligibility criteria. Three sections of 38 U.S.C. provide VA authority to pay non-VA emergency care claims.⁸

To qualify for payment or reimbursement, each non-VA emergency care claim must meet administrative and clinical criteria for eligibility under the appropriate legal authority. Voucher examiners and clinical review nurses determine if the claim meets eligibility criteria (illustrated in appendix B).⁹

OIG's analysis of claims data indicates claims are generally *denied* because

- The claimant did not meet the filing requirement deadline,
- A VA facility was determined to have been available, or
- The condition was determined not to be an emergency.¹⁰

Claims are generally *rejected* because they are missing necessary information such as place of service, codes, medical records, or correct patient information. When a claim is rejected, a notice

⁸ 38 U.S.C. § 1703, *Contracts for hospital care and medical services in non-Department facilities*, defines the requirements for contracting of “authorized” non-VA emergency care. These types of claims are referred to as authorized claims; 38 U.S.C. § 1728, *Reimbursement of certain medical expenses*, defines the requirements for reimbursement of “unauthorized” care claims for service-connected disabilities. These types of claims are referred to as unauthorized claims; 38 U.S.C. § 1725, *Reimbursement for emergency treatment*, defines the requirements for reimbursement of “unauthorized” care claims for nonservice-connected disabilities. These types of claims are referred to as Millennium Bill (otherwise known as Mill Bill) claims.

⁹ VHA's Community Care Eligibility Criteria for Emergency Care lists the administrative and clinical requirements under 38 U.S.C §§ 1703, 1728, and 1725.

¹⁰ VA availability is generally based on a clinical determination of distance, nature of condition, and ability of the VA facility to render needed emergency treatment.

is sent to the claimant requesting additional information to process the claim. The claimant must provide additional information within the prescribed time frame.

Organizational Structure

VHA OCC supports veterans who obtain medical care and services through non-VA providers and is led by the Deputy Under Secretary for Health for Community Care. A primary service line in OCC is Delivery Operations. Staff in Delivery Operations manage all programs that allow veterans and their family members to receive care and services outside of VA, including the programs that pay for such care. Delivery Operations includes the Claims Adjudication and Reimbursement (CAR) function. Since fiscal year (FY) 2017 the leadership chain of VHA’s OCC and CAR experienced several changes, including three directors of CAR.

CAR personnel process payments of claims for medical care obtained outside of VA, and the director of CAR reports to the executive director of OCC’s Delivery Operations. During the scope of this audit, data indicated there were about 1,300 claims-processing staff who receive, research, and adjudicate claims, and about 130 licensed nurses to review the clinical eligibility of veterans’ non-VA care claims. CAR also leveraged about 350 contract staff to assist in verifying and distributing incoming claims.

The Claims Decision-Making Process

CAR staff process claims through the Fee Basis Claims System (FBCS), the official system of record for all non-VA care claims adjudication. As shown in Figure 1, when processing a claim, voucher examiners research the veteran’s health records and document necessary information for claim adjudication, such as dates of service and the date the claim was filed with VA. Voucher examiners review the administrative eligibility requirements for the three payment authorities in hierarchical order to determine the appropriate payment authority to process the claim (Figure 2). The voucher examiner may deny or reject the claim based on its failure to meet administrative eligibilities, or if instructed by clinical staff that it does not meet clinical eligibilities.

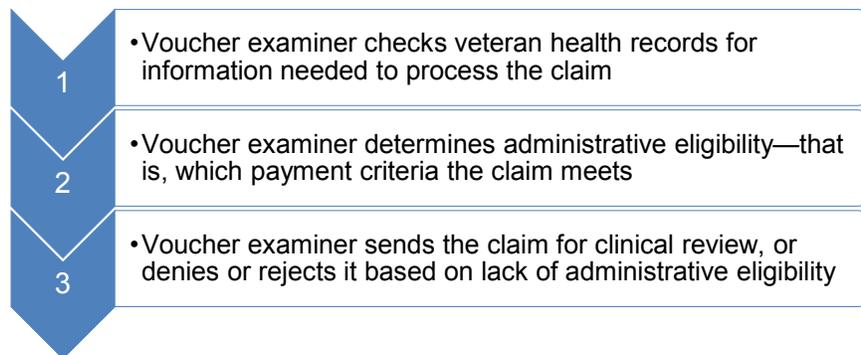


Figure 1. General steps to process non-VA emergency care claims
 (Source: VA OIG analysis of legal authorities, as described in footnote 8 and VHA policy)

When notification of emergency care is not received within 72 hours of admission, the claim should be considered under the second two authorities—unauthorized and Mill Bill—in sequence. When considering a claim under these two authorities and when administrative eligibility is met, the claim is suspended for clinical review. A clinical review nurse researches the claim and the veteran’s records before documenting a final claim decision on the clinical tracking record. The nurse also researches the appropriate payment authority that applies to the claim. The claim is routed back to a voucher examiner for final adjudication based on the clinical review instructions. Payment of each claim for an episode of care occurs only if the claim meets the administrative and clinical requirements of the eligible payment authority.

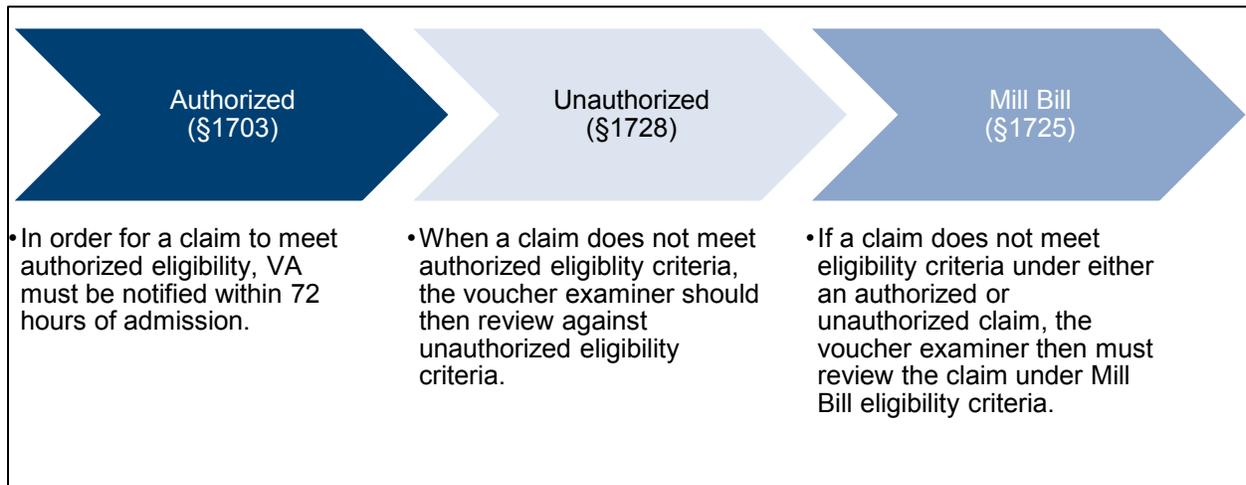


Figure 2. Precedence of legal authorities for processing non-VA emergency care claims
 (Source: VA OIG analysis of legal authorities)

In FY 2017, CAR data shows that voucher examiners processed over 4.5 million non-VA emergency care claims.¹¹ Figure 3 illustrates the percentage of claims that CAR accepted, denied, and rejected.

¹¹ The 4.5 million claims did not include authorized non-VA emergency care claims. The OIG identified the FY 2017 emergency care claims data using methodology provided by CAR. During the sample review of claims from this population, the audit team identified a number of claims that were not for emergency treatment but for an office visit or care for a nonveteran. Therefore, the total number of claims identified using the CAR parameters may overstate the number of actual non-VA emergency care claims.

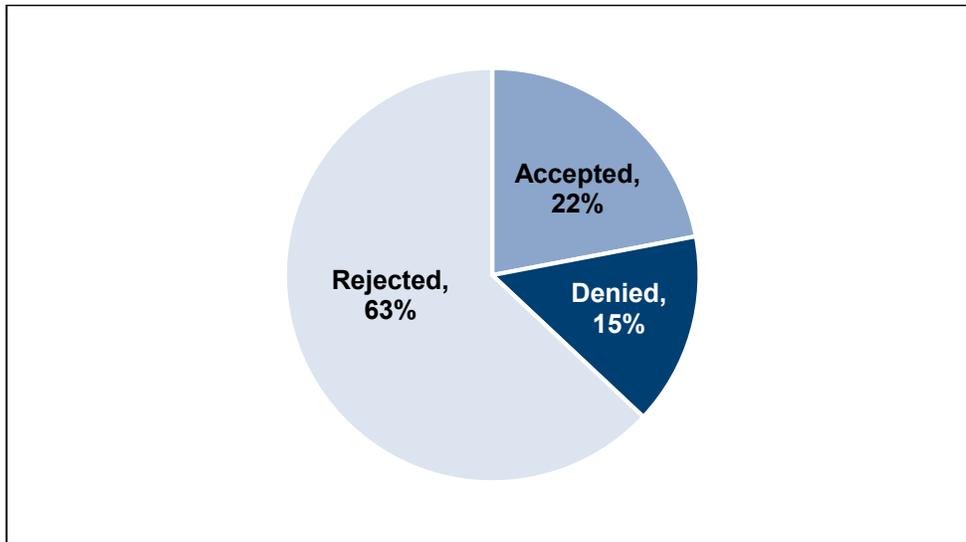


Figure 3. The percentage of non-VA emergency care claims (not including authorized claims) that CAR accepted, denied, and rejected
 (Source: Non-VA emergency care claims decisions for FY 2017; derived from VA’s Corporate Data Warehouse)

What the OIG Did

The scope of this audit focused on non-VA emergency care claims-processing activities and oversight by OCC CAR personnel nationwide. The audit work included site visits to nine CAR locations.¹² The audit team’s findings in this report are drawn from

- Interviews with 182 staff and leaders,
- Observations of claims-processing activities,
- Survey responses from 435 CAR staff in every CAR region,¹³
- Assessments of a statistically selected sample of 180 denied and 60 rejected non-VA emergency care claims that were scanned or electronically received from April through September 2017, and
- Reviews of relevant VA email records.

Appendixes C and D provide additional details on what the audit team did, and appendix F provides additional details on the survey responses.

¹² The OIG team conducted site visits from January through May 2018 to the following locations: Cleveland, Ohio (Region 1); Columbia, Missouri (Region 3); Denver, Colorado (Region 4); Kansas City, Missouri (Region 3); Minneapolis, Minnesota (Region 4); Perry Point, Maryland (Region 2); St. Cloud, Minnesota (Region 4); Vancouver, Washington (Region 5); and Washington, DC (Region 2).

¹³ The OIG distributed an electronic survey to 1,333 CAR staff.

Results and Recommendations

The following OIG findings are discussed in this report:

- A significant number of denied and rejected claims were inappropriately processed, some leading to wrongful denials and rejections.
- OCC's CAR culture created pressure for timely production.
- CAR lacked sufficient quality controls over denied and rejected claims.
- Additional barriers affected claims processing.

Since FY 2017, the OCC experienced several leadership changes, including three CAR directors. While the findings in this report cannot be tied directly to the lack of stability in key leadership positions, it provided the context in which problems were allowed to continue without remediation.

Finding 1: A Significant Number of Denied and Rejected Claims Were Inappropriately Processed, Some Leading to Wrongful Denials and Rejections

Nationwide, the audit team determined that claims processors rejected or denied non-VA emergency care claims inappropriately an estimated 31 percent of the time during the review period. When CAR denies claims, the claimant—which can ultimately be the veteran—is responsible for paying for the care.

The audit team assessed 240 denied or rejected non-VA emergency care claims that were scanned or electronically received from April 1 through September 30, 2017, and processed under 38 U.S.C. §§ 1728 (unauthorized claims) and 1725 (Millennium Bill claims).¹⁴ To determine whether claims were inappropriately processed, the audit team reviewed claims against authorized, unauthorized, and Mill Bill criteria to assess whether the claims were administratively eligible for payment. Generally, processing errors occurred because voucher examiners inconsistently applied claims adjudication criteria.

The audit team projected the sample review results to the population of denied and rejected non-VA emergency care claims and determined that CAR inappropriately processed an estimated 196,000 of 632,000 of those claims (31 percent), affecting about 60,800 veterans. Inappropriately processed claims resulted in either a wrongful denial or rejection, or an increased risk that claimants would not take the necessary actions to respond to the claims decision because they did not receive an accurate reason why their claim was not approved.

¹⁴ The 240 claims consisted of 180 denied and 60 rejected claims. This consisted of 30 denied and 10 rejected claims from each CAR region, and as a result of the congressional requests, the team reviewed an additional 30 denied and 10 rejected from the CAR facilities in Minneapolis and St. Cloud, Minnesota, which are located in Region 4.

Impact of Inappropriate Processing

To determine whether claims should have been approved, the audit team assessed the claims to determine if they met specific payment criteria and collaborated with OIG's Office of Healthcare Inspections to determine if the claims were clinically eligible for payment. For the projected 196,000 inappropriately processed claims, CAR staff should have approved approximately 45,000 claims for payment for about 17,400 veterans.

The processing errors did not always result in an inaccurate decision. However, these errors are significant because they increase the risk that claimants would not take the necessary actions to respond to the claim decision because they did not receive an accurate reason why their claim was not approved. The audit team estimated that for 151,000 of 196,000 inappropriately processed claims, voucher examiners generally should have either routed claims to CAR nurses for clinical review, suspended the claims, denied the claims with appropriate denial reasons, or in some instances rejected the claims for additional support.

Evidence and Examples of Inappropriately Processed Claims and Wrongful Denials

The estimated 632,000 claims consisted of 170,000 denied claims and 462,000 rejected claims. Of the estimated 196,000 processing errors, 81,500 were denied claims and 114,000 were rejected claims.¹⁵ The claimant then has the burden of appealing a denied claim or resubmitting information for rejected claims, both of which result in additional processing for CAR staff.

The audit team's nationwide accuracy review found a more significant error rate among denied claims (48 percent) than rejected claims (25 percent). Therefore, the following sections and examples focus on the different ways that CAR staff inappropriately processed denied claims.

Inappropriately Denied Claims

The audit determined that CAR inappropriately processed an estimated 81,500 of the 170,000 claims they denied (48 percent). Figure 4 presents the processing error rates based on the volume of denied claims per region. For example, of the claims denied by Region 3 voucher examiners, an estimated 70 percent were processed inappropriately.

¹⁵ Estimates may not sum exactly due to the rounding.

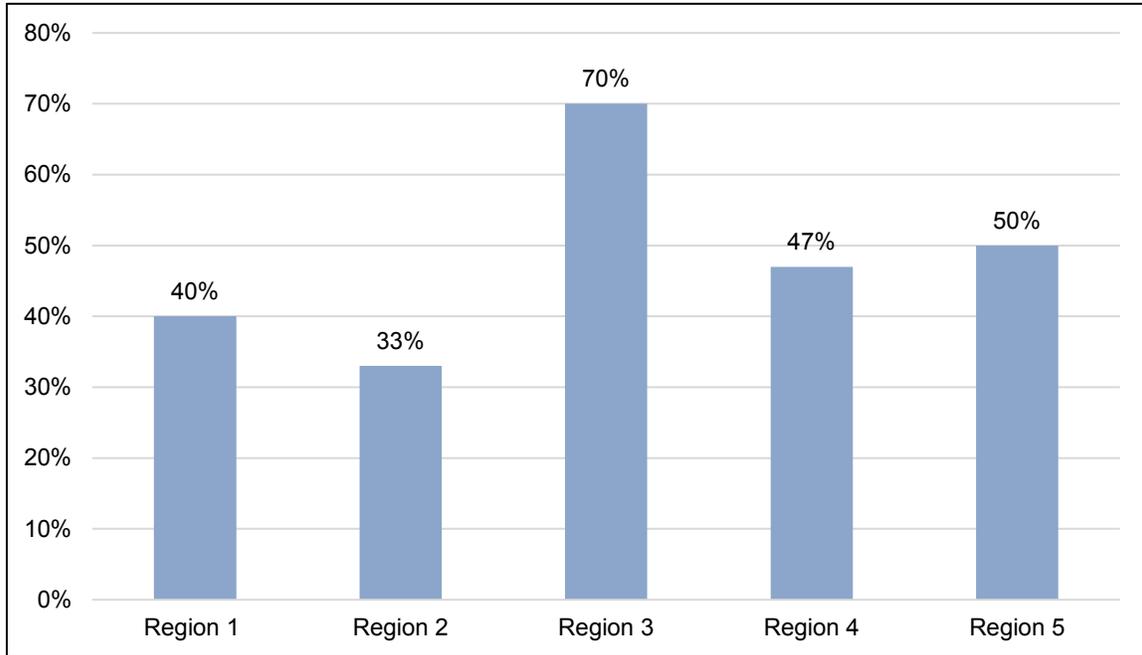


Figure 4. *Estimated processing error rates for denied non-VA emergency care claims per region. Note: Information in the figure is based on the projected overall likelihood that an error would occur within each region. The differences in error rates displayed in Figure 4 are statistically significant between Region 1 and Region 3, Region 2 and Region 3, and Region 3 and Region 4. There is no statistically significant difference in error rates between regions unless stated otherwise. (Source: VA OIG statistical sample analysis, projected results)*

Inappropriately Denied When Reviewed Under Incorrect Payment Authority

The audit team found that voucher examiners did not always follow the hierarchy of payment authorities when reviewing claims, and therefore did not always forward the claim to an OCC clinician for clinical eligibility review.

Example 1

A veteran presented to a non-VA emergency department with the chief complaint of seizures on July 5, 2017. This veteran was 50-percent service-connected disabled and contacted VA within 72 hours of being admitted to the emergency department. Based on this information, the claim met eligibility criteria for an authorized claim; however, a voucher examiner denied this claim with the reason “Denied because of 38 U.S.C. § 1725 No VA Treatment in Past 24 Months” without a clinical review. Since this veteran met the administrative eligibility criteria, the audit team concluded that this claim should have been assessed by a clinician to confirm whether the care rendered was related to a service-connected disability or an adjunct condition. The audit team found that not only was this claim not assessed by a clinician, but a voucher examiner inappropriately

completed the required clinical tracking record. The voucher examiner made the assessment that the veteran's service-connected disability was not related to the emergency episode of care, and the claim was ultimately denied. The audit team determined that the claim was administratively eligible under a different authority, and the veteran's history of VA treatment was not applicable.

CAR concurred that this claim was inappropriately denied and that the voucher examiner should have only documented the administrative eligibility. This inappropriate denial potentially resulted in the non-VA provider billing the veteran about \$15,000.

Inappropriately Denied When Administratively or Clinically Eligible

Voucher examiners inappropriately denied claims when the claim was administratively or clinically eligible, such as denying a claim for not being timely filed when it was, or not determining whether a veteran had received medical services within the past 24-month period. As a result, voucher examiners did not always forward the claim to clinical staff for review and potential approval.

Example 2

A nonservice-connected disabled veteran presented to, and was subsequently discharged from, a non-VA emergency department on March 9, 2017. VA received an electronic claim for the non-VA emergency care on May 13, 2017, which was 65 days from the date of discharge. The audit team noted that the claim did not meet eligibility criteria for an authorized claim or an unauthorized claim; therefore, the claim should have been reviewed against Mill Bill eligibility criteria. Mill Bill eligibility criteria require that the claim be filed within 90 days of the date of discharge from the facility that provided the emergency treatment. The audit team determined that the voucher examiner inappropriately applied OCC's criteria and denied this claim for not being timely filed. CAR agreed with the audit team's assessment of this claim.

Inappropriately Denied When Other Health Insurance Was Present

Voucher examiners inappropriately denied claims when the veteran had other health insurance, instead of holding the claims for future processing.¹⁶ Based on OIG’s assessment of CAR data, CAR denied about 14,000 claims for the reason “Other Health Insurance Present” during FY 2017.

Example 3

A veteran with active Medicare insurance presented to a non-VA emergency department on July 17, 2017. The voucher examiner administratively reviewed the claim and appropriately routed the claim to the clinician for a clinical review. Based on the clinical tracking record, the clinician determined that the emergency episode of care was not related to a service-connected or adjunct condition, and the claim was subsequently reviewed against Mill Bill eligibility criteria. At the time, guidance from CAR leaders instructed voucher examiners to suspend claims for veterans that had active health insurance. The voucher examiner inappropriately applied criteria and denied this claim with the reason of “Other Health Insurance Present” when the claim should have been suspended. CAR agreed with the audit team’s assessment of this claim.

Recommendation 1 addresses the need for VHA to reevaluate all claims denied after April 8, 2016, for the reason of “other health insurance” for appropriate corrective action.

Clinical Errors Resulted in Inappropriate Denials

CAR clinical review nurses did not always appropriately determine clinical eligibility, which resulted in inappropriately denied claims. The audit team consulted with the OIG Office of Healthcare Inspections to determine if sample claims met clinical eligibility. The OIG Office of Healthcare Inspections assessed claims to determine if

- The episode of care was clinically emergent, or considered emergent by a prudent layperson,
- A VA medical facility was feasibly available, and
- Emergency care rendered was related to the veteran’s service-connected disability.

¹⁶ On April 8, 2016, the U.S. Court of Appeals for Veterans Claims ruled that Congress intended that veterans be reimbursed for the portion of their emergency medical costs not covered by other health insurance and for which they would otherwise be personally liable (*Staab v. McDonald*, 28 Vet. App. 50 (2016)). *The Bulletin*, 5, no. 9, (April 28, 2016), a publication for the non-VA medical care community, instructed that all Mill Bill claims subject to other health insurance criteria must not be rejected or denied, and they must be held until new guidance is developed. Effective January 9, 2018, VA revised 38 CFR § 17.1005 concerning payment or reimbursement for emergency treatment for nonservice-connected conditions at non-VA facilities.

The OIG determined that CAR clinical review nurses should have clinically approved some of the non-VA emergency care claims in the audit sample because the episode of care met the definition of emergency given by the authority under which the claim might qualify for payment. In other cases, a VA medical facility was not feasibly available, or the veteran did obtain emergency care in relation to a service-connected condition.

Inappropriately Denied for Other Reasons

- Voucher examiners denied claims for the reason “not timely filed,” but the paper claim did not have a date stamp. Without a date stamp on the claims, the voucher examiners did not have assurance that the claims were not filed on time. The audit team observed unprocessed mail several weeks old at visited CAR facilities. Some voucher examiners told the audit team that they date stamp everything, some examiners told the team they date stamp only medical records, and other examiners told the audit team they did not date stamp incoming mail at all. Mail deficiencies are discussed further in a subsequent section of this report.
- Voucher examiners denied claims without a clinical assessment to confirm that the veteran had not received VA treatment in the past 24 months.¹⁷
- Claims were denied for third-party liability instead of rejected, but no evidence of a third-party liability existed.¹⁸ Voucher examiners could not reject claims for third-party liability because the reason is no longer on FBCS’s list of standard reasons. As a result, the audit team identified claims that were denied for third-party liability instead of rejected, but no evidence of a liability existed. Voucher examiners should have rejected the claim to obtain further support of a third-party liability or exhaustion of such payment coverage.
- Voucher examiners did not follow clinical direction. For example, a clinician determined that an episode of care was eligible and should be approved against unauthorized

¹⁷ Per 38 CFR §§ 17.1002(d) and 17.1006, a clinician has to make the determination that no VA treatment was provided in the past 24 months. Based on the CAR Standardized Administrative and Clinical Review Template, the voucher examiner was responsible for determining if a veteran was enrolled and received medical services within a 24-month period. However, neither the template nor the training provided to voucher examiners explains that a clinician is needed to make this determination.

¹⁸ Under 38 U.S.C. § 1728, VA acts as secondary payer when a third party is financially responsible for coverage of emergency treatment expenses received for service-connected conditions. In some cases, under 38 U.S.C. § 1725, VA may act as secondary payer when certain third-party liability exists for emergency treatment received for nonservice-connected conditions (e.g., situations involving auto insurance or workers’ compensation claims). For such instances, VA coverage is limited to the amount for which the veteran is personally liable after the amount of third-party coverage (e.g., exhausting coverage of automobile personal injury protection insurance coverage). *The Bulletin*, 3, no. 13 (June 26, 2014), states the rejection reason included “clarification of auto insurance vs. other 3rd party liability processes and requirements. It is imperative that sites utilize this rejection reason and forward the letter prior to denying a claim for third party liability.”

eligibility criteria, but a voucher examiner inappropriately denied the claim for failure to meet obsolete Mill Bill eligibility criteria.

- Voucher examiners used an incorrect denial reason.
- Voucher examiners inappropriately made a clinical assessment.

Inappropriately Rejected Claims

Claims are generally rejected because they are missing necessary information such as place of service, codes, medical records, or correct patient information. In this situation, a notice is sent to the claimant requesting additional information to process the claim.

While the audit team's accuracy review found a more significant error rate among denied claims, the audit team determined that CAR inappropriately processed an estimated 114,000 of 462,000 of the claims they rejected (25 percent). When rejected, the claimant has the burden of timely providing additional information based on the rejection reason. The audit team determined that CAR staff inappropriately rejected claims for the following reasons:

- The voucher examiner did not identify the medical records that were available.
- The voucher examiner did not identify the patient in the claims-processing system.
- The voucher examiner used an incorrect rejection reason.

Recommendation 2 addresses the need for VHA to implement a clearly defined decision matrix that allows staff to accurately determine when claims should be denied, rejected, or approved; initiate a process to systematically audit denied and rejected claims; and take corrective actions as needed based on audit results.

Recommendation 3 addresses the need for VHA to develop and implement a control to ensure claims processors have the appropriate options in the claims-processing system of record to request evidence necessary to substantiate third-party liability claims.

Financial Burden on Veterans

Denied and rejected claims could shift the financial burden of non-VA care from VA to the veteran. An estimated 60,800 veterans whose claims were inaccurately processed during the last two quarters of FY 2017 were at risk of potential undue financial burden in the billed amount of an estimated \$716 million as a result of claims processors inappropriately denying or rejecting non-VA emergency care claims. The audit team could not determine whether providers billed veterans for inappropriately processed claims that VA did not reimburse. However, the risk of undue financial burden exists for individuals who may ultimately be billed by the non-VA provider for their episode of emergency care.

While not all claims-processing errors resulted in an inaccurate decision, the audit team found that CAR should have approved an estimated 45,000 non-VA emergency care claims for payment for about 17,400 veterans during the last two quarters of FY 2017.

The total billed amount for emergency care rendered for the estimated 45,000 claims was at least \$53.3 million during the six-month period, representing improper underpayments to the claimants. According to Office of Management and Budget Circular A-123, Appendix C, an improper payment includes inappropriate denials of payment or service.¹⁹ The OIG further estimated errors could result in \$533 million in improper underpayments over five years if corrective actions are not taken.²⁰

Non-VA facilities and providers may have billed veterans for some or all of the costs of the emergency care services after CAR did not approve the claims, which could cause significant stress and undue financial hardship on the veterans.

On February 2, 2016, VA's Assistant Deputy Under Secretary for Health for Community Care expressed similar concerns in testimony to the House Committee on Veterans' Affairs, Subcommittee on Health:

In FY 2014, approximately 30 percent of the 2.9 million emergency treatment claims filed with VA were denied, amounting to \$2.6 billion in billed charges that reverted to Veterans and their [other health insurance]. Many of these denials are the result of inconsistent application of the "prudent layperson" standard from claim to claim and confusion among Veterans about when they are eligible to receive emergency treatment through community care.

Recommendation 4 addresses the need for VHA to reevaluate for appropriate corrective action all sample claims identified in this audit as inappropriately denied and rejected.

CAR Did Not Effectively Monitor Veterans' Claims Appeals

Although claimants can appeal denied claims, the OIG found that CAR was not effectively monitoring veterans' appeals of non-VA emergency care claims decisions. According to the

¹⁹ Office of Management and Budget Circular A-123, Appendix C, states, "An improper payment is 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. Incorrect amounts are overpayments or underpayments that are made to eligible recipients (including inappropriate denials of payment or service, any payment that does not account for credit for applicable discounts, payments that are for an incorrect amount, and duplicate payments)."

²⁰ The estimated value represents the total billed amount. VA documentation states that VA payment rates for emergency care are generally 100 percent of Medicare rates for service-connected conditions and 70 percent of Medicare rates for nonservice-connected conditions. In addition, the OIG estimated that if OCC continued to inaccurately deny or reject claims they should have approved as estimated in table D.1 for a six-month period, based on payment rates in effect at the time of this review, this could lead to an estimated \$533 million in improper payments over five years. The five-year estimate is an extrapolation of the six-month estimate.

former CAR director, claimants who disagree with the CAR decision to deny a claim can contact the local CAR facility by phone, letter, or form for reconsideration of the claim. If claimants disagree with the results of reconsideration, they may formally appeal by filing a Notice of Disagreement for review by the Board of Veterans' Appeals.

According to a CAR program analyst, CAR started collecting appeals data in September 2017 in response to the Veterans Appeals Improvement and Modernization Act of 2017.²¹ In October 2017, the then VHA Executive in Charge requested a meeting with VHA personnel regarding the inventory of VHA appeals and how they are tracked. In response, an OCC CAR analyst attempted to collect the following information from CAR facilities:

- What is used by your facility to track claims/appeals?
- Does your facility report on Notices of Disagreement and Statements of the Case?
- Can you provide the number of Notices of Disagreement pending?

One CAR VA Community Care (VACC) manager stated their facility was “so far behind” with appeals and had appeals in multiple boxes and file cabinets over the years that were never inventoried. In response to the manager, a CAR administrative officer reported that the request for appeals data was not feasible and noted that having so many appeals in a disorganized manner would raise a lot of questions.

An issue briefing document, prepared in October 2017 for the then executive director for OCC Delivery Operations in response to a meeting request from the then VHA Executive in Charge, outlined concerns that VA field offices were not accurately capturing appeals data. The issue briefing document included a finding that VHA was not tracking appeals data, which created a data integrity issue for both the Board of Veterans' Appeals and VHA.

To assess these issues further, the OIG initiated a separate audit in October 2018 regarding CAR's management and oversight of appeals of non-VA care claims decisions.

Recommendations 1–4

1. The Under Secretary for Health reevaluates all claims denied after April 8, 2016, for the reason of “other health insurance” for appropriate corrective action.²²
2. The Under Secretary for Health implements a clearly defined decision matrix that allows staff to accurately determine when claims should be denied, rejected, or approved; initiate a process to systematically audit denied and rejected claims; and take corrective actions as needed based on audit results.

²¹ *Veterans Appeals Improvement and Modernization Act of 2017*, Pub. L. No. 115-55.

²² Recommendations directed to the Under Secretary for Health were submitted to the Executive in Charge, who has the authority to perform the functions and duties of the Under Secretary for Health.

3. The Under Secretary for Health develops and implements a control to ensure claims processors have the appropriate options in the claims-processing system of record to request evidence necessary to substantiate third-party liability claims.
4. The Under Secretary for Health reevaluates all sample claims identified in this audit as inappropriately denied and rejected for appropriate corrective action.

Management Comments

The Executive in Charge, Office of the Under Secretary for Health, stated that VHA recognizes the impact erroneously denied and rejected claims may have on veterans and that they take seriously their responsibility to pay claims timely and accurately. The Executive in Charge concurred with recommendations 1–4 and provided corrective action plans with anticipated implementation by late 2019.

In response to recommendation 1, the Executive in Charge stated that OCC will take corrective actions on claims determined to have been improperly denied for the presence of other health insurance after April 8, 2016.

For recommendation 2, the Executive in Charge stated that OCC has revised and standardized all claim denial and rejection reasons and is fully revising the Emergency Care Claim Processing Standard Operating Procedures and developing additional job aides and tools to assist staff with making accurate eligibility and adjudication decisions. He further stated that OCC initiated weekly quality and accuracy reviews covering rejected and denied claims, and review results are regularly discussed at the CAR level for nationwide awareness and discussion of additional internal controls needed to prevent future errors.

For recommendation 3, the Executive in Charge stated that OCC implemented controls to ensure claims processors have appropriate processes and tools to adjudicate claims with a partial payment by a third party. He stated that all OCC claims-processing sites have disabled the denial reason related to third-party liability and that weekly accuracy reviews of denied and rejected claims are conducted by supervisors to monitor the disposition of these claims.

In response to recommendation 4, the Executive in Charge stated that all sample claims identified in this audit as inappropriately denied and rejected will be reevaluated for appropriate corrective action. He further stated that OCC will begin issuing letters to negatively affected veterans explaining the error and OCC's readjudication actions.

OIG Response

The Executive in Charge's comments and corrective action plans are responsive to the intent of the recommendations. The OIG will monitor implementation of planned actions and will close the recommendations when VA provides sufficient evidence demonstrating progress in

addressing the issues identified. The full text of the responses from the Executive in Charge is in appendix G.

The Executive in Charge also provided technical comments related to this finding, which are also included in appendix G. The OIG carefully considered these comments and took the following actions. The OIG updated footnote 8 to clarify that 38 U.S.C § 1703 is a contract authority. The OIG also updated footnote 16 to indicate that updated regulations regarding other health insurance criteria were published on January 9, 2018. The Executive in Charge also stated VHA began processing held claims on that date. The OIG did not remove footnote 18 in reference to 38 U.S.C § 1725, as this footnote and criteria was specifically in reference to claims subject to third-party liability such as an automobile accident or worker's compensation claims, as noted in the footnote and corresponding paragraph. The Executive in Charge provided similar comments regarding third-party liability discussed in appendix B.

The technical comments also noted that the 38 U.S.C. § 1725 information in Figure B.2 does not reflect the changes made to implement the ruling in *Staab v. McDonald*, 28 Vet. App. 50 (2016). Since the figure in appendix B represented criteria in use during the scope of the audit team's data review, and the *Staab* ruling was implemented after the scope of that review, the OIG did not revise the figure. The Executive in Charge stated that OCC updated processing guidance in accordance with the interim final rule published on January 9, 2018, and that OCC is developing additional job aides and tools to assist staff with making accurate eligibility and adjudication decisions. These will be provided as part of deliverables for recommendation 2.

Finding 2: OCC's CAR Culture Created Pressure for Timely Production

The audit team determined that VA staff in OCC's CAR worked under a claims-processing production culture that placed more emphasis on the quantity of processed claims than the accuracy of the claims decisions. Prioritizing production stemmed from a backlog of unprocessed claims more than 30 days old, which OCC and CAR leaders tried to reduce. Appendix A provides additional details on instances of concerted claims-processing efforts, and the emphasis on timeliness, to meet goals and reduce backlogs.

Interviews and survey responses revealed that some voucher examiners were verbally directed or encouraged to deny non-VA emergency claims to meet production standards. Additionally, some examiners who had not been directly encouraged to reject or deny claims responded that they still felt the CAR culture creates "systemic pressure to favor speed over accuracy." Overall, the responses revealed that the claims-processing environment prioritized quantity over quality.

In addition, voucher examiners reported that the production and accuracy standards at the fully successful level were too high and did not allow enough time to do a thorough and complete job of assessing claims. Through interviews, the audit team identified factors in CAR's claims-processing environment that staff considered to be incentives, such as overtime and telework privileges, that were tied to meeting or exceeding production targets. While production standards were tied directly to performance evaluations and overtime and telework opportunities, accuracy of claims decisions did not hold a similar weight.

OCC Claims-Processing Goals

In 2016, the then VA Secretary implemented the MyVA transformation, which included "breakthrough priorities." One of the priorities was to improve community care. The goals included processing and paying non-VA care claims within 30 days, 85 percent of the time, and reducing the claims backlog to less than 10 percent of the total inventory. At the start of FY 2016 the inventory of non-VA aged claims was about 482,000 claims out of 1.7 million (28 percent).²³

In February 2017, it was reported that the then Assistant Deputy Under Secretary for Community Care requested that OCC determine what it would take to process claims within 30 days about 95 percent of the time. The goal increased further to 98 percent of the time for a campaign called "The Road to 98 Percent." According to a former CAR director, the goal to process 98 percent of claims within 30 days was based on a health insurance industry standard. However, the former CAR director also stated the claims-processing system, FBCS, involves manual processes that

²³ During this audit, the overall goal of processing 85, 95, or 98 percent of claims was 30 days for authorized, clean claims, and 45 days for unauthorized emergency care claims. Aged claims are authorized claims over 30 days old and unauthorized claims over 45 days old.

result in low production compared to industry standards. As of November 2018, the inventory of non-VA aged claims had risen to about 993,000 claims out of 2.7 million (36 percent).

According to the regional officers and VACC managers' performance standards, 40 percent of their overall rating focuses on eliminating aged claims and reducing improper payments for approved claims. CAR leaders' performance standards did not include specific measures for accurately denying or rejecting claims.

Voucher Examiners Reported Their Standards Did Not Allow Sufficient Time to Make Accurate Decisions

Voucher examiners stated they could not do a thorough job and process enough claims to meet the production targets in their performance standards. About 24 percent (94 of 394) of staff who responded to the audit team's survey indicated they could not process the necessary number of non-VA emergency care claims per their performance standards to receive a fully successful performance rating on production targets. In addition, over 20 percent (81 of 394) of staff indicated they were unsure. Some of the voucher examiners that indicated they were not able to process the necessary numbers of claims provided the following comments:

- “They have an unreasonable number to meet if you are going to thoroughly research each claim to ensure the correct determination.”
- “Processing takes an inordinate amount of time due to the inefficiency of the FBCS program, the amount of steps required to process a claim, as well as the complexity of statutes and regulations applied to non-VA emergency claims.”
- “There are many tasks and responsibilities that are not rated or evaluated that we are required to perform. The performance standard does not ensure quality work. Only quantity.”

In addition to survey responses, an additional 22 voucher examiners stated during interviews that they could not meet the production standards or were unsure if they could meet production standards. For example, they said

- Production numbers are unrealistic, and staff feel stressed out about the numbers.
- Production targets are unattainable. Numbers are stressed more than accuracy.
- There are too many interruptions, such as answering phone calls, opening mail, or other customer service duties.

Production Standards Developed, Then Revised Downward

Voucher examiners were held to claims-processing production standards. CAR leaders stated that performance standards are a normal tool in government performance appraisals and have long been in place in voucher examiner performance plans.

According to the then CAR deputy director, the Veterans Engineering Resource Center conducted time studies that led to the development of production standards. The Veterans Engineering Resource Center team visited five claims-processing sites in May 2015 and collected more than 13,000 observations to provide recommendations for productivity ranges and standards. On October 1, 2015, based on the time studies, CAR implemented production standards. In May 2016, CAR decreased the production standards by 30 percent. According to the then CAR director, this occurred because management observed the claims-processing productivity standard was too high, and more than 25 percent of the staff did not meet standards.

Voucher examiners' performance standards included production standards as a critical element.²⁴ At the general schedule-6 (GS-6) level, voucher examiners' production standards included processing 13 unauthorized or Mill Bill claims per hour to receive a fully successful rating, and 15 to receive an exceptional rating. The production standards for the GS-5 and GS-4 levels were reduced by 20 percent and 40 percent, respectively.

Based on interviews with CAR staff, voucher examiners received a work-production credit when they rejected or denied a claim or sent the claim for payment. Voucher examiners did not receive credit for researching the claim and then suspending the claim for clinical review. Voucher examiners may receive multiple work production credits for denying a batch of claims or sending multiple claims to payment that are for the same episode of care. One non-VA emergency care visit or episode of care may have multiple claims with the same adjudication, which would allow the voucher examiner to receive multiple work production credits for all claims associated with the episode of care.

Non-Claims-Processing Duties Assigned to Voucher Examiners

Supervisors acknowledged that voucher examiners' performance standards did not fully capture their workload. Voucher examiners also provide customer service such as answering incoming calls from claimants and processing incoming and outgoing mail, otherwise referred to as nonproduction time. According to CAR leaders and supervisors, employees and supervisors were responsible for excluding nonproduction time when determining their claims-processing productivity.

²⁴ The voucher examiner's performance standards include three critical elements (claims processor production targets, voucher examiner accuracy standards, and voucher examiner customer service standards) and two noncritical elements (voucher examiner teamwork standards and voucher examiner mission support standards).

One VACC manager said voucher examiners may receive a fully successful or higher rating without meeting their production targets because supervisors allow for unplanned processing complications that are beyond examiners' immediate control. A CAR facility supervisor told the audit team that all their employees would need to be placed on performance improvement plans if they were held to nationally defined standards, implying that they would not meet the standards. The audit team determined that the amount of nonproduction time varied significantly across processing locations and among voucher examiners, which impacted CAR's ability to accurately estimate overall processing standards and expectations.

In June 2016, CAR started developing a productivity tool to assist supervisors with logging and tracking employee performance and to track national productivity information. CAR implemented and mandated the tool in May 2018. The then CAR director indicated that, based on data thus far, more than 50 percent of CAR staff would not meet production standards based upon the tool's output, and stated that additional time studies were forthcoming.

Recommendation 5 addresses the need for VHA to reevaluate production targets, work production credits, and application of non-processing time for voucher examiners to ensure the production targets include claims research time.

CAR Claims-Processing Environment Focused on Production Over Accuracy

CAR leaders, including the former CAR director, the then deputy director, regional officers, and some VACC managers, told the audit team they emphasize and value the importance of accurate claims processing. However, as described in the following sections, CAR managers, supervisors, and voucher examiners reported in interviews and survey responses that the CAR claims-processing environment led staff to focus on production over accuracy. This included voucher examiners reporting that they were aware of other voucher examiners denying or rejecting claims in an effort to meet productivity targets.

The audit team interviewed 182 CAR personnel, including 116 voucher examiners who indicated that they process non-VA emergency care claims, and obtained survey responses from 435 CAR staff, including 394 voucher examiners who indicated they process non-VA emergency care claims. The interviewees and survey respondents represented each CAR region.²⁵ In addition to their answers to the survey questions, which are detailed in appendix F, survey respondents provided detailed comments in their responses.

²⁵ About 70 percent of the 116 voucher examiners the OIG interviewed also completed the survey.

Examiners Directed or Encouraged to Improperly Deny and Reject Claims

During interviews and on survey responses, 10 voucher examiners indicated they were directed or encouraged to improperly deny veterans' non-VA emergency care claims to meet production standards.²⁶ The voucher examiners indicated the instruction was verbal. This included direction from supervisors and a VACC manager located in all five regions. Some of these voucher examiners also provided comments to their affirmative survey responses, which included the following:

- “I was told by my supervisor to focus on ‘speed before accuracy.’ I didn't feel that this is an acceptable practice, and thus was unable to meet productivity.”
- “Numbers are everything, the faster the better is what we are told.”
- “Been told to process faster, even if that means inaccuracy. Click and pick.”

Recommendation 6 addresses the need for VHA to request and ensure the Office of Resolution Management conducts an organizational assessment of the specific CAR locations where staff reported they were directed or encouraged to improperly process claims, and to take appropriate action.²⁷

Most voucher examiners responded that they were not specifically directed or encouraged to deny non-VA emergency care claims to meet production standards. These voucher examiners answered “No” to the survey question; however, the OIG determined that the comments accompanying their responses indicated the pressure to meet standards was cultural:

- “Supervisor’s [sic] do not tell us to RTP [return to provider] or deny claims, they push the numbers on us. The standard is set high and the supervisors expect us to maintain that and that's when the processors, who feel the pressure, do things like deny or RTP in order to meet numbers.”²⁸
- “The pressure to reject or deny without due diligence is structural, not personal. When employee metrics are weighted primarily on production, there is systemic pressure to favor speed over accuracy.”

²⁶ Based on interviews and survey responses, 17 voucher examiners indicated they were directed or encouraged to improperly deny veterans' non-VA emergency care claims to meet production standards. The audit team followed up with the majority of these individuals and determined that seven were not specifically directed to improperly deny claims but were either provided with some degree of inappropriate guidance or were aware of other examiners improperly processing claims.

²⁷ The audit team provided these specific CAR locations to the then CAR deputy director during the audit.

²⁸ RTP refers to an FBCS processing selection, Return to Provider, otherwise referred to as rejecting the claim.

Examiners Aware of Inaccurate Denials and Rejections

In a different survey question, 154 of 394 voucher examiners (39 percent) answered affirmatively when asked if they were aware of any instances in which claims processors inaccurately denied or rejected non-VA emergency care claims for productivity standards (Figure 5). These affirmative respondents spanned all five geographical regions.

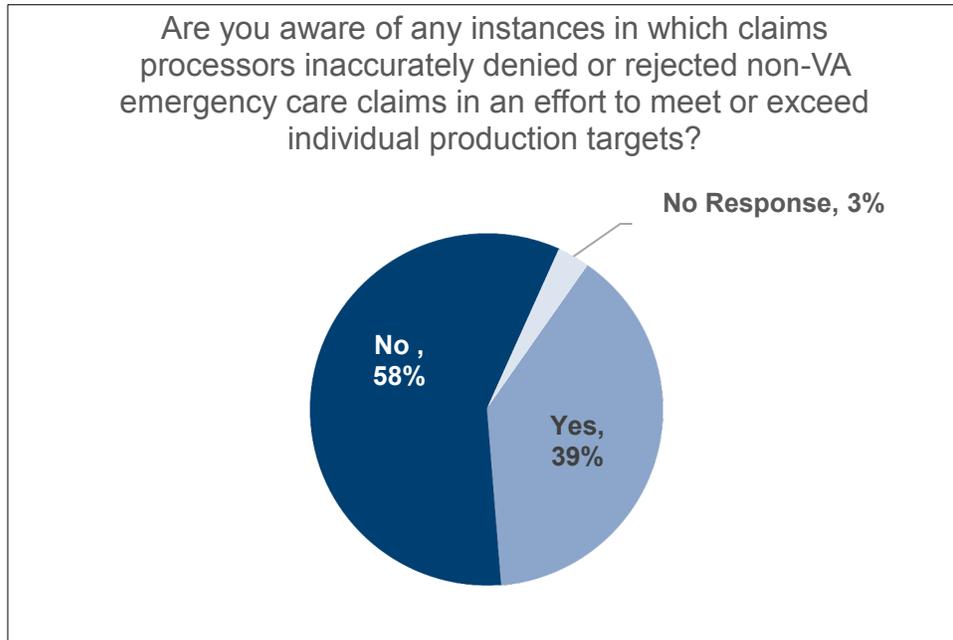


Figure 5. Results of OIG survey question 6
(Source: VA OIG analysis of survey responses)

Comments from voucher examiners showed that they felt productivity standards created pressure “to meet numbers” in any way possible:

- “With the pressure of meeting the standard individuals are in an extreme hurry and rejecting and denying are the easiest way to get claims out without spending a lot of time looking for the right action to take.”
- “Some processors are feeling the stress of having to meet the numbers instead of just working without the added pressure of meeting numbers. Therefore, they are making unnecessary mistakes which are causing mo[r]e corrections, phone calls from vendors, and angry veterans.”
- “The ‘Numbers’ game is unofficially enforced. Management says quality over quantity, but whenever you do not meet ‘their expected’ quota, you are called into the office and asked why you haven’t been performing.”

- “The bosses just threaten you with being fired to get your numbers. Constant non stop intimidation. The atmosphere is terrible. I think it is more that processors just rapidly slop claims through as fast as they can just to hit their numbers.”

Managers and supervisors also reported during interviews that CAR leaders emphasized quantity of non-VA emergency care claims processed versus quality of the examiners’ claims decisions. Their statements reflect the following concerns:

- FBCS does not produce any management reports tracking the quality of denied and rejected claims.
- The emphasis nationwide is quantity over quality.
- The focus now is on quantity; what happened to the quality aspect of processing claims? Errors are unmanageable.

Recommendation 7 addresses the need for VHA to implement a strategic plan to ensure CAR emphasizes the accuracy of claims-processing decisions.

Production Incentives

Production standards are designated as a critical element of the voucher examiners’ annual performance appraisal; therefore, individual productivity is crucial in order to be eligible for an annual performance bonus. CAR staff stated a voucher examiner must receive an overall rating of outstanding or excellent to receive an annual performance bonus. To receive such ratings, the voucher examiner must be rated by the supervisor as exceptional for the three critical elements of the performance appraisal: productivity, accuracy, and customer service. The FY 2017 annual bonus awarded to eligible voucher examiners at levels GS-4 through GS-6 was \$500 for an outstanding rating and \$350 for an excellent rating. Although performance ratings are directly tied to performance bonuses, the OIG did not find that performance bonuses were a driving factor to inappropriately process claims in order to meet production standards.

The OIG determined from interviews and surveys that voucher examiners felt that supervisors utilized productivity as an incentive to receive overtime opportunities and telework privileges. OCC policy instructs supervisors to authorize overtime only to examiners who meet performance standards. Similarly, according to voucher examiners interviewed or surveyed, telework opportunities were tied to the quantity of claims processed. Examiners who didn’t consistently meet the production numbers were not considered for overtime and had telework privileges removed.

When a voucher examiner researches a claim, determines that it has met administrative eligibility requirements, and sends it to clinical review, the voucher examiner does not receive credit for that work until clinical staff send the claim back for a final adjudication decision. In contrast,

examiners receive work credit as soon as they deny or reject a claim. Voucher examiners provided comments to their survey responses, which included the following:

- “RTP [return to provider], Deny or reroute are options used to ‘beat’ the system and meet numbers. Quantity is all that seems to matter, not quality and [t]hen people see that errors [a]re not being looked at, only numbers than [sic] shortcuts will be taken to meet productivity.”
- “CAR has focused much on quantity and fudging numbers moving claims to unused queues rather than the quality of what’s being processed.”
- “I feel there is too much pressure to perform to standards. More emphasis on production and running reports vs getting the job done correctly with appropriate help. I feel many errors could be avoided if we did not have the pressure of productivity.”

The overall culture to decrease the backlog, incentives to meet production targets, and the structure of earning work production credit presented a risk of inappropriately processed claims.

Recommendation 8 addresses the need for VHA to implement controls to ensure eligibility for overtime, telework, and annual performance bonuses for CAR staff considers all facets of performance.

Recommendations 5–8

5. The Under Secretary for Health reevaluates production targets, work production credits, and application of non-processing time for voucher examiners to ensure the production targets include claims research.
6. The Under Secretary for Health requests and ensures the Office of Resolution Management conducts an organizational assessment of the Claims Adjudication and Reimbursement processing locations where staff reported they were directed or encouraged to improperly process claims, and to take appropriate action.
7. The Under Secretary for Health implements strategic plans to ensure the Office of Community Care, Claims Adjudication and Reimbursement Directorate, emphasizes the accuracy of claims-processing decisions.
8. The Under Secretary for Health implements controls to ensure eligibility for overtime, telework, and annual performance bonuses for Claims Adjudication and Reimbursement staff includes all facets of performance.

Management Comments

The Executive in Charge concurred in principle with recommendations 5 and 6 and concurred with recommendations 7 and 8. The Executive in Charge provided action plans for each recommendation, with completion dates targeted for no later than October 2019.

In response to recommendation 5, the Executive in Charge stated that OCC eliminated the critical production-related performance element from the voucher examiners' FY 2018 and FY 2019 performance plan. The Executive in Charge stated that OCC initiated discussions to fully revise voucher examiner performance plans to align with CAR's new strategic direction, and the performance plan will emphasize balance across production, accuracy, quality, customer service, and teamwork.

In response to recommendation 6, the Executive in Charge stated OCC concurs in principle that an organizational assessment of processing locations where staff reported they were directed or encouraged to improperly process claims is warranted but considers responsibility for the assessment to fall within the authority of the Executive Director of OCC Delivery Operations. The Executive Director will charter a workgroup that will include those with expertise aimed at helping CAR managers and supervisors change and adopt behaviors important to focusing on quality management and may also include the Office of Resolution Management and other subject matter experts knowledgeable about employee engagement, inclusion, and psychological safety.

In response to recommendation 7, the Executive in Charge stated that OCC is currently implementing a comprehensive strategic and transformational plan. He further stated that a cornerstone of CAR's strategic plan is a renewed emphasis on quality assurance and accuracy of claims-processing decisions.

In response to recommendation 8, the Executive in Charge stated that CAR has drafted new performance plans and standards for staff, which take into consideration many facets of performance. He stated all facets of new performance standards will factor into the determination of overtime and telework assignments. He further stated that CAR recently created a nationwide overtime policy.

OIG Response

The Executive in Charge's comments and corrective action plans are responsive to the intent of the recommendations. The OIG will monitor implementation of planned actions and will close the recommendations when VA provides sufficient evidence demonstrating progress in addressing the issues identified. The full text of the responses from the Executive in Charge is in appendix G.

Finding 3: CAR Lacked Sufficient Quality Controls Over Denied and Rejected Claims

CAR management lacked a standardized quality assurance function or mechanism for evaluating the accuracy of claims the voucher examiners processed. The former CAR director did not receive reports on the accuracy rate of denied and rejected claims, and the then CAR deputy director stated that there was no requirement for frontline supervisors to review denied and rejected claims.

CAR did not have policy that requires supervisors to assess the accuracy of claims decisions. This is significant because, according to CAR data, denied and rejected claims accounted for nearly 80 percent of the unauthorized and Mill Bill claims processed. Although CAR monitored production on a national level, the then CAR deputy director told the audit team that supervisors were responsible for monitoring and assessing accuracy at the local level. The then deputy director stated that different monitoring techniques are used, and CAR did not prescribe a specific method to assess the accuracy of claims because there is a varying degree of difficulty involved in processing the different types of claims. Further, different techniques may be needed at the local level.

According to the voucher examiner performance standards, voucher examiners must process at least 96.5 percent of claims accurately to receive a fully successful rating, and at least 98.5 percent of claims accurately to receive an exceptional rating. According to the performance standards, the accuracy rate is based on “spot checks of uncorrected data entries or omissions.”²⁹ The performance standards indicate that errors are determined by data input that causes erroneous payments, incorrect veteran selection, or incorrect vendor selection. The accuracy standard is based on a random sample review of claims for errors, and there is not a minimum standard number of claims to review. Both the former and the then CAR directors told the audit team that it was assumed the supervisors would also assess the accuracy of denied and rejected claims, in addition to approved claims.

Quality Controls Varied

The audit team determined that supervisors’ quality assurance methods varied. Supervisors at two of nine facilities the audit team visited stated they assessed all types of claims decisions, including rejected and denied claims, to determine if the claim was appropriately adjudicated. Supervisors at the remaining seven facilities stated they assessed accuracy by relying on the

²⁹ The audit team requested clarification of the performance standard language “uncorrected data entries or omissions.” The then CAR deputy director stated the intent is that claims are reviewed for accuracy.

Program Integrity Tool reports, the Quality Inspector Tool, or reviewing claims decisions on a summary level by assessing the claim program authority and the denial or rejection reason.³⁰

According to voucher examiners' performance standards, there was no standard method for calculating accuracy and determining whether a voucher examiner met or exceeded the 96.5 percent target for a fully successful rating. Nearly half the voucher examiners who responded to the audit team survey answered that that they were not aware of supervisors reviewing any of their claims for accuracy (Figure 6).

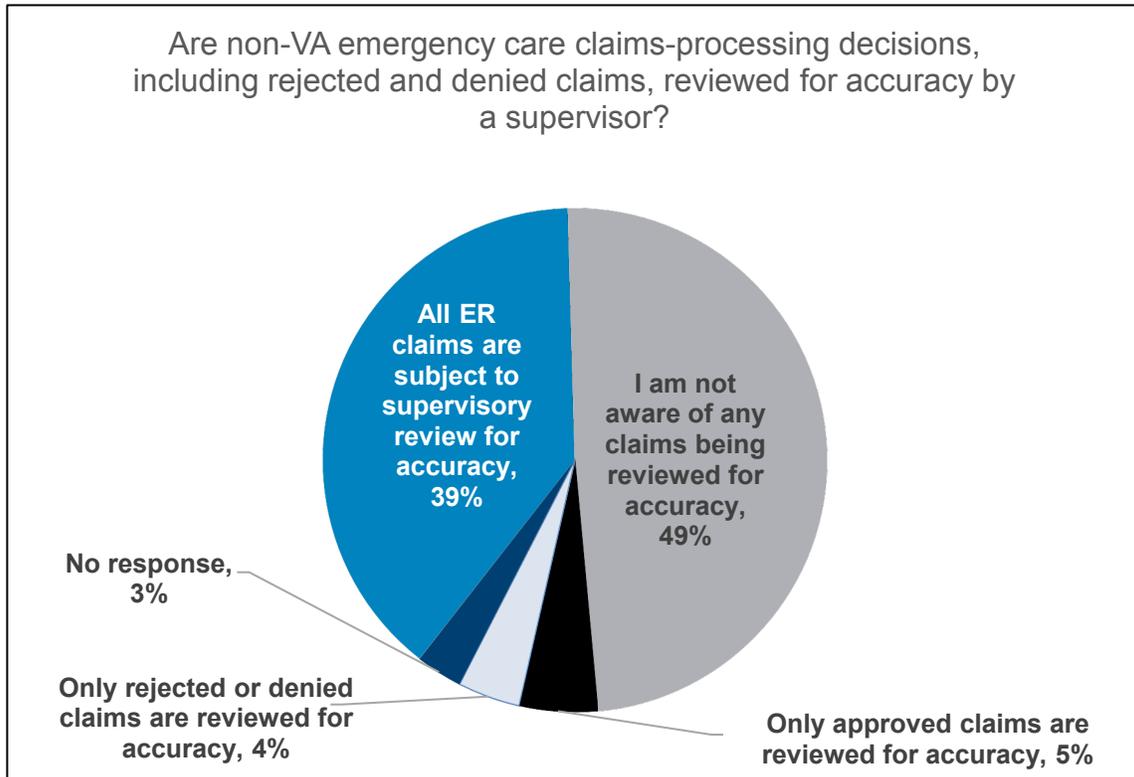


Figure 6. Results of OIG survey question 8.
(Source: VA OIG analysis of survey responses)

According to the performance standards, supervisors should discuss accuracy rates with voucher examiners monthly. Based on survey responses, about 20 percent of voucher examiners who reported that claims were reviewed for accuracy were not aware of the results of those reviews. During interviews, supervisors responded that claims accuracy reviews occurred mostly when an approved claim sent to payment was rejected by the Quality Inspector Tool.

³⁰ The Program Integrity Tool report identifies a potential improper payment. The Quality Inspector Tool was developed to help ensure payments are being processed correctly.

Quality Issues Since at Least 2014

VHA was aware of quality assurance deficiencies as early as March 2014, when the Government Accountability Office (GAO) issued a report regarding veterans' Mill Bill emergency care benefits.³¹ GAO found "VA staff who processed claims did not comply with applicable requirements of the Millennium Act, its implementing regulations, or VA policies when they denied the claims."³² In response to the 2014 GAO report, the then CAR deputy director established an internal control workgroup consisting of clinical staff.

Starting in October 2017, the workgroup began auditing denied claims for August, October, and November 2017, and January 2018, and identified errors each month ranging from 18 to 34 percent of the denial decisions. The top denial reason used inappropriately was the prudent layperson criteria. Although the workgroup identified errors during this effort, two clinical nurses and an administrative officer from the group stated no action was taken with the audit results. In addition, the administrative officer stated that the workgroup audited limited facilities because it did not have access to necessary data for every facility. The administrative officer also stated that the workgroup stopped conducting audits because it was waiting on CAR to add clinical leaders.

The lack of quality assurance created a risk that denied and rejected non-VA emergency care claims would not be accurately adjudicated.

Recommendation 9

9. The Under Secretary for Health develops and implements a clearly defined and effective quality assurance program that encompasses all claims decisions and includes a standardized process for supervisors to determine and effectively monitor the extent to which claims processors accurately rejected and denied non-VA emergency care claims.

Management Comments

The Executive in Charge concurred with recommendation 9 and stated that CAR's strategic plan includes the creation of a new quality assurance product. He stated that the CAR quality assurance plan includes initiatives to create and enhance the quality assurance product line at the regional and national levels, and includes hiring quality assurance officers, internal control specialists, policy analysts, and trainers. Furthermore, key initiatives of the plan include growing

³¹ GAO, *VA Health Care Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit*, GAO-14-175 (Washington, DC, March 2014).

³² The Veterans Millennium Health Care and Benefits Act authorizes the Secretary to reimburse for the reasonable value of emergency treatment furnished in a non-Department facility for veterans who are active Department healthcare participants and who are personally liable for such treatment.

and perfecting internal quality and accuracy reviews, with improved automated generation of samples, as well as clinical workgroup quality and accuracy reviews.

OIG Response

The Executive in Charge's comments and corrective actions plans are responsive to the intent of the recommendation. The OIG will monitor implementation of planned actions and will close the recommendation when VA provides sufficient evidence demonstrating progress in addressing the issues identified, to include effectively monitoring the accuracy of rejected and denied claims.

The full text of the response from the Executive in Charge is in appendix G.

Finding 4: Additional Barriers Affected Claims Processing

Processing errors during the verification and distribution portion of the claim adjudication process impacted voucher examiner claims-processing accuracy and timeliness. Backlogs of unprocessed mail at some facilities also negatively affected veterans' outcomes when applying for reimbursement of non-VA emergency care. According to the former CAR director, voucher examiners are often responsible for collateral duties, such as processing mail, which take their time away from processing claims.

Processing Errors Increased Work for Voucher Examiners

CAR management, supervisors, and voucher examiners stated that errors made in the verification and distribution portion of the claims adjudication process resulted in additional work for the voucher examiners. Contractors' staff generally performed the verification and distribution function for CAR, leaving voucher examiners mainly with the research and adjudication of the non-VA emergency care claims. According to voucher examiners, when the contract staff made errors such as assigning the incorrect payment authority during distribution, CAR voucher examiners needed to correctly assign it to the appropriate authority to proceed with the claim's adjudication. Voucher examiners said that contractor and CAR claims-processing errors led to increased customer service calls from frustrated veterans and non-VA healthcare providers.

Backlogs of Incoming Mail Presented Risk That Veterans' Claims Would Not Be Approved

The audit team identified incoming mail that was postmarked about one month prior at two of nine visited CAR facilities. Incoming mail typically consisted of benefits claims and medical records for claims that, if left unopened, CAR could inappropriately deny as not being timely filed within 90 days, as well as time-sensitive appeals. The backlogs of mail documents also placed veterans' claims or appeal information at risk of being lost or destroyed prior to scanning.

The then CAR deputy director told the audit team that CAR's expectation was for staff to scan paper claims into VA's FBCS within 24 hours of receipt. Furthermore, two CAR regional officers said that processing sites require all mail to be scanned into FBCS within 24 hours of receipt and, along with outgoing mail, be certified to management that all mail is timely processed.

The audit team concluded that CAR management did not enforce this control, and based on discussions with CAR leaders and managers, mail processing issues were not always communicated through reporting lines. As previously noted, the audit team identified instances in which CAR staff inappropriately denied claims for untimely filing because mail was not scanned into VA records systems or properly date-stamped. The audit team identified 12 paper

claims during sample reviews that voucher examiners denied as not timely filed but were not given a date stamp to prove when VA received the claim.

In the 2014 GAO report on Mill Bill emergency care benefits, GAO recommended that “VA implement measures to ensure that all VA facilities comply with VA’s policy requirement that incoming claims be date-stamped and scanned into FBCS on the date of receipt.”³³

VA’s action plans indicated they added questions to the field assistance visit checklist to monitor VA facilities’ compliance with the scanning and date-stamping requirements. However, VA discontinued the field assistance visit program in October 2014. In November 2015, VA began requiring supervisors at VA facilities to certify that their staff were scanning incoming claims and medical records daily. The audit team concluded that CAR management did not ensure facilities timely scanned or date-stamped mail upon receipt, which placed veterans at risk for inappropriate decisions.

Recommendation 10 addresses the need for VHA to develop and implement clearly defined controls to ensure CAR facilities routinely communicate backlogs of incoming mail to OCC leaders, with associated action plans to accurately record the date the documents were received.

Backlogs of Outgoing Mail Presented Risk That Veterans Would Not Be Informed of the Claims Decision

The audit team identified unsent outgoing mail that had been printed between one and two months earlier at three of nine visited CAR facilities (some pictured in Figure 7). The outgoing mail typically included claim denial and rejection letters needing time-sensitive responses from claimants, such as providing requested records or filing appeals.

³³ GAO, *VA Health Care Actions Needed to Improve Administration and Oversight of Veterans’ Millennium Act Emergency Care Benefit*, GAO-14-175 (Washington, DC, March 2014).

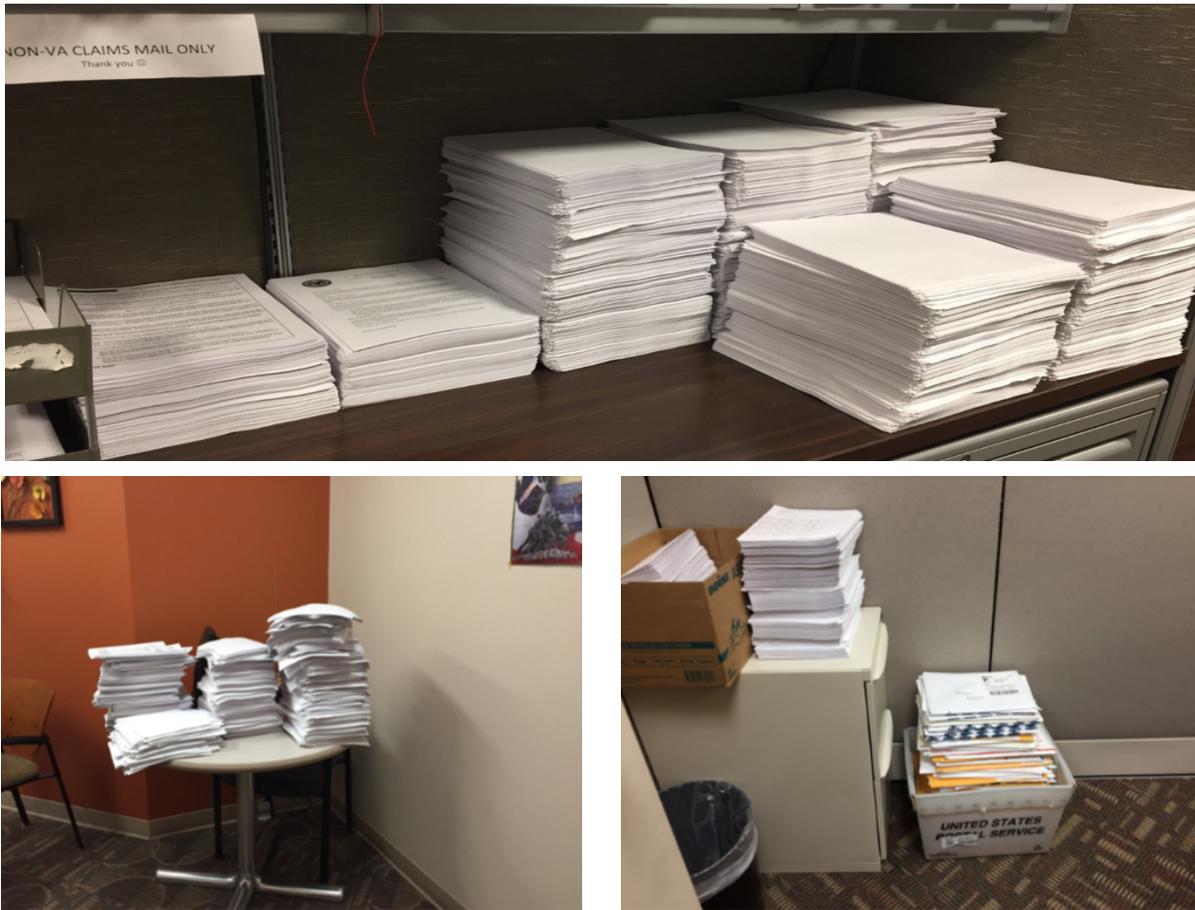


Figure 7. Top – Outgoing claim denial and rejection letters at a CAR Region 1 facility. Bottom left and right – Outgoing mail, consisting of claim denial and rejection letters, as well as incoming mail waiting to be processed at a CAR Region 4 facility.

(Source: VA OIG; photos taken during site visits on February 1 and April 19, 2018)

In March 2017, the then CAR deputy director emailed the then CAR director about issues with five years of unsent claim denial and rejection letters to veterans. The correspondence indicated that the then CAR director and the Region 3 officer had only just learned about the region’s 320,000 unsent letters to veterans and had previously been told there were no large backlogs of mail. The then CAR director later concluded to Region 3 that “it is very important to ensure the denials/rejects are sent due to Veterans[’] due process.”

The former CAR director stated that the VA medical centers requested that CAR staff not mail veteran letters because of wording complications and veterans not understanding the letters. Supervisors at six of the visited facilities stated they mailed rejection letters to the non-VA providers, but indicated they either did not send or could not provide evidence that VA mailed required rejected claim correspondence to veterans. The former CAR director and a site

supervisor believed that the rejection letter would confuse the veteran and lead to more customer service phone calls. According to law,³⁴

[T]he Secretary shall provide to the claimant and the claimant's representative, if any, . . . notice of any information, and any medical or lay evidence, not previously provided to the Secretary that is necessary to substantiate the claim. As part of that notice, the Secretary shall indicate which portion of that information and evidence, if any, is to be provided by the claimant and which portion, if any, the Secretary . . .

VHA was aware of mail processing issues as early as March 2014, when the 2014 GAO report on Mill Bill emergency care benefits stated,

The lack of documentation for many of the claims we reviewed at the four VA facilities we visited suggests that the four VA facilities we visited did not notify some veterans that their Millennium Act claims were denied and of their rights to appeal these denials. If similar situations are occurring at other VA facilities nationwide, where veterans are not informed of Millennium Act claim denials or of their appeal rights, and the claims have been inappropriately denied, then veterans could become financially liable for emergency care that VA should have covered.

GAO recommended VA require supervisors to develop mechanisms for verifying veteran denial letters are printed and mailed. VA's action plans for emphasizing the importance of verifying that veteran denial letters are printed and mailed included printing an article in the April 2014 biweekly bulletin and making an announcement during the July 2014 bimonthly Veterans Integrated Service Network (VISN) call. In December 2016, VA collected information from each VISN about the process it used for verifying that denial letters for Millennium Act claims were printed and mailed to veterans. However, the audit team determined that CAR did not timely mail denial letters, putting veterans at risk of not knowing that CAR denied or rejected their claims. Recommendation 11 addresses the need for timely communication of claims decisions to veterans and providers and what actions the veteran may take in response.

Recommendations 10–11

10. The Under Secretary for Health develops and implements clearly defined controls to ensure Claims Adjudication and Reimbursement processing facilities routinely communicate backlogs of incoming mail to Office of Community Care leaders with associated action plans to accurately record the date the documents were received.

³⁴ 38 U.S.C. § 5103, *Notice to claimants of required information and evidence.*

11. The Under Secretary for Health develops and implements clearly defined controls to ensure Claims Adjudication and Reimbursement processing facilities and VA medical centers timely communicate claims decisions to veterans and providers to ensure veterans are notified of what VA needs to adjudicate the claims and what actions the veteran may take in response.

Management Comments

The Executive in Charge concurred in principle with recommendation 10 and concurred with recommendation 11. In response to recommendation 10, the Executive in Charge stated that to address the overall concern of delayed paper mail processing upon receipt by VA, OCC implemented the Paper to Electronic Data Interchange initiative, which is intended to ensure that community care claims and records are digitized promptly and that newly submitted claims and supporting documentation are received electronically. The Executive in Charge stated that during phase one of the initiative, OCC forwarded paper claims to an outside vendor for scanning and electronic conversion, and in phase two community providers are to send paper claims and supporting documents directly to a centralized claims intake center. The Executive in Charge also stated that OCC instructed claims-processing staff in March 2019 to begin using the claim date provided by the provider to determine if a claim was filed timely. He stated that this process change affords maximum leniency for the timely filing of paper claims and is expected to end timely filing denials resulting from delays in paper mail processing.

In response to recommendation 11, the Executive in Charge stated VA is deploying a new claims-processing system, the Electronic Claims Adjudication Management System (eCAMS). The Executive in Charge stated eCAMS will replace the Fee Basis Claims System legacy system and that all outbound correspondence through eCAMS will eventually be centralized and mailed from the Financial Services Center. Furthermore, weekly reviews of correspondence in processing queues will be performed by CAR managers and leaders to ensure correspondence is being printed timely.

OIG Response

The Executive in Charge's comments and corrective action plans are responsive to the intent of the recommendations. As noted in the Executive in Charge's response to recommendation 10, OCC recognizes the impact delays in processing paper mail after receipt by VA can have when making timely filing determinations. While the Executive in Charge concurred in principle with recommendation 10, the OIG maintains that OCC needs to ensure CAR facilities effectively and timely forward all their paper claims to the outside vendor for scanning and conversion, or otherwise communicate the backlog to OCC. The OIG will monitor implementation of planned actions and will close the recommendations when VA provides sufficient evidence demonstrating progress in addressing the issues identified. The full text of the responses from the Executive in Charge is in appendix G.

Regarding OCC instructing claims-processing staff to begin using the claim date provided by the provider to determine if a claim was filed timely, the OIG notes that this action is inconsistent with the Code of Federal Regulations (CFR) requirement. As discussed in appendix B, under 38 CFR §17.127, *Date of Filing Claims*: “The date of filing any claim for payment or reimbursement of the expenses of medical care and services not previously authorized shall be the postmark date of a formal claim, or the date of any preceding telephone call, telegram, or other communication constituting an informal claim.”

The Executive in Charge also provided technical comments related to this finding, included in appendix G, that indicated the discussion on mail backlogs was inaccurate in some instances because it did not clearly explain the differences between processing of claims filed by providers and claims filed by veterans. The comments noted that generally rejection notices are not sent to the veteran because it could cause confusion. The OIG clarified in the section that the issue of outgoing mail pertained to claimants in general, which include non-VA providers. The OIG previously stated in this report that a claimant may be a veteran or non-VA provider or facility, and maintains that claimants should be timely notified of the claims decisions and have the ability to provide a timely response. Similarly, the recommendation addresses the need for VHA to ensure timely communication of claims decisions to veterans and providers.

The Executive in Charge recommended clarification of footnote 43 to reflect that it only applies to 38 U.S.C. § 1728. The OIG did not revise this footnote because 38 CFR §17.127 indicates the date of filing for payment and reimbursement of medical expenses is for claims not previously authorized, and based on what the audit team found, the final payment authority is not always known at the time a claim is received. Specifically, the payment authority is determined as voucher examiners process the claim.

Appendix A: Timeline of OCC Efforts to Meet Claims-Processing Goals

OCC leaders emphasized to CAR leaders the need to improve timeliness and to reduce and eliminate the backlog of claims. According to the performance standards of the CAR director and the then deputy director, 30 percent of their overall rating included meeting production targets and reducing the backlog of claims. Since 2015, OCC and CAR have encouraged overtime and conducted periodic backlog reduction efforts in an attempt to meet goals.

The following timeline represents instances of concerted claims-processing efforts to meet goals and reduce backlogs leading up to and during the scope of the audit team’s sample claims assessment, including CAR inquiries to change policy regarding who makes the prudent layperson decision.³⁵

December 2016

CAR developed a competition between CAR regions in response to OCC’s request for what they referred to as another “Backlog Blitz” to meet a goal of 85 percent of claims processed timely by the end of December 2016. Part of the strategy for this effort was that claims processors would be focused on “moving claims through quickly” with weekly winners and “most valuable players” selected each week of the competition for those who processed the most claims.

The then executive director of OCC’s Delivery Operations requested that CAR start its efforts earlier than planned to reach the goal and suggested including other types of claims that contractors processed in their performance that would move the claims-processing figures in their favor. The then executive director requested in an email to the then CAR director that a big push was needed to meet the goal of 85 percent of claims processed timely, and suggested, “perhaps you can look at the CHOICE claims working through the FSC [Financial Services Center] and count [them] in our TOTAL claims processed.”³⁶

February 2017

The then CAR director indicated that the then Deputy Under Secretary for Health for Community Care requested OCC determine what it would take to process claims within 30 days

³⁵ 38 CFR 17.1006 and 17.1002 (b) state a clinician is responsible for determining if “the initial evaluation and treatment is for a condition of such a nature that a prudent layperson would have reasonably expected that delay in seeking immediate medical attention would have been hazardous to life or health.” A prudent layperson in this context is a person with average knowledge of health and medicine. Clinicians apply this standard to veterans’ unauthorized care to determine whether to pay non-VA emergency care claims.

³⁶ According to CAR staff, the Financial Services Center provided CAR with claims-processing work. The Financial Services Center provides a wide range of financial services to the VA, such as payment processing. The audit team did not determine if other types of claims were actually included in the calculations, as suggested.

about 95 percent of the time. The then CAR director indicated that 200 to 300 additional staff might eliminate overtime and the claims backlog and meet the goal of 95 percent in six months.

March 2017

The then Deputy Under Secretary for Health for Community Care and the then executive director of OCC's Delivery Operations presented to VISN Directors the "Road to 98 Percent" initiative to eliminate the backlog and meet a timeliness standard similar to that of the private health insurance industry. The presentation indicated the goal was for VHA OCC to process 98 percent of authorized claims within 30 days and unauthorized claims within 45 days, and that this would occur within seven to nine months (October–December 2017).

May 2017

The then Deputy Under Secretary for Health for Community Care directed the start of a command center to focus on improving the timeliness of claims processing at four low-performing processing locations. According to a May 2017 report of contact, during one of the phone calls intended to focus on improving the timeliness of claims processing, a meeting participant explained to managers and supervisors how teams went through internal control checks to ensure accurate and proper payment. According to the report of contact, the Region 3 officer indicated that this practice created a bottleneck and needed to stop immediately. A supervisor explained that due to the high number of improper payments by inexperienced staff, the internal control was essential. The Region 3 officer further stated per the report of contact, "I don't want to say accuracy doesn't matter, but accuracy doesn't matter." In addition, the Region 3 officer stated that "timeliness was the primary focus of [then Deputy Under Secretary for Health for Community Care] and that we were not to worry about payment accuracy." The report of contact also described another call where the then CAR director indicated that the then Deputy Under Secretary for Health for Community Care was concerned with timeliness.

July 2017

According to the then CAR deputy director, at the request of the then Deputy Under Secretary for Health for Community Care, OCC and CAR leaders encouraged additional overtime to further progress in timeliness and eliminating the backlog as they approached the end of the fiscal year. According to VHA data, CAR staff substantially increased their overtime hours per pay period between July and December 2017.

August 2017

The Region 3 officer inquired with the OCC director of policy and planning regarding the possibility of allowing nonclinical staff, rather than clinical staff, to apply the prudent layperson standard when adjudicating claims in an effort to improve the claims-processing backlog. The

director of policy and planning informed the Region 3 officer that the action would not comply with regulations. The then deputy director persisted with the attempt to allow nonclinical staff to apply the prudent layperson standard when adjudicating claims and told the director of policy and planning that CAR was not following a similar regulation that required a clinician to review whether a veteran had received care at a VA facility within a 24-month period.

Regulations state, “a designated VA clinician at the VA medical facility of jurisdiction will make the determination” that “[a]t the time the emergency treatment was furnished, the veteran was enrolled in the VA health care system and had received medical services under authority of 38 U.S.C. chapter 17 within the 24-month period preceding the furnishing of such emergency treatment.”³⁷ The audit team’s accuracy review identified several instances in which nonclinical staff made the determination whether a veteran had received care at a VA facility within a 24-month period, and identified one instance where a nonclinical staff member reviewed a claim for clinical eligibility.

³⁷ 38 CFR §§17.1002 (d) and 17.1006.

Appendix B: Background

OCC Claims Adjudication and Reimbursement Governance Structure

In FY 2015, OCC implemented a new organizational structure to manage non-VA care claims processing, divided into five geographical regions.³⁸ VHA documentation shows that this regional management structure was implemented to establish a single, shared-services organization responsible for claims processing, appeals, clinical reviews, and bills of collection.

Each of the five regions has a regional officer who reports to the director and deputy director of CAR (Figure B.1). Throughout the regions, CAR has VACC managers that report to their respective regional officer. CAR staff in the five regions are located either at geographically consolidated sites or VHA medical facilities. CAR facilities have one or more local supervisors who oversee voucher examiners. These local supervisors and clinical nurses report to the VACC managers. According to the then CAR deputy director, CAR staff also may process claims from other regions as needed.

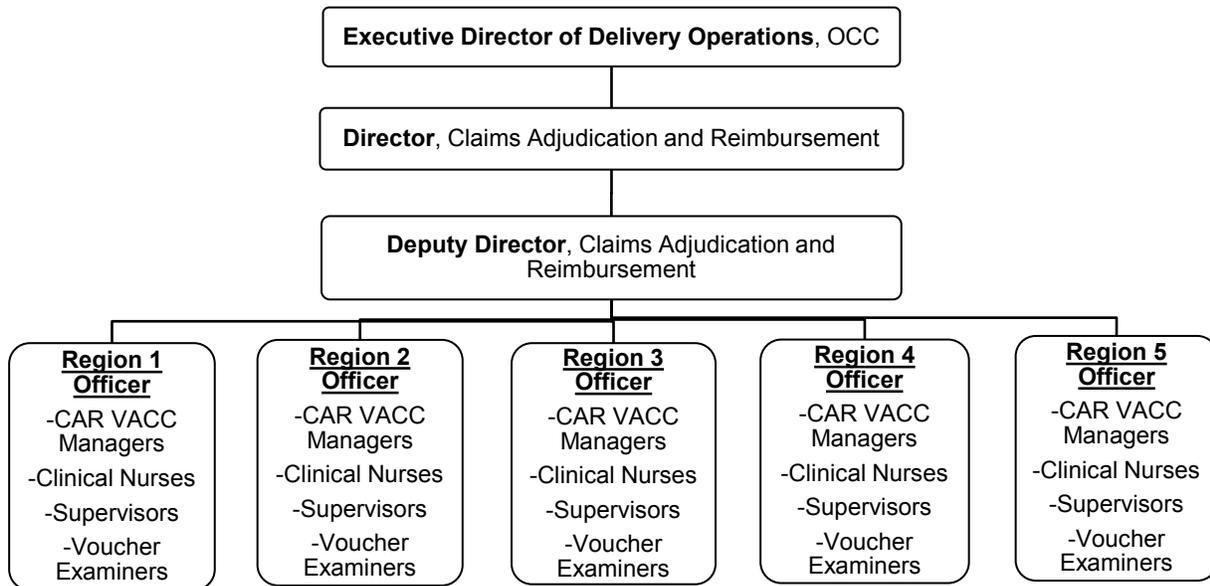


Figure B.1. VHA OCC's Claims Adjudication and Reimbursement organization chart
(Source: OIG analysis of OCC CAR organizational chart for FYs 2017 and 2018)

According to CAR data, CAR has almost 1,800 staff, including about 15 VACC managers, 70 claims supervisors, and 1,300 claims-processing staff who receive reimbursement claims, research the veterans' administrative eligibilities, and adjudicate claims. CAR employs about

³⁸ OCC's five geographical regions encompass corresponding VISNs. Region 1 includes VISNs in the Northeast (1, 2, 3, 4, 10 and 11); Region 2 includes VISNs in the East (5, 6, 7, and 8); Region 3 includes VISNs in the Midwest (9, 12, 15, and 16); Region 4 includes VISNs in the North and South (17, 18, 19, and 23); and Region 5 includes VISNs in the West (20, 21, and 22).

130 licensed nurses to review the clinical eligibility of veterans' non-VA care claims. The approximately 280 remaining staff work in the following roles:

- Administration and program office
- Payment center
- Reconsiderations and appeals
- Finance/reconciliation
- Internal controls/training/oversight
- Provider/customer relations

According to the former CAR director, CAR also relies on about 350 contract staff to assist in verifying and distributing incoming claims.

Besides processing claims, voucher examiners answer phone calls, assist claimants face-to-face, scan incoming mail, and process outgoing claim decision letters.

CAR Claims-Processing Workload

According to data provided by CAR in October 2017, CAR staff processed over 16.6 million non-VA emergency care claims (unauthorized and Mill Bill) from January 2015 through September 2017. One non-VA emergency care visit, or episode of care, can consist of multiple claims, including an institutional claim and several provider claims. In addition, the number of claims does not equate to the number of veterans, as one veteran may have multiple claims. CAR either accepts the claim for payment, denies the claim, or rejects the claim to the community provider for additional information. In some cases, if a rejected claim is resubmitted by the claimant, it is considered a new claim.

CAR officials reported that VHA paid about \$1.37 billion for reimbursement of all non-VA emergency care for veterans in FY 2017.³⁹ The total billed amount for all non-VA emergency care claims CAR denied in FY 2017 was \$1.95 billion. According to OCC, VA medical center funding follows historical values of prior years for budgeting.

CAR Claims Review Process

The claims process begins when a claim is submitted, either electronically or in paper form. CAR processing staff receive electronic claims through FBCS, the official system of record for all non-VA emergency care claims adjudication. When a claimant submits a paper claim, CAR processing staff sort, scan, and upload the claim and associated information into the FBCS.⁴⁰

³⁹ Values for authorized, unauthorized, and Mill Bill non-VA emergency care claims.

⁴⁰ Processing staff consist of lead voucher examiners, voucher examiners, program support clerks, and in some cases contract staff.

CAR processing staff verify claim information, assign a payment authority, and link the claim to any applicable prior authorizations for care on file in a veteran's electronic health record. Once in FBCS, claims are routed by CAR supervisors to voucher examiners' queues for processing.

Prior GAO Findings and Recommendations

GAO issued a report in March 2014 regarding veterans' Millennium Act emergency care benefits.⁴¹ GAO found that VA staff did not comply with applicable Millennium Act requirements when they denied the claims, such as not notifying veterans as required that their Millennium Act claims were denied. GAO also found weaknesses in VA's oversight of these claims. VA did not collect adequate data for monitoring the appropriateness of Millennium Act claim denials. GAO also found that VA staff failed to date stamp and timely scan incoming claims. GAO made 12 recommendations to VA, which included the following:

- Require VA facilities to audit the appropriateness of Millennium Act claim approvals and denials or establish performance measures related to the appropriateness of claims decisions.
- Clarify policy for claims processing, such as forwarding claims sent to the wrong facility.
- Require VA facilities to assist the veteran in determining if the claim is eligible for coverage by auto insurance or a third party before denying the claim.
- Clarify guidance that specifies clinicians should determine whether emergent care is related to the veteran's service-connected disability before other criteria are applied.
- Establish a reporting mechanism for VA facilities to provide VA Central Office with data related to appropriateness of decisions to approve or deny Millennium Act claims.
- Develop mechanisms for verifying that veteran denial letters are printed and mailed.
- Improve oversight by increasing focus on determining whether claims are appropriately denied and ensure deficiencies are corrected.
- Ensure all VA facilities date stamp and scan incoming claims on the date of receipt.

Criteria

In addition to federal regulations, a VHA directive outlines the three payment authorities to acquire and pay for non-VA emergency care claims.⁴² Each non-VA emergency care claim must meet administrative and clinical criteria for eligibility under the appropriate legal authority. Voucher examiners and clinical review nurses determine if the claim meets eligibility criteria

⁴¹ GAO, *VA Health Care Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit*, GAO-14-175 (Washington, DC, March 2014).

⁴² VHA Directive 1601, *Non-VA Medical Care Program*, January 23, 2013.

using VHA’s Community Care Eligibility Criteria for Emergency Care chart, shown in Figures B.2 and B.3.

VHA’s Community Care Eligibility Criteria for Emergency Care Chart

<p>38 U.S.C. § 1703 (38 CFR §§ 17.52-17.56) Outpatient – Emergency Care (Authorized Claims)</p> <p><u>Must meet ALL of the following:</u></p> <ul style="list-style-type: none"> - VA notification within 72 hours [38 CFR 17.54(a)] – and - Claims filed within 6 years [31 U.S.C. § 3702(b)] - and - Clinical definition of an emergency [38 CFR 17.52(a)(3)] - and - VA and other Federal facilities were not feasibly available [38 CFR 17.120(c)] – AND <p><u>Must meet one [38 CFR 17.52]:</u></p> <ol style="list-style-type: none"> 1. A VA-rated service-connected (SC) disability – or 2. A disability for which a Veteran was released from active duty – or 3. A disability of a Veteran who has a disability rated as permanent and total (P&T) in nature from a SC disability – or 4. A disability associated with and held to be aggravating a service-connected disability – or 5. For any disability of a Veteran participating in a rehabilitation program under 38 U.S.C. Chapter 31 and when there is a need for hospital care or medical services for any of the reasons listed in 38 CFR 17.48(i) – or 6. Any disability of a Veteran who has a VA SC disability rating of 50 percent or greater – or (Note: A service-connected disability rated at 50 percent or more is for one disability, not as a result of combining multiple disabilities.) 7. A Veteran who received hospital care, nursing home care, domiciliary care, or medical services, and requires care or services to complete treatment, for up to 12 months... -- or 8. A Veteran receiving increased VA pension or additional compensation based on need for aid and attendance or housebound benefits... -- or 9. A Veteran who develops an emergency while receiving hospital care or medical services in a VA or VA contracted facility ... – or 10. Hospital care or medical services that will obviate the need for hospital admission for Veterans in Alaska, Hawaii, Virgin Islands and other territories of the United States ... - or 11. Hospital care or medical services while in authorized travel status as indicated in 38 CFR 17.52(a)(8) – or 12. For any disability of a Veteran receiving VA contract nursing home care, and in need of emergency treatment... 	<p>38 U.S.C. § 1703 (38 CFR §§ 17.52-17.56) Inpatient – Emergency Care (Authorized Claims)</p> <p><u>Must meet ALL of the following:</u></p> <ul style="list-style-type: none"> - VA notification within 72 hours [38 CFR 17.54(a)] – and - Claims filed within 6 years [31 U.S.C. § 3702(b)] - and - Clinical definition of an emergency [38 CFR 17.52(a)(3)] - and - VA and other Federal facilities were not feasibly available [38 CFR 17.120(c)] - AND <p><u>Must meet one [38 CFR 17.52]:</u></p> <ol style="list-style-type: none"> 1. A VA-rated service-connected (SC) disability – or 2. A disability for which a Veteran was released from active duty – or 3. A disability of a Veteran who has a disability rated as permanent and total (P&T) in nature from a SC disability – or 4. A disability associated with and held to be aggravating a service-connected disability – or 5. For any disability of a Veteran participating in a rehabilitation program under 38 U.S.C. Chapter 31 and when there is a need for hospital care or medical services for any of the reasons listed in 38 CFR 17.48(i) – or 6. A Veteran who develops an emergency while receiving hospital care or medical services in a VA or VA contracted facility ... - or 7. Female Veteran 8. Hospital care or medical services that will obviate the need for hospital admission for Veterans in Alaska, Hawaii, Virgin Islands and other territories of the United States ... -- or 9. Hospital care or medical services while in authorized travel status as indicated in 38 CFR 17.52(a)(8) – or 10. For any disability of a Veteran receiving VA contract nursing home care, and in need of emergency treatment... <p>Note: Payment is limited to the point of stabilization, except when:</p> <ul style="list-style-type: none"> - VA is contacted upon stabilization – and - VA cannot accept the transfer of the Veteran – and - The community care facility made and documented reasonable attempts to transfer the Veteran to a VA or other Federal facility
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Figure B.2. *OIG adaptation of VHA’s Community Care Eligibility Criteria for Emergency Care chart (See Figure B.3 for a continuation of this figure.)*

(Source: VA Community Care Desk Procedures Eligibility Chart, dated February 8, 2017)

<p>38 U.S.C. § 1728 (38 CFR §§ 17.120-17.132) Emergency Care (Outpatient and Inpatient) (Unauthorized Claims)</p> <p><u>Must meet ALL of the following:</u></p> <ul style="list-style-type: none"> - Claims filed within 2 years [38 CFR 17.126] - and - Prudent layperson definition [38 CFR 17.120(b)] - and - VA and other Federal facilities were not feasibly available [38 CFR 17.120(c)] - AND <p><u>Must meet one [38 CFR 17.120]:</u></p> <ol style="list-style-type: none"> 1. A VA-rated service-connected (SC) disability – or 2. For nonservice-connected disabilities associated with and held to be aggravating a service-connected disability – or 3. For any disability of a Veteran who has a disability rated as permanent and total (P&T) in nature from a SC disability – or 4. For any illness, injury, or dental condition in the case of a Veteran participating in a rehabilitation program under 38 U.S.C. Chapter 31, and medically determined to be in need of hospital care or medical services (including dental) for any of the reasons listed in 38 CFR 17.47(i)(2) <p>Note: Payment is limited to the point of stabilization, except when:</p> <ul style="list-style-type: none"> - VA is contacted upon stabilization – and - VA cannot accept the transfer of the Veteran – and - The community care facility made and documented reasonable attempts to transfer the Veteran to a VA facility or other Federal facility 	<p>38 U.S.C. § 1725 (38 CFR §§ 17.1000-17.1008) Emergency Care (Outpatient and Inpatient) (Mill Bill Claims)</p> <p><u>Must meet ALL of the following:</u></p> <ul style="list-style-type: none"> - Claims filed within 90 days [38 CFR 17.1004(d)] - and - Prudent layperson definition [38 CFR 17.120(b)] - and - VA and other Federal facilities were not feasibly available [38 CFR 17.120(c)] - AND <p><u>Must meet one [38 CFR 17.1002]:</u></p> <ol style="list-style-type: none"> 1. The emergency services were provided in a hospital emergency department or a similar facility – and 2. Veteran was enrolled in the VA health care system and had received medical services under authority of 38 U.S.C. Chapter 17 within the 24-month period preceding the furnishing of such emergency treatment – and 3. Veteran is financially liable to the provider of emergency treatment for that treatment – and 4. Veteran has no coverage under a health-plan contract (no other health insurance - OHI) for payment or reimbursement* – and 5. The claimant has no contractual or legal recourse, and has exhausted without success all liability claims and remedies reasonably available to the Veteran or provider against a third party for payment of such treatment for extinguishing, in whole, the Veteran’s liability to the provider – and 6. The Veteran is not eligible for reimbursement under 38 U.S.C. § 1728 for the emergency treatment <p>Note: Payment is limited to the point of stabilization, except when same conditions as 38 U.S.C 1728.</p> <p>*Potentially subject to change if the Staab Ruling is upheld.</p>
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Figure B.3. *OIG adaptation of VHA’s Community Care Eligibility Criteria for Emergency Care chart (Continued from Figure B.2.)*
 (Source: VA Community Care Desk Procedures Eligibility Chart, dated February 8, 2017)

Payment Authorities

According to trainings given by the Quality Workforce Development and VHA Community Care Operations Program Office, when voucher examiners process claims, they must keep in mind the order of legal authorities. Specifically, when a claim does not meet the administrative and clinical eligibility for an authorized claim, the voucher examiner should next review a claim against unauthorized claim eligibility criteria. When a claim is not eligible under either authorized or unauthorized eligibility criteria, the voucher examiner must lastly review the claim against Mill Bill eligibility criteria.

Filing Date

Federal regulation states that “[t]he date of filing any claim for payment or reimbursement of the expenses of medical care and services not previously authorized shall be the postmark date of a

formal claim, or the date of any preceding telephone call, telegram, or other communication constituting an informal claim.”⁴³

Clinical Review Requirements

Federal regulations state that a designated VA clinician will make the determination whether a veteran was enrolled in the VA health care system and had received medical services within the 24-month period preceding the furnishing of emergency treatment.⁴⁴ In other words, for a voucher examiner to deny a claim with the denial reason of “38 U.S.C. 1725 No VA Treatment in Past 24 Months,” a clinician needs to make that determination. Yet the CAR Standardized Administrative and Clinical Review Template indicated the voucher examiner was responsible for determining if a veteran was enrolled and received medical services within a 24-month period.

Third-Party Liability

When certain third-party liability exists for emergency treatment rendered to veterans for nonservice-connected conditions (e.g., situations involving auto insurance or workers’ compensation claims), VA may act as a secondary payer. VA acts as secondary payer when a third party is financially responsible for coverage of emergency treatment expenses received for service-connected conditions (under 38 U.S.C. § 1728). In some cases, VA may act as secondary payer when certain third-party liability exists for emergency treatment received for nonservice-connected conditions (under 38 U.S.C. § 1725). In such instances, VA coverage is limited to the amount for which the veteran is personally liable after exhausting the third-party coverage (e.g., automobile personal injury protection insurance).

In the 2014 GAO report on Mill Bill emergency care benefits, GAO recommended VA “establish a policy regarding processing Millennium Act claims to require VA facilities to assist the veteran in determining whether a claim is eligible for coverage by auto insurance or another third party before denying the claim.” As a result, a new Millennium Bill Third Party Liability Request for Additional Information rejection reason was created. According to OCC guidance, the rejection reason included “clarification of auto insurance vs. other 3rd party liability processes and requirements. It is imperative that sites utilize this rejection reason and forward the letter prior to denying a claim for third-party liability.”⁴⁵

⁴³ 38 CFR §17.127, *Date of filing claims*.

⁴⁴ Per 38 CFR §§ 17.1002(d) and 17.1006, a clinician has to make the determination that no VA treatment was provided in the past 24 months.

⁴⁵ *The Bulletin*, 3, no. 13, (June 26, 2014).

Appendix C: Scope and Methodology

Scope

The audit team performed audit work from December 2017 through May 2019. During this audit, the audit team provided interim briefings to CAR leaders. The audit scope was nationwide and covered non-VA emergency care claims-processing activities and decisions during FY 2017 and 2018. In coordination with VA OIG statisticians, the team selected a statistical sample of denied and rejected non-VA emergency care claims that were scanned or electronically received during the six-month period of April 1 through September 30, 2017. Appendix D contains specific details of statistical sampling methodologies.

Methodology

To address the audit objectives, the audit team

- Reviewed applicable laws, regulations, policies, procedures, and guidelines regarding non-VA emergency care claims;
- Interviewed 182 CAR staff with direct knowledge and responsibility for processing non-VA emergency care claims, including CAR leaders, regional officers, VACC managers, supervisors, lead examiners, and voucher examiners;
- Conducted a survey of voucher examiners consisting of questions about processing non-VA emergency care claims;
- Reviewed voucher examiner performance standards and ratings;
- Reviewed a statistical sample of denied or rejected non-VA emergency care claims and associated supporting documentation to determine if the claims were inappropriately processed;
- Conducted a clinical assessment of some sampled claims to determine if the episode of care in question was clinically emergent or considered emergent by a prudent layperson, if a VA medical facility was feasibly available, and if the emergency care rendered was related to the veteran's service-connected disability;⁴⁶
- Reviewed relevant VA email records; and
- Conducted site visits to nine CAR facilities, covering all five OCC regions. Four sites were selected based on congressional inquiries. The remaining five sites were selected

⁴⁶ This assessment was conducted by OIG healthcare inspectors.

based on the percentage of denied and rejected claims during the last two quarters of FY 2017. Selected sites included both consolidated and nonconsolidated sites:

- Region 1: Cleveland, Ohio
- Region 2: Perry Point, Maryland; Washington, DC
- Region 3: Columbia, Missouri; Kansas City, Missouri
- Region 4: Denver, Colorado; Minneapolis, Minnesota; St. Cloud, Minnesota
- Region 5: Vancouver, Washington

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, including taking the following actions:

- Reviewed patient and billing information of sampled claims, such as patient name and claim date of service, to verify whether the information was consistent with the veterans' information in the electronic health record;
- Interviewed CAR staff, reviewed relevant email records, and reviewed survey responses for potentially fraudulent activities within the scope of the audit; and
- Solicited the OIG's Office of Investigations to determine if there were any ongoing cases involving processing of non-VA emergency care claims.

The audit team did not identify any instances of fraud during this audit.

Data Reliability

The OIG used computer-processed data from VA's Corporate Data Warehouse. To test for reliability, the audit team determined whether any data were missing from key fields, included any calculation errors, or were outside the time frame requested. The audit team also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. The OIG compared claims documentation from VA's FBCS system to claims data in VA's Corporate Data Warehouse. The audit team concluded that the data obtained and relied on were sufficiently reliable for the purposes of this audit.

Government Standards

We conducted this performance audit in accordance with generally accepted government auditing standards. Those 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 objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix D: Statistical Sampling Methodology

To determine whether VA medical claims processors inappropriately processed denied or rejected non-VA emergency care claims, the audit team selected a statistical sample of

- Denied Uniform Bill (UB-04) and Health Care Financing Administration (HCFA) unauthorized and Millennium Bill claims, and
- Rejected UB-04 and HCFA unauthorized and Millennium Bill claims.⁴⁷

Population

To determine whether VA medical claims processors inappropriately processed denied or rejected non-VA emergency care claims, the audit team selected a sample of denied and rejected UB-04 and HCFA unauthorized and Millennium Bill claims. The population consisted of 750,106 rejected claims and 220,339 denied claims that were scanned or electronically received from April 1 through September 30, 2017.

The scope included claims that were processed under 38 U.S.C. §1728 (unauthorized claims) and 38 U.S.C. §1725 (Millennium Bill claims).⁴⁸ The audit team contacted the OCC Department of Informatics and Data Analytics to obtain their methodology and further identify potential non-VA emergency care claims. According to the Department of Informatics and Data Analytics, non-VA emergency care claims can be identified by the place of service or revenue code on HCFA and UB-04 claims, respectively. Ultimately, the audit team reviewed a population of UB-04 claims with a revenue code containing any of the following: 045X, 0450, 0451, 0452, 0456, or 0459. In addition, to ensure all non-VA emergency care claims were included, the audit team also included any claims with a description of “EMER,” or “ER.” For HCFA claims, the audit team reviewed claims with a place of service of 11, 20, 22, and 23.

Sampling Design

To assess non-VA emergency care claims, the audit team used a stratified random sample. From the population, the audit team sampled 180 denied and 60 rejected non-VA emergency care claims. The audit team ultimately reviewed a total of 359 claims, but only provided an assessment for 240 claims. The remaining 119 were replaced because the audit team determined

⁴⁷ The UB-04 claim is the official HCFA form used by hospitals and healthcare centers when submitting bills to Medicare and third-party payers for reimbursement for health services. The HCFA claim is the official standard form used by physicians and other providers when submitting claims for reimbursement to Medicare or Medicaid for health services.

⁴⁸ Non-VA emergency care claims included unauthorized, Mill Bill, and service-connected emergency claims. The universe of claims for the last two quarters of FY 2017 consisted of about 1 percent of claims that were categorized as service-connected emergency care. The 240 claims assessed by the audit team were either unauthorized or Mill Bill claims.

that the original claim was not an emergency episode of care, was not for a veteran’s non-VA emergency episode of care or was not processed by a voucher examiner.

Weights

The audit team calculated estimates in this report using weighted sample data. Sampling weights are computed by taking the product of the inverse of the probabilities of selection at each stage of sampling.

Projections and Margins of Error

The margins of error and confidence intervals are indicators of the precision of the estimates. If the OIG 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.

Table D.1 presents estimates over the sample population, including the sample results, estimate, margin of error, lower 90 percent value and upper 90 percent value.

Table D.1. Statistical Projections – Non-VA Emergency Care Claims Denial and Rejection Errors

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
Non-VA Emergency Care Claims – In Scope	240	631,930	70,349	561,582	702,279
Inappropriately Processed	99	195,606 (31%)	55,338 (8%)	140,268 (23%)	250,944 (39%)
Inappropriately Processed – Billed Amount	99	\$716,150,400	\$327,119,400	\$389,031,000	\$1,043,270,000
Inappropriately Processed – Unique Veterans	99	60,837	18,735	42,102	79,573
Total Denied Claims	180	170,148	10,601	159,547	180,749
Inappropriately Processed - Denied Claims	86	81,526 (48%)	12,577 (7%)	68,949 (41%)	94,103 (55%)
Total Rejected Claims	60	461,783	69,546	392,237	531,328

Non-VA Emergency Care Claims Inappropriately Denied and Rejected

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
Inappropriately Processed – Rejected Claims	13	114,081 (25%)	53,890 (11%)	60,191 (14%)	167,970 (36%)
Inappropriately Processed Denial Percentage – Region 1*	12	40%	15%	25%	55%
Inappropriately Processed Denial Percentage – Region 2*	10	33%	14%	19%	48%
Inappropriately Processed Denial Percentage – Region 3*	21	70%	14%	56%	84%
Inappropriately Processed Denial Percentage – Region 4*	28	47%	14%	32%	61%
Inappropriately Processed Denial Percentage – Region 5*	15	50%	15%	35%	65%
Inappropriately Processed – Claim Should Have Been Approved	28	44,959	24,831	20,129	69,790
Inappropriately Processed – Claim Should Have Been Approved – Billed Amount	28	\$174,017,515	\$120,733,820	\$53,283,695	\$375,164,371
Errors – Claims Should Have Been Approved – Unique Veterans	28	17,434	9,335	8,099	26,769

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
Inappropriately Processed Claims Should Have Been Suspended, Rejected for Additional Information, or Denied with Accurate Denial Reason	71	150,647	50,643	100,004	201,290

Source: VA OIG analysis of statistically sampled results projected over the sample population. Data used for analysis and projections was obtained from the VA's Corporate Data Warehouse.

** The only statistically significant differences are between Region 1 and Region 3, Region 2 and Region 3, and Region 3 and Region 4. There is no statistically significant difference in error rate between region unless stated otherwise.*

Appendix E: Potential Monetary Benefits in Accordance with Inspector General Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
1-4, 9	OCC inappropriately denied or rejected claims it should have approved, in the estimated amount of \$53.3 million during a six-month period. The OIG further estimated errors could result in \$533 million in improper underpayments over a period of five years if corrective actions are not taken.	\$0	\$533 million
	Total	\$0	\$533 million

Note: The estimated value represents the total billed amount. VA documentation states that VA payment rates for emergency care are generally 100 percent of Medicare rates for service-connected conditions and 70 percent of Medicare rates for nonservice-connected conditions. In addition, OIG estimated that if OCC continued to inaccurately deny or reject claims it should have approved as estimated in table D.1 for a six-month period, based on payment rates in effect at the time of this review, this could lead to an estimated \$533 million in improper underpayments over five years. The five-year estimate is an extrapolation of the six-month estimate. The six-month estimate is a conservative estimate (based on the lower limit of the 90 percent confidence interval) therefore the five-year estimate is also conservative.

Appendix F: Survey Results

The audit team conducted a survey of CAR staff that process non-VA emergency care claims. The audit team distributed the survey to 1,333 CAR staff via email and during site visits. In total, 435 people responded to the survey. Of the 435 responses, 394 answered that they processed non-VA emergency care claims. The figures below illustrate responses from those 394 voucher examiners.

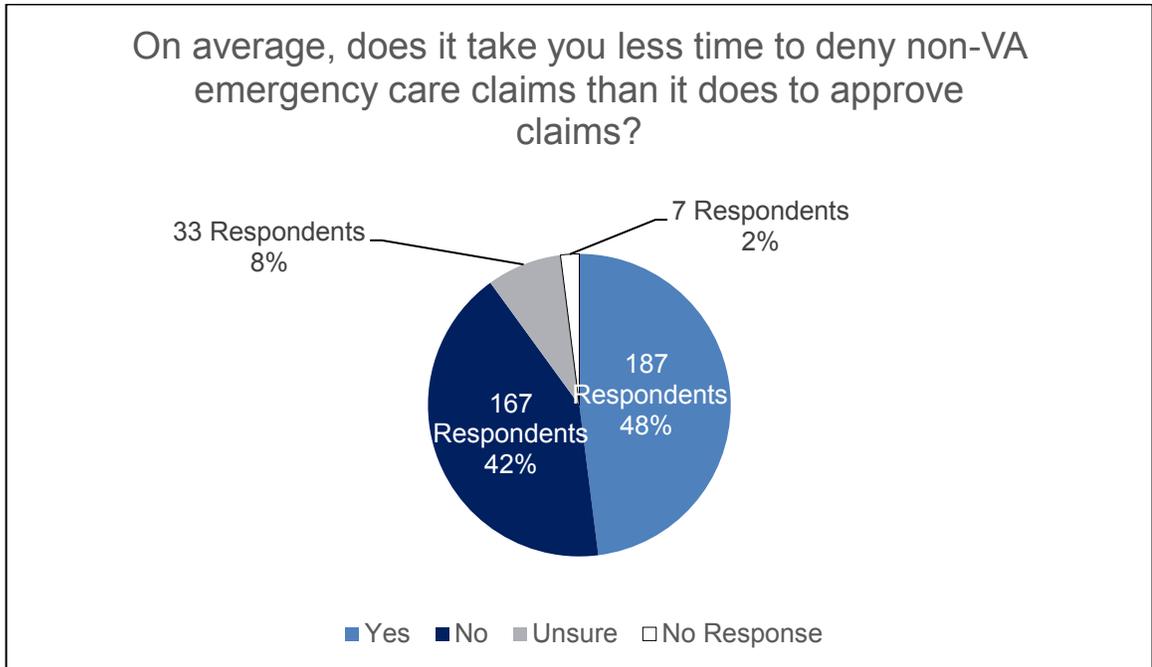


Figure F.1. Pie chart of responses to question 2
(Source: VA OIG analysis of survey responses)

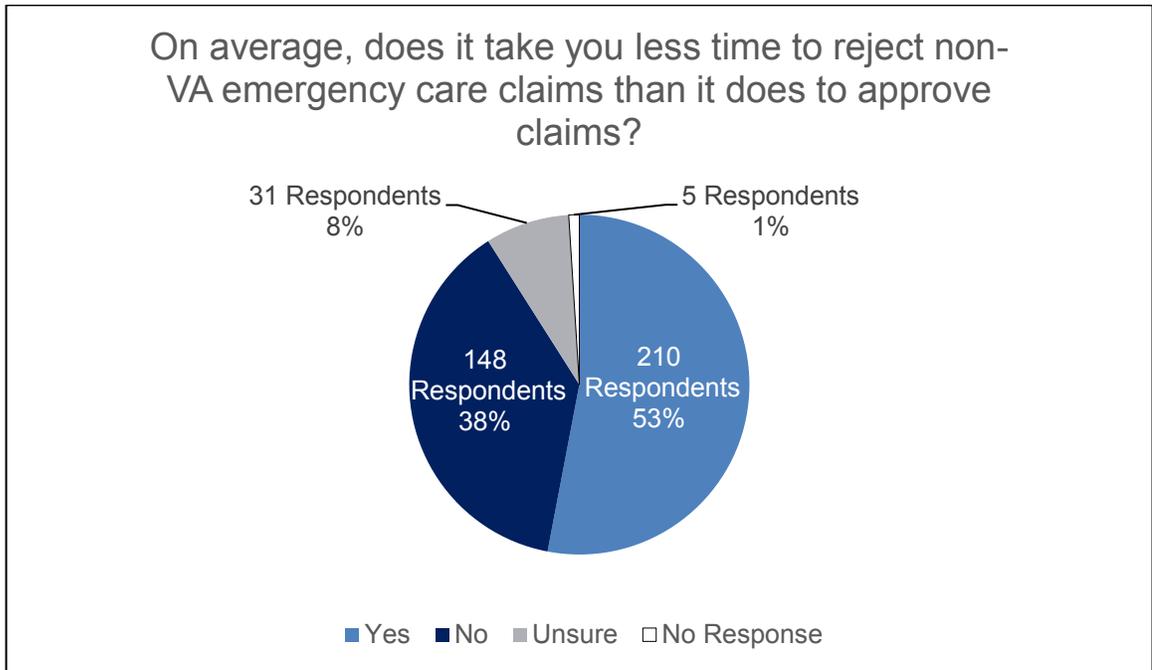


Figure F.2. Pie chart of responses to question 3
(Source: VA OIG analysis of survey responses)

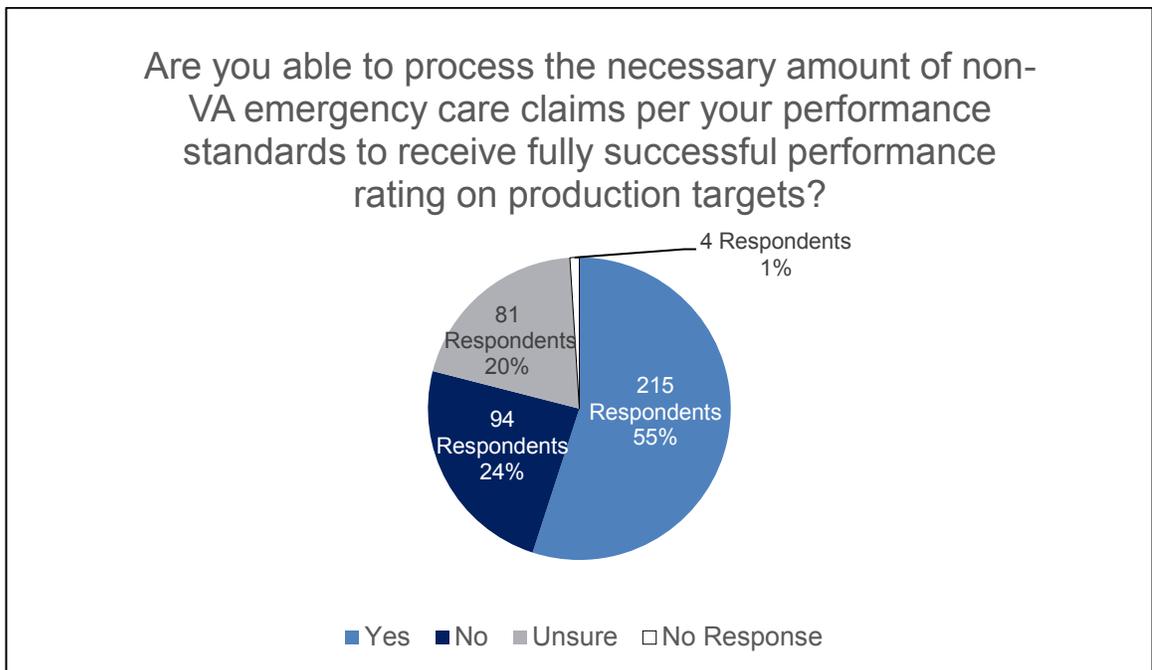


Figure F.3. Pie chart of responses to question 4
(Source: VA OIG analysis of survey responses)

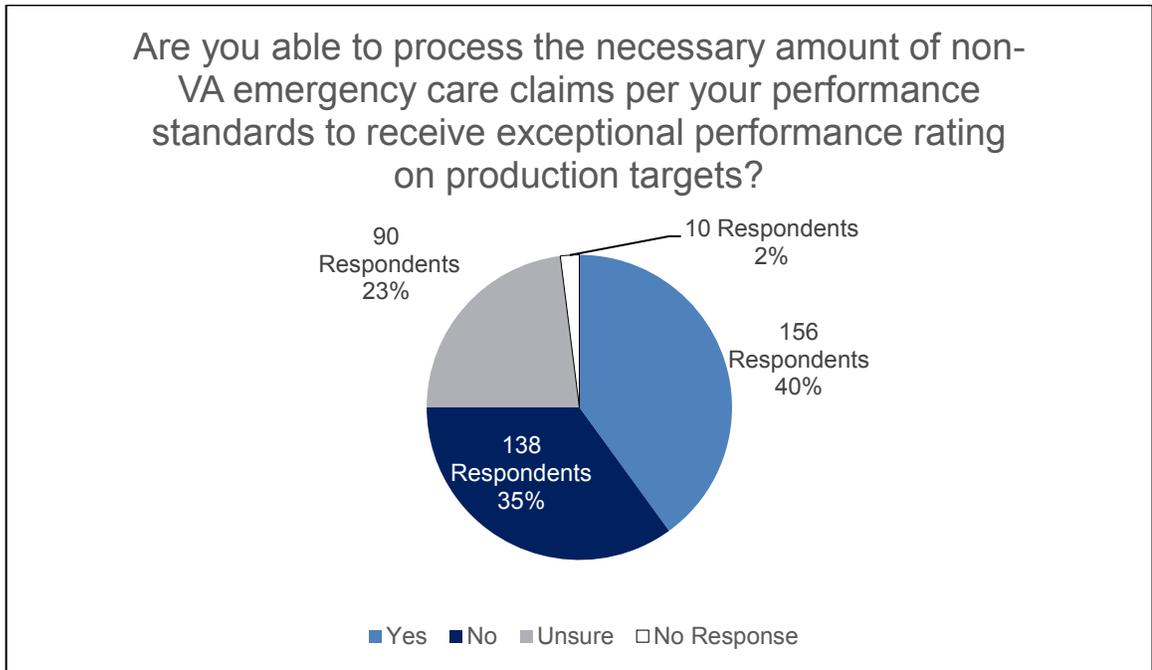


Figure F.4. Pie chart of responses to question 5
(Source: VA OIG analysis of survey responses)

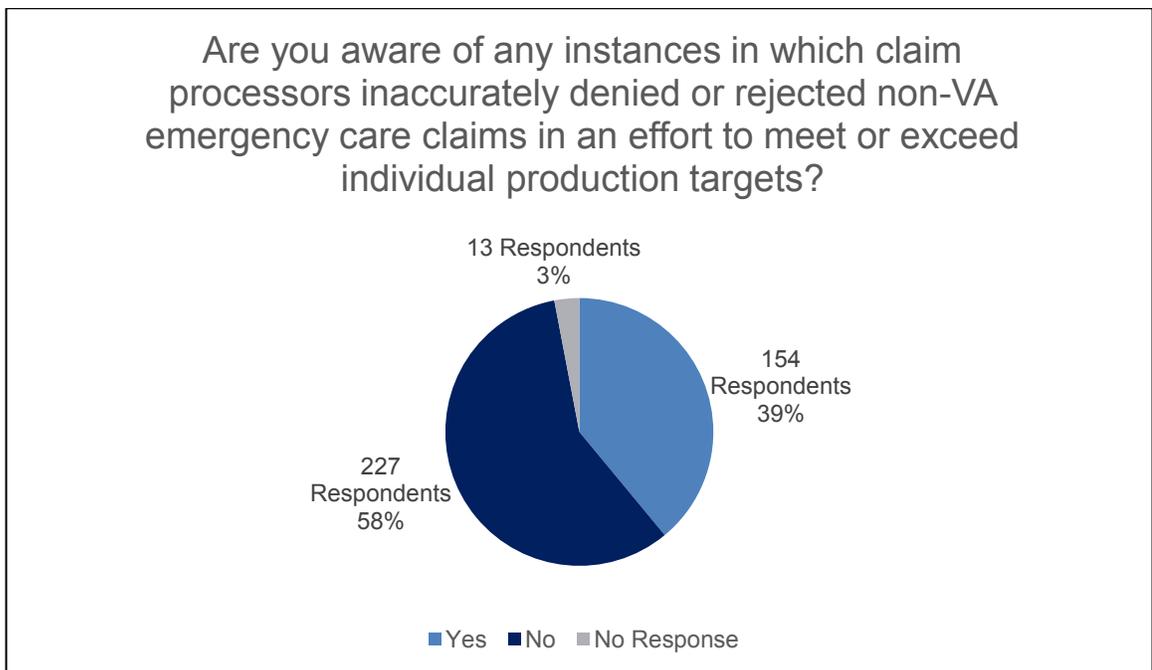


Figure F.5. Pie chart of responses to question 6
(Source: VA OIG analysis of survey responses)

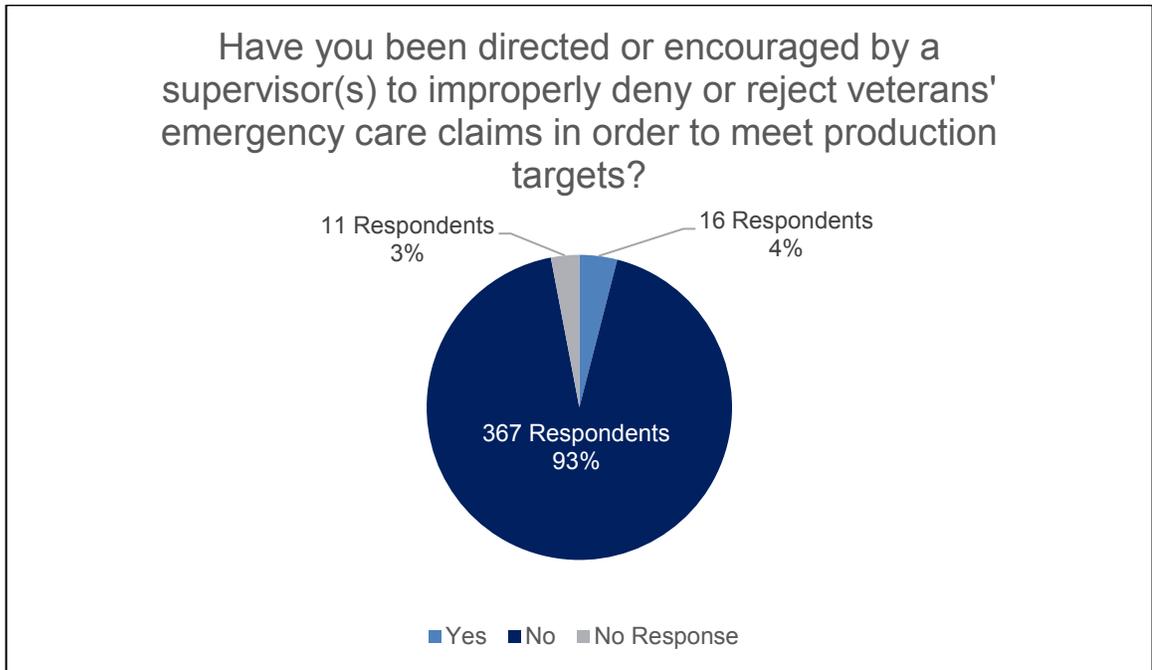


Figure F.6. Pie chart of responses to question 7
(Source: VA OIG analysis of survey responses)

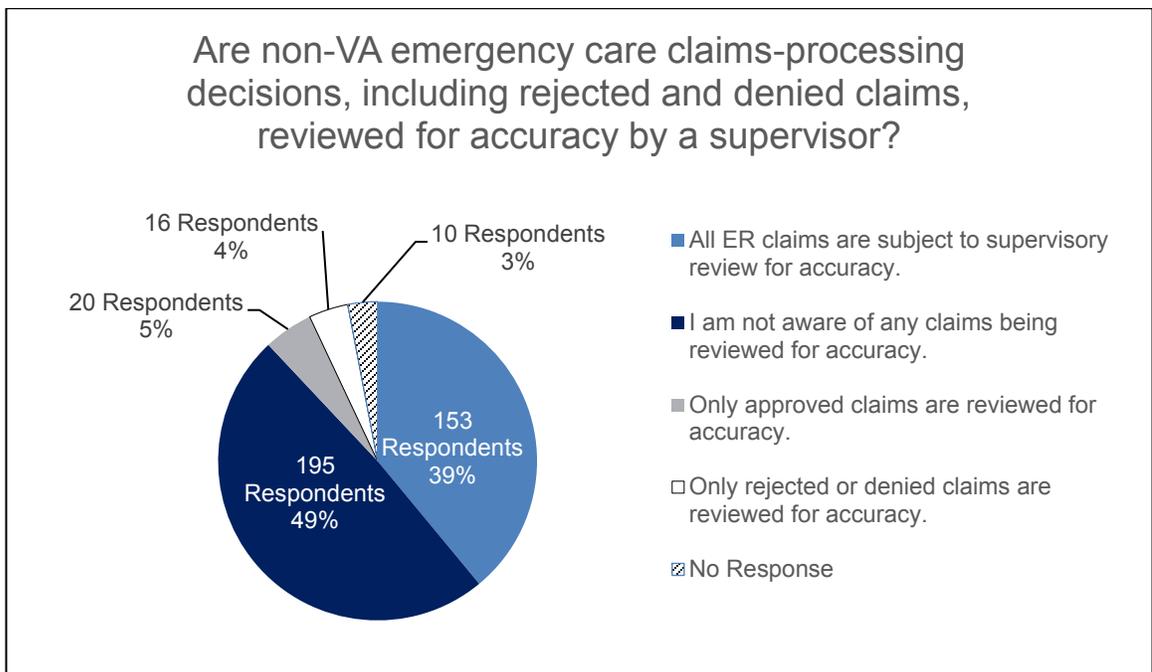


Figure F.7. Pie chart of responses to question 8
(Source: VA OIG analysis of survey responses)

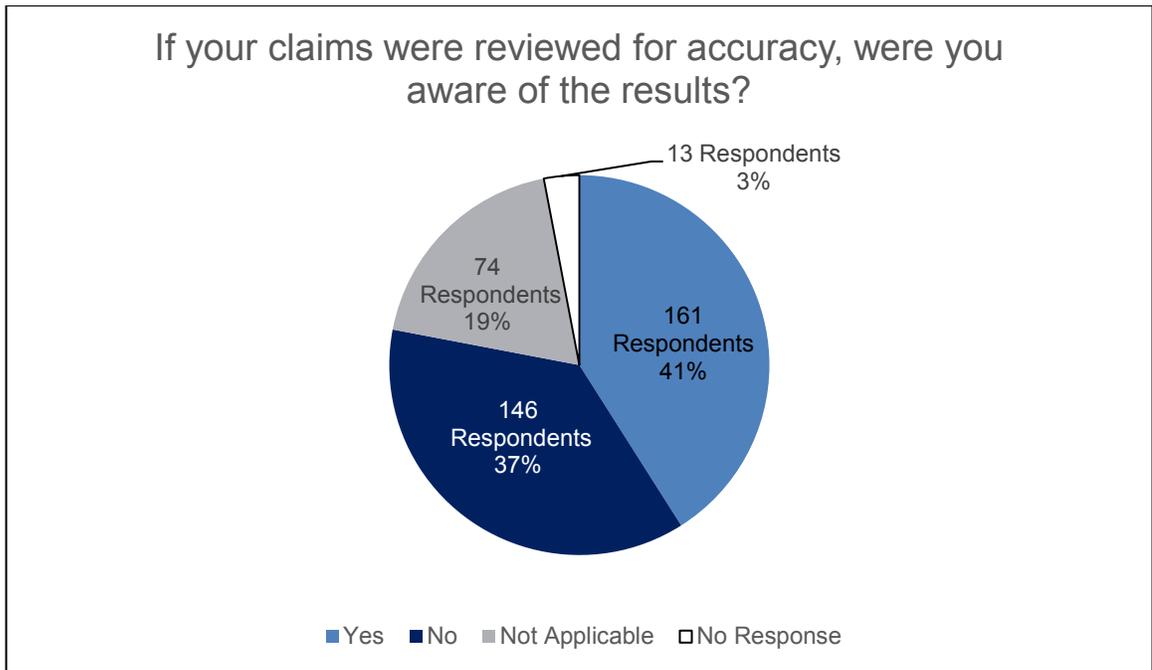


Figure F.8. Pie chart of responses to question 9
(Source: VA OIG analysis of survey responses)

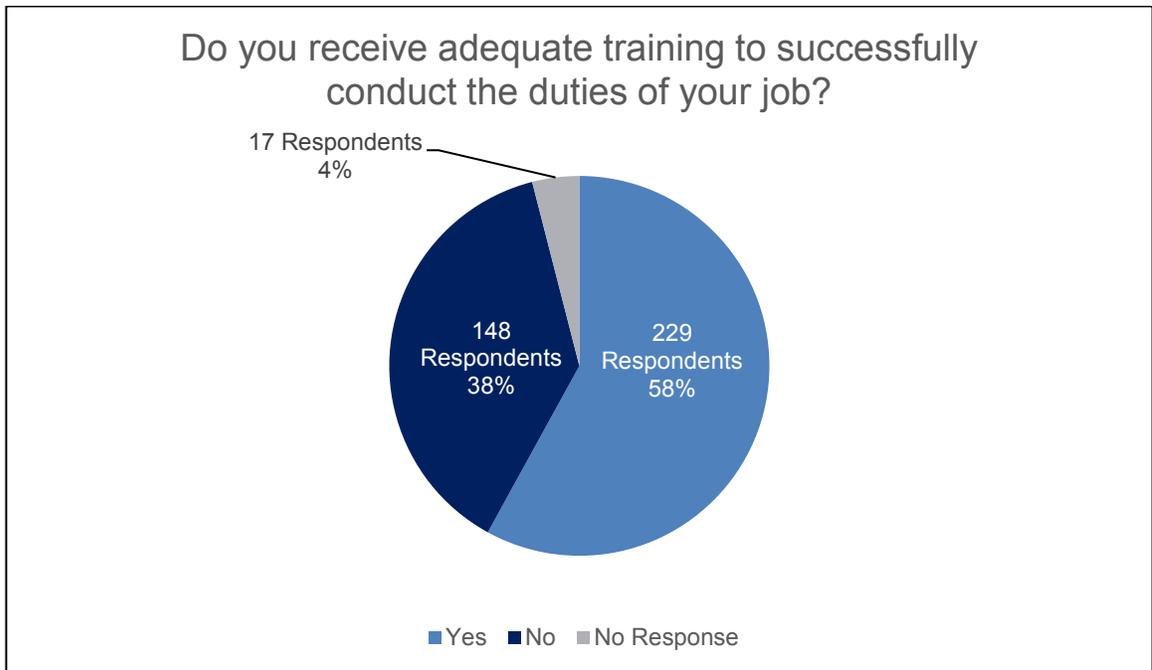


Figure F.9. Pie chart of responses to question 10
(Source: VA OIG analysis of survey responses)

Appendix G: Management Comments

Department of Veterans Affairs Memorandum

Date: June 24, 2019

From: Executive in Charge, Office of the Under Secretary for Health (10)

Subj: OIG Draft Report, Non-VA Emergency Care Claims Inappropriately Denied and Rejected (VIEWS # 01118154)

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 Non-VA Emergency Care Claims Inappropriately Denied and Rejected. I concur with recommendations 1-4, 7-9 and 11 and concur in principle with recommendations 5, 6 and 10. I am providing the attached technical comments and action plan to address OIG's recommendations.
2. The Veterans Health Administration (VHA) is committed to continuously improving its processes and developing effective measures for non-VA emergency care claims processing. VHA is invested in protecting the interests and welfare of Veterans who rely on us to provide dependable, high-quality health care. Paying claims timely and accurately is a priority for VHA and we take this responsibility very seriously.
3. VHA greatly appreciates OIG's findings, but it is important to note that the sample reviewed included claims from April to September 2017, and prior to receiving the OIG's findings, VHA's Office of Community Care (OCC) had self-identified most concerns found in the OIG report and began taking corrective actions. OCC took steps more than a year ago to implement numerous improvements to mitigate many of the findings in the report. Improvements included:
 - a. Changing claims processing guidance and offering training to voucher examiners to enable greater accuracy and quality;
 - b. Revising processes and adjusting system functions affecting the handling of other health insurance (OHI) claims as well as those used to correct denied claims and communicate with providers and Veterans;
 - c. Standardizing language used in denial notices and rejection reason explanations and implementing revised guidance to assist voucher examiner staff in claims decision-making;
 - d. Initiating nationwide quality and accuracy reviews, specifically on denied and rejected claims, to assess processing accuracy and identify additional staff training needed to address processing error trends; and
 - e. Revising performance plans to eliminate production-related elements affecting voucher examiners in fiscal year 2018-2019.
4. OCC is continuing to make strategic and transformative changes to the Claims Adjudication and Reimbursement Directorate (CAR). These changes will significantly improve the claim processing environment ensuring greater quality, automation, and a positive work environment. These changes include:
 - a. Fully revising voucher examiners performance plans to align with the new strategic direction for CAR. The revised performance plan emphasizes balance across production, accuracy, quality, customer service, and teamwork dimensions.
 - b. Consolidating operations and focusing the organization on value-added activities and new product lines, with a concentration on education, training, quality, provider engagement, appeals and contractor performance.
 - c. Placing greater emphasis on process standardization, best practices, specialization, and workload oversight and balancing.

- d. Chartering a workgroup with members who are knowledgeable about employee engagement, inclusion, and psychological safety. The workgroup will also include those with expertise aimed at helping CAR managers and supervisors change and adopt behaviors important to focusing on quality management.
 - e. Continuing to move towards elimination of paper claims as well as strengthening and modernizing the claims information technology infrastructure. Part of these modernization efforts includes implementation of the Electronic Claims Adjudication Management System (eCAMS). eCAMS is a modern, efficient, and automated software product that will process health care claims submitted by community providers and enable greater accuracy in claims handling.
5. VHA is reviewing the audit's sample claims and OHI denials and has initiated necessary corrective actions. OCC will provide impacted Veterans with a notice of the error and OCC's re-adjudication actions and will be advised that they can contact the Community Care Contact Center if they need help with provider bills or negative financial reporting. Impacted Veterans will have 1 year from the date of the new decision notice to file an appeal. VHA will take these actions for the period covered by the OIG's sample, and for any other claims determined to have been improperly denied between April 8, 2016 and January 9, 2018. VHA is already taking actions to address improperly denied claims after January 9, 2018.
6. If you have any questions, please email Karen Rasmussen, M.D., Director for GAO-OIG Accountability Liaison at VHA10EGGOALAction@va.gov.

(Original signed by)

Richard A. Stone, M.D.

Attachments

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report: Audit of Non-VA Emergency Care Claims Inappropriately Denied and Rejected

Date of Draft Report: May 13, 2019

Recommendations/	Status	Completion Date
Actions		

Recommendation 1: The Under Secretary for Health reevaluates all claims denied after April 8, 2016, for the reason of “other health insurance” for appropriate corrective action.

VHA Comments: Concur

The Veterans Health Administration (VHA) recognizes the impact erroneously denied claims may have on Veterans and we take seriously our responsibility to pay claims timely and accurately.

VHA’s Office of Community Care (OCC) will take corrective actions on claims determined to have been improperly denied for the presence of other health insurance (OHI) after April 8, 2016. The claimants will be provided with a notice of the error and OCC’s re-adjudication actions and will advise Veterans they can contact the Community Care Contact Center if they need help with provider bills or negative financial reporting.

In addition, the claims will be reopened, any missing evidence will be requested (including evidence regarding any payment by OHI), and claims will be re-adjudicated upon receipt of any such missing evidence. Claimants will have 1 year from the date of the new decision notice to file an appeal.

VHA will take these actions for the period covered by the OIG’s sample and for any other claims determined to have been improperly denied between April 8, 2016 and January 9, 2018. VHA is already taking actions to address improperly denied claims after January 9, 2018.

To demonstrate completion of this recommendation, OCC will provide the following documentation:

- Copy of Veteran Communication Letter
- Listing of affected Veterans notified of erroneously denied/rejected claims

Status:	Target Completion Date:
In process	November 2019

Recommendation 2: The Under Secretary for Health implements a clearly defined decision matrix that allows staff to accurately determine when claims should be denied, rejected, or approved; initiates a process to systematically audit denied and rejected claims; and takes corrective actions as needed based on audit results.

VHA Comments: Concur

In March 2018, after an internal audit of non-VA emergency claims, the Office of Community Care (OCC) began to develop and implement a portfolio of targeted process and organizational improvements aimed at addressing non-VA emergency claim processing accuracy and quality. To assist staff with making decisions on when claims should be denied, rejected, or approved, OCC is revising existing standard operating procedures (SOP) and developing additional job aides and tools to assist staff with making accurate eligibility and adjudication decisions.

OCC has revised and standardized all claim denial and rejection reasons. The Emergency Care Claim Processing SOP document was updated with additional guidance on the use of standardized denial and rejection reasons. OCC communicated and distributed the revised SOP to existing staff. An OCC Special Audit Team review, completed in April 2019, found a 98 percent degree of compliance with the use of standardized denial or rejection reason codes.

To systematically audit denied and rejected claims, in November 2018, OCC initiated weekly quality and accuracy reviews covering rejected and denied claims. OCC Claims Adjudication and Reimbursement Directorate (CAR) supervisors analyze the findings from these reviews to identify individual and group remedial training needs, as well as to determine local claims processing accuracy and trends. The reviews help to identify inappropriate denial reasons, non-standard denial reason usage and employees with patterns of inappropriate denials. Review results are regularly discussed at the CAR Directorate level for nationwide awareness, best practice sharing, and discussion of additional internal controls needed to prevent future errors.

The clinical workgroup within CAR now regularly reviews rejection and denial reasons on clinical decisions. In addition, pre-decisional denial secondary reviews by CAR Regional Clinical Managers began in February 2019. These reviews enable the Regional Clinical Managers to assess accuracy, quickly overturn incorrect decisions, and conduct on the spot training with staff.

Finally, OCC is fully revising the Emergency Care Claim Processing SOP, and related training offerings to incorporate additional guidance and instructions important to claim adjudication and decisioning.

To demonstrate completion of this recommendation, OCC will provide the following documentation:

- Revised Emergency Care Claim Processing SOP
- Supervisor Quality and Accuracy Review SOP
- OCC fiscal year 2019 Millennium Act Standard Denial Reason Analysis

Status:

In process

Target Completion Date:

August 2019

Recommendation 3: The Under Secretary for Health develops and implements a control to ensure claims processors have the appropriate options in the claims processing system of record to request evidence necessary to substantiate third-party liability claims.

VHA Comments: Concur

The Office of Community Care (OCC) implemented the following controls to ensure claims processors have appropriate processes and tools to adjudicate claims with a partial payment by a third party, including under a health-plan contract.

In March 2019, OCC eliminated the Fee Basis Claim System prompt that triggered a claim denial when a voucher examiner indicated that other health insurance was present. All OCC claims processing sites have disabled the denial reason titled: "Veteran has Third Party Liability." If other payer information is not

submitted with the claim, the claim will be rejected with an indication that additional supporting documentation is necessary to determine the Department of Veterans Affairs allowable amount after any payment by a third party.

The Emergency Care Claim Processing Standard Operating Procedures (SOP) document has been updated and this direction communicated and distributed to the field. Ad hoc spot checks are performed to verify that claims are rejected rather than denied when third party liability documentation is needed. Weekly accuracy reviews of denied and rejected claims are conducted by supervisors to monitor the disposition of these claims.

OCC is fully revising the Emergency Care Claim Processing SOP and related training offerings to incorporate additional guidance and instructions important to claim adjudication and decisioning.

To demonstrate completion of this recommendation, OCC will provide the following documentation:

- Ad hoc spot check report confirming rejection, rather than denial, of claims
- Revised Emergency Care Claim Processing SOP

Status:	Target Completion Date:
In process	August 2019

Recommendation 4: The Under Secretary for Health reevaluates all sample claims identified in this audit as inappropriately denied and rejected for appropriate corrective action.

VHA Comments: Concur

The Veterans Health Administration (VHA) recognizes the impact erroneously denied and rejected claims may have on Veterans and we take seriously our responsibility to pay claims timely and accurately. All sample claims identified in the Office of Inspector General audit as inappropriately denied and rejected will be reevaluated for appropriate corrective action. The Office of Community Care (OCC) will begin issuing letters to negatively affected Veterans. These letters will explain the error and OCC's re-adjudication actions and advise Veterans about how they can contact the Community Care Contact Center should they need help with providers for costs paid out of pocket and/or negative financial reporting. Any new decisions issued after corrective action is taken will provide a 1 year appeal period from the date of the new decision.

To demonstrate completion of this recommendation, OCC will provide a listing of affected Veterans from the audit, with the action taken on each.

Status:	Target Completion Date:
In process	September 2019

Recommendation 5: The Under Secretary for Health reevaluates production targets, work production credits, and application of non-processing time for voucher examiners to ensure the production targets include claims research.

VHA Comments: Concur in principle

In October of 2018, the Office of Community Care (OCC) eliminated the critical production-related performance element from the voucher examiner fiscal year (FY) 2018 performance plan. There is no need to reevaluate production targets or work production credits because production targets have been eliminated as well for FY 2019.

OCC initiated discussions to fully revise voucher examiner performance plans to align with the new strategic direction for the Claims Adjudication and Reimbursement Directorate (CAR). The revised performance plan emphasizes balance across production, accuracy, quality, customer service, and teamwork dimensions. The revised CAR performance framework and voucher examiner plan is currently under union review. The voucher examiner performance plan takes into consideration all facets of activities important to CAR's values and future direction.

Upon the Veterans Health Administration and union agreement, OCC will begin national implementation. The new performance framework will become effective in FY 2019 if the performance plan is union approved by July 2019; otherwise, the plan will become effective with the next FY performance period.

To demonstrate completion of this recommendation, OCC will provide the revised/approved performance plan ready for implementation.

Status:	Target Completion Date:
In process	September 2019

Recommendation 6: The Under Secretary for Health requests and ensures the Office of Resolution Management conducts an organizational assessment of the Claims Adjudication and Reimbursement processing locations where staff reported they were directed or encouraged to improperly process claims and take appropriate action.

VHA Comments: Concur in principle

The Office of Community Care (OCC) concurs in principle that an organizational assessment of processing locations where staff reported they were directed or encouraged to improperly process claims is warranted but considers responsibility for the assessment to fall within the authority of the Executive Director (ED) of OCC Delivery Operations (DO). OCC believes it is prudent for the ED to conduct the organizational assessment. This effort is in alignment with the work DO has undertaken to ensure a positive workplace culture is in place to support a balanced set of values that includes production, accuracy, quality, customer service, and teamwork.

The ED will charter a workgroup, that may include the Office of Resolution Management as well as other subject matter experts within the Veterans Health Administration knowledgeable about employee engagement, inclusion, and psychological safety. The workgroup will also include those with expertise aimed at helping Claims Adjudication and Reimbursement Directorate managers and supervisors change and adopt behaviors important to focusing on quality management.

To demonstrate completion of this recommendation, OCC will provide the following documentation:

- Organizational Assessment Workgroup Charter
- Organizational Assessment report

Status:	Target Completion Date:
In process	October 2019

Recommendation 7: The Under Secretary for Health implements strategic plans to ensure the Office of Community Care, Claims Adjudication and Reimbursement, emphasizes the accuracy of claims processing decisions.

VHA Comments: Concur

In September 2018, leaders from the Office of Community Care's (OCC) Claims Adjudication and Reimbursement Directorate (CAR) completed development of a comprehensive strategic and transformational plan which affirms and communicates a mission, vision and goals centered on quality, service, accountability, and customer experience. The plan encompasses specific strategies for CAR's transformation over a 2-year horizon including:

- Moving the organization from being a manual, decentralized claims processing unit to one that is regionally centralized and automated.
- Placing greater emphasis on process standardization, best practices, specialization, and workload oversight and balancing.
- Consolidating operations and focusing the organization on value-add activities and expansion into new product lines, such as quality, provider engagement, appeals and contractor performance.

A cornerstone of the CAR's strategic plan is a renewed emphasis on quality assurance (QA) and accuracy of claims processing decisions. CAR defined quality initiatives for implementation at the regional and national levels. CAR's QA Plan defines milestones with specific goals, activities with interdependencies, and key outcomes/deliverables. The plan includes the hiring of new QA positions which include: QA Officers at the Program and each regional level, Internal Controls Specialists, Policy Analysts and Trainers.

OCC is currently implementing both the CAR strategic and QA plans. CAR has already hired several of the key QA positions and is on track to complete the initiatives defined for the first milestone.

OCC is overseeing progress through regular meetings with the CAR management team and staff. These meetings focus on progress and successes as well as provide a forum for problem-solving and refinement of future plans. Weekly QA plan meetings are also conducted regionally and nationally covering: process improvement results and opportunities, QA and accuracy review results, standardization issues and internal control needs and documentation efforts. Results reviewed at the national level guide system-wide improvements such as revised standard operating procedures, training, or other process improvements.

To demonstrate completion of this recommendation, OCC will provide the following documentation:

- Overall CAR Strategic Plan
- CAR Quality Assurance Plan
- 6-Month Quality Assurance Plan Progress Report

Status:	Target Completion Date:
In Progress	August 2019

Recommendation 8: The Under Secretary for Health implements controls to ensure eligibility for overtime, telework, and annual performance bonuses for Claims Adjudication and Reimbursement staff includes all facets of performance.

VHA Comments: Concur

Department of Veterans Affairs overtime (OT), telework, and annual performance bonus determinations must conform with applicable regulations, policies, and collective bargaining agreements. Per VA policy, employee performance is one consideration among others for OT and telework determinations.

The Office of Community Care (OCC) Claims Adjudication and Reimbursement Directorate (CAR) has drafted new performance plans and standards for staff which take into consideration many facets of performance. Elements such as accuracy, quality, customer service, and teamwork will be considered when assessing performance and determining an annual performance rating and awards under the new framework. All facets of new performance standards will factor into the determination of OT and telework assignments. CAR recently created a nationwide OT policy. CAR presented the proposed policy to the union for ratification in May 2019. Once agreed to, the policy will become effective immediately.

OCC will hold meetings and discussions with CAR managers and staff to introduce and implement the new performance framework and policy changes. These forums will help to ensure understanding of the changes being implemented.

To demonstrate completion of this recommendation, OCC will provide the following documentation:

- Revised/approved performance plan ready for implementation
- Revised CAR OT policy

Status:

In process

Target Completion Date:

September 2019

Recommendation 9: The Under Secretary for Health develops and implements a clearly defined and effective quality assurance program that encompasses all claims decisions and includes a standardized process for supervisors to determine and effectively monitor the extent to which claims processors accurately rejected and denied non-VA emergency care claims.

VHA Comments: Concur

A cornerstone of the Office of Community Care's (OCC) Claims Adjudication and Reimbursement Directorate (CAR) strategic plan is a renewed emphasis on quality assurance (QA) and accuracy of claims processing decisions. The strategic plan includes the creation of a new QA product.

The QA plan has been developed and defines milestones with specific goals, activities with interdependencies on other departments, and key outcomes/deliverables. The plan includes initiatives to create and enhance the QA product line at the regional and national levels. It includes the hiring of new QA positions which includes: QA Officers at the program and each regional level, Internal Controls Specialists, Policy Analysts and Trainers.

CAR is implementing the plan and has hired several of the key QA positions and is on track to complete key initiatives defined for the initial milestone:

- Grow and perfect internal quality and accuracy reviews, including improved automated generation of samples, storage and tracking of results and analysis;
- Grow and perfect clinical workgroup quality and accuracy reviews, including pre-decisional secondary reviews;
- Complete Program Integrity Tool Business Rules – Inpatient payments and enhanced duplicate detection;
- Align Regional Policy Analysts with Program Office QA team to write and standardize desk procedures; and

- Fully revise the Emergency Care Claim Processing standard operating procedures (SOPs), and related training offerings to incorporate additional guidance and instructions important to claim adjudication and decisioning.

OCC is overseeing CAR's strategic plan implementation and holds regular meetings with the CAR management team and staff. These meetings focus on progress and successes as well as provide a forum for problem-solving and refinement of future plans. Weekly QA plan progress meetings are also conducted regionally and nationally covering: process improvement results and opportunities, QA and accuracy review results, standardization issues and internal control needs and documentation efforts. Results reviewed at the nation level guide system-wide improvements such as revised SOP's, training, or other process improvements.

To demonstrate completion of this recommendation, OCC will provide the following documentation:

- Overall CAR Strategic Plan
- CAR QA Plan
- Fiscal year 2020, 1st Quarter QA Plan Progress Report
- Revised Emergency Care Claim Processing SOP with included quality assurance actions and monitoring

Status:

Target Completion Date:

In Progress

December 2019

Recommendation 10: The Under Secretary for Health develops and implements clearly defined controls to ensure Claims Adjudication and Reimbursement processing facilities routinely communicate backlogs of incoming mail to Office of Community Care leaders with associated action plans to accurately record the date the documents were received.

VHA Comments: Concur in principle

The Office of Community Care (OCC) recognizes the impact delays in processing paper mail after receipt by the Department of Veterans Affairs (VA) can have when making timely filing determinations. To address this concern, in March 2019, OCC instructed claims processing staff to begin using the claim date provided by the provider to determine if a claim was filed timely. This process change affords maximum leniency for the timely filing of paper claims and is expected to end timely filing denials resulting from delays in paper mail processing.

To address the overall concern of delayed paper mail processing upon receipt by VA, the Office of Community Care (OCC) implemented the Paper to Electronic Data Interchange (P2E) Initiative. This initiative is intended to ensure that community care claims and records are digitized promptly, and that newly submitted claims and supporting documentation is received electronically.

OCC anticipates that the volume of incoming paper claims will dramatically reduce later this year as the P2E Initiative moves into Phase 2. During Phase 1 of the initiative, OCC forwarded paper claims to an outside vendor for scanning and electronic conversion. In Phase 2, targeted to begin in July 2019, community providers will send paper claims and supporting documents directly to a centralized claims intake center. At this time, all claims and records will either be submitted electronically or converted to electronic transactions. This electronic process will all but eliminate paper processing.

In addition, OCC is updating regulations to mandate that providers use Electronic Data Interchange. OCC is incorporating an electronic claims submission process like the Centers for Medicare and Medicaid Services.

To demonstrate completion of this recommendation, OCC will provide the following documentation:

- Revised Emergency Care Claims Processing
- Demonstrated implementation of Phase 2 paper to electronic conversion

Status:	Target Completion Date:
In Progress	December 2019

Recommendation 11: The Under Secretary for Health develops and implements clearly defined controls to ensure Claims Adjudication and Reimbursement processing facilities and VA medical centers timely communicate claims decisions to veterans and providers to ensure veterans are notified of what VA needs to adjudicate the claims and what actions the veteran may take in response.

VHA Comments: Concur

The Office of Community Care (OCC) is proceeding with plans to automate and centralize outbound correspondence handling to ensure more timely communication of claims decisions.

The Department of Veterans Affairs (VA) is deploying a new claims processing system. The Electronic Claims Adjudication Management System (eCAMS) is a modern, efficient, and automated product that will process health care claims submitted by community providers. eCAMS will replace the Fee Basis Claims System legacy system. The quality and timeliness of claims adjudication and decision-making will improve, with fully automated claims adjudication, as will the accuracy of payment processing and timeliness of communications sent to Veterans and providers. eCAMS is currently in testing with national deployment expected to complete by November 2019. All outbound correspondence through eCAMS will eventually be centralized and mailed from the Financial Services Center (FSC).

Until eCAMS and FCS handling is fully implemented, outbound correspondence will still be sent from CAR processing locations. Weekly reviews of correspondence in processing queues will be performed by CAR managers and leaders to ensure correspondence is being printed timely. In addition, CAR is currently evaluating locations and equipment for centralization of outbound mail to ensure greater efficiency, controls, and timeliness.

To demonstrate completion of this recommendation, OCC will provide monthly reporting of correspondence print queue reviews at CAR processing locations.

Status:	Target Completion Date:
In process	December 2019

VETERANS HEALTH ADMINISTRATION (VHA)

Technical Comments

OIG Draft Report: Audit of Non-VA Emergency Care Claims Inappropriately Denied and Rejected

Date of Draft Report: May 13, 2019

- Suggested change (page 2 Footnote 7)⁴⁹: We recommend revising the footnote as follows, “38 U.S.C. 1703, *Contracts for hospital care and medical services in non-Department facilities*, defines the requirements for authorized non-VA care. In certain instances, described in 38 C.F.R. 17.54, VA may deem non-VA emergency treatment to be authorized under section 1703 if VA is notified of an admission within 72 hours.”

Justification: Section 1703 is a contract authority, not a reimbursement authority, and the 72-hour rule is regulatory, not statutory.
- Suggested change (page 11 Footnote 17): We recommend this footnote be removed.

Justification: The Department of Veterans Affairs (VA) is not a secondary payer under 38 U.S.C. 1725. When VA reimburses under this authority, VA is the only payer.

The 1725 reference in this footnote is outdated and does not reflect the changes made to implement *Staab v. McDonald*, 28 Vet. App. 50 (2016). VA is now secondary payer to all third party payers, including health insurance plans. VA must obtain evidence of any payment by a responsible third party to determine the VA allowable payment amount. If information about the third party payment is not received with the claims, they are rejected with an appropriate notice to submit supporting documentation to allow VA to process accordingly.
- Suggested change (page 10 Footnote 15): We recommend updating this footnote to state that VHA published implementing regulations on January 9, 2018, and began processing held claims on that date.
- Suggested change (pages 28-29): The discussion on pages 28-29, leading to recommendations 10-11, is inaccurate in some instances because it does not clearly explain the differences between the processing of claims filed by providers (the majority of VHA’s claims) and claims filed by Veterans. Provider claims are processed in accordance with industry standards using rejection notices and explanations of benefits, which use remark codes to explain the bases for rejection and denial. Providers are accustomed to and understand these types of communications and procedures, and rejection notices seeking information within the providers’ possession or obtainable by the providers are generally not sent to the Veteran as well because it could cause confusion. Claims filed by a Veteran or provider that are being denied trigger the right to appeal. The Veteran is provided with notices in accordance with Chapter 51. We recommend this section be updated accordingly.
- Additional/Clarifying Information (page 37 Chart): The 1725 information contained in the chart is no longer applicable and does not reflect the changes made to implement *Staab v. McDonald*, 28

⁴⁹ OIG Note: Some references in this attachment to footnotes and page numbers changed during the editing and reformatting of this report.

Vet. App. 50 (2016). VA is now secondary payer to all third-party payers, including health insurance plans. VA must obtain evidence of any payment by a responsible third party to determine the VA allowable payment amount. If information about the third-party payment is not received with the claims, they are rejected with an appropriate notice to submit supporting documentation to allow VA to process accordingly. Office of Community Care (OCC) updated processing guidance in accordance with the IFR published on 1/9/18.

OCC is developing additional job aides and tools to assist staff with making accurate eligibility and adjudication decisions. These will be provided as part of deliverables for Recommendation 2.

6. Suggested change (page 38 Filing Claims Timely): We recommend revising this paragraph to clarify that the quoted provision applies to 38 U.S.C. 1728 specifically.
7. Suggested change (page 38 Third-Party Liability): We recommend updating this paragraph to account for the change in the law after Staab.

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

OIG Contact and Staff Acknowledgments

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