



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

VHA Improperly Paid and
Reauthorized Non-VA
Acupuncture and
Chiropractic Services

AUDIT

REPORT #20-01099-249

DECEMBER 8, 2021



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Executive Summary

The Veterans Health Administration (VHA) Office of Community Care (OCC) manages VA programs that allow veterans to receive medical care, including acupuncture and chiropractic services, from local non-VA providers. The VA Office of Inspector General (OIG) conducted this audit of acupuncture and chiropractic care by non-VA providers after becoming aware of patterns that suggested questionable billing practices by those providers. The OIG sought to determine whether VHA ensured the payments it made to non-VA acupuncture and chiropractic providers were authorized and supported. In addition, the OIG assessed if VHA followed guidance while reauthorizing community acupuncture and chiropractic care. Paying for unauthorized and unsupported care constitutes improper payments and puts taxpayer dollars, which should be used to benefit eligible veterans, at risk of fraud, waste, or abuse. Further, not documenting assessments of prior treatments before reauthorizing additional care, as required, may interfere with veterans' care.¹

From October 1, 2017, through September 30, 2019 (fiscal year [FY] 2018 and FY 2019), VHA paid community care providers about \$114 million for acupuncture services and \$89 million for chiropractic services through the Veterans Access, Choice, and Accountability Act of 2014 (the Choice Act) or the MISSION Act. According to both laws, these services need to be authorized by a VA medical facility before being delivered by a non-VA provider.² These non-VA community care acupuncture and chiropractic services included approximately 607,000 acupuncture claims and 883,000 chiropractic claims. Contractors, referred to as third-party administrators, processed and paid the claims. VA then reimbursed the contractors.

What the Audit Found

On the basis of its review of paid claims, the OIG estimated that VHA improperly paid non-VA providers about \$85.4 million for acupuncture and about \$51.3 million for chiropractic services for the two-year review period (both for initial and ongoing care). Payments were improper

¹ VA *Office of Community Care Field Guidebook*. The OCC has designed this guidance to instruct VA staff on how to administer community care, and this guidance is frequently changed and updated. This report uses the term "request for additional care" in lieu of OCC's terms "secondary authorization request" or "request for services."

² The Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014). The Choice Act states, "In the case of an eligible veteran... the Secretary shall... [provide the care at VA or] authorize that such care or services be furnished to the eligible veteran under this section for a period of time specified by the Secretary." The VA MISSION Act of 2018, Pub. L. No. 115-182 (2018). The MISSION Act states, "[The] covered veteran may only receive care or services under this section upon the authorization of such care or services by the Secretary."

because they were not authorized, not allowed as coded, or lacked supporting documentation.³ While evaluating the reauthorization process, the OIG also found that VHA facility staff with approval authority did not always reauthorize care in accordance with guidance. Appendixes A and B detail the audit scope and overall methodology and the sampling methodology.

VHA Improperly Paid Acupuncture and Chiropractic Claims

By not exercising firm control over the payment process and post-payment review of the medical documentation for non-VA acupuncture and chiropractic care, VHA incurred improper payments for care that was not authorized or supported by medical documentation. The audit team estimated that improper payments amounted to about \$137 million for acupuncture and chiropractic care during FY 2018 and FY 2019. On the basis of the improper payments from FY 2018 and FY 2019, the OIG estimates that the questioned costs would total about \$341.7 million through FY 2022.⁴ Appendix C presents the OIG's estimated questioned costs.

Breaking that amount into its components, the audit team estimated that 51,200 acupuncture claims (8 percent) and 83,300 chiropractic claims (9 percent) lacked the authorizations required by law.⁵ The Financial Services Center (FSC) staff explained that the system they use when processing VA reimbursements to third-party administrators was designed to automatically pay claims issued within one year of the authorization date, instead of restricting payments to the number of visits or specific dates allowed under the authorization.⁶ In addition, the payment system does not flag unallowable treatments on claims that are submitted by non-VA providers. The OCC reviews some claims as part of the annual improper payment audits, and the FSC stated that it reviews inpatient and high-dollar claims and conducts a quarterly review of a random sample of claims. However, the audit team determined that the OCC did not perform

³ The Payment Integrity Information Act of 2019, Pub. L. No. 116-117 (2020); Office of Management and Budget Circular A-123, app. C, "Requirements for Payment Integrity Improvement," June 26, 2018. Both sources define improper payments as any payments that are not supported by documentation or not allowed under statutory requirements. For this audit, this includes payments not authorized in accordance with the Choice and MISSION Acts and those not supported by medical documentation. On March 5, 2021, OMB updated Office of Management and Budget Circular A-123, app. C, "Requirements for Payment Integrity Improvement." Under this update, unsupported claims would be classified as unknown payments, meaning the agency is unable to determine whether they are proper or improper. Since the audit work for this report was substantially complete before the March 5, 2021, revised circular, this report uses the language of the 2018 version and characterizes these payments as improper.

⁴ The OIG extrapolated the questioned costs from FY 2018 and FY 2019 through FY 2022 based on when effective actions could address the problems identified in this audit. Although the corrective actions to address the OIG recommendations may be implemented by the end of FY 2022, it is likely VHA may not realize benefits from these corrective actions until then. To calculate the extrapolation through the end of FY 2022, the audit team multiplied the FY 2018 and FY 2019 questioned costs by 2.5.

⁵ Choice Act of 2014; MISSION Act of 2018.

⁶ The Financial Services Center is an enterprise center of the VA Franchise Fund, which provides common administrative services to VA and other federal government clients.

internal audits specific to when visits and treatments exceeded authorizations for the Plexis Claims Manager payment system.⁷

As to unsupported claims in FYs 2018 and 2019, the audit team estimated that 76 percent of acupuncture claim treatments and 55 percent of chiropractic claim treatments were not fully supported by medical documentation that complied with VHA requirements for completeness and accuracy.⁸ These unsupported treatments can be further broken down into not supported because medical documentation was missing or not supported because the documentation was insufficient (figure 1).

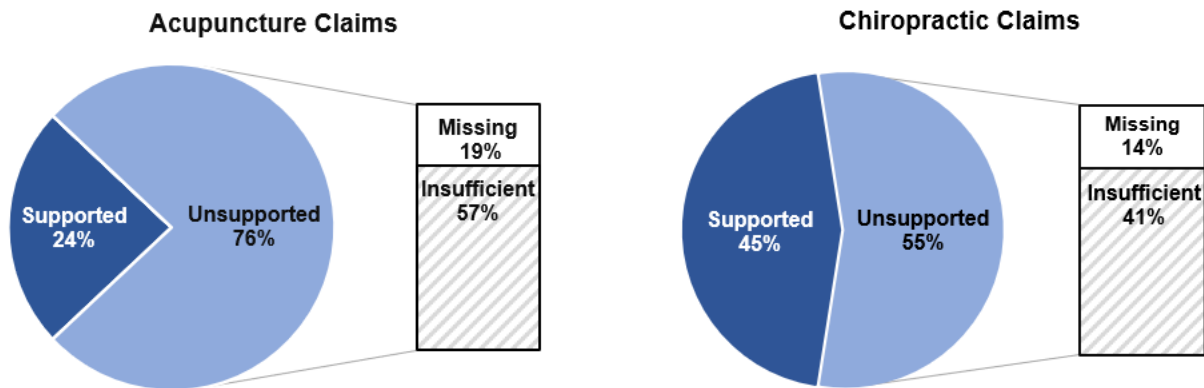


Figure 1. Composition of acupuncture and chiropractic claims reviewed.

Source: Codings specialists’ analysis of sampled claims and medical documentation.

Unsupported claims are not easily detected because the OIG found that VHA staff at medical facilities did not retrospectively audit medical documentation to determine whether non-VA acupuncture and chiropractic services were billed appropriately, even though retrospective reviews are required by VA guidance.⁹ To mitigate unsupported claims, VHA could perform post-payment audits and develop processes to act on the corresponding results. VHA also does

⁷ The Plexis Claims Manager payment system was used to process the acupuncture and chiropractic claims evaluated during this audit.

⁸ VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015. According to the handbook, “The medical facility Director, or designee, is responsible for establishing policies and processes in compliance with this Handbook, to include ensuring . . . Non-VA medical care is documented,” and “the latest United States editions of the American Medical Association’s CPT . . . must be used to provide uniform disease and operation terminology.” For billing purposes, a treatment is represented by a Current Procedural Terminology code.

⁹ VHA Guidebook, *HIM Clinical Coding Program Guide Version 1.4*, chap. 5, sec. m, September 7, 2018.

not ensure that continuing medical education related to documenting acupuncture and chiropractic care is available to non-VA providers.¹⁰

Although the absence of a single required element makes the medical documentation incomplete for billing purposes, such documentation may be sufficient from a clinical standpoint. The OIG did not assess in this audit whether the deficient documentation affected care delivery.

VHA Staff Did Not Follow Guidance When Reauthorizing Non-VA Acupuncture and Chiropractic Care

According to the *OCC Field Guidebook*, authorizers of non-VA care must evaluate the efficacy of care already received. This helps ensure that veterans receive the right care, in the right setting, at the right time, and for the right clinical reasons. However, VHA facility staff with approval authority did not always follow the *OCC Field Guidebook* when reauthorizing additional acupuncture and chiropractic care.¹¹ These staff did not document their evaluations of the efficacy of prior non-VA care as required. Further, in some of these cases, veterans themselves directly requested additional care through VA providers or staff, and the guidebook did not provide clear instruction on how these requests should be handled. OCC clinical integration officials (staff responsible for national oversight of care coordination) said that the guidebook was not applicable in these circumstances because local community care staff do not make the determination to authorize more care. Therefore, when veterans directly requested additional care, the guidebook's lack of clarity and applicability was another reason approvers did not document evaluations of prior non-VA care or clinical justifications for continuing this care.

According to OCC officials, noncompliance with the *OCC Field Guidebook* occurred because approving officials who order care, which may be fulfilled in the community based on veteran eligibility, report up the supervisory chain to the chiefs of staff at their respective medical facilities and not to the OCC program office. As a program office, the OCC has no mechanism to enforce medical facility personnel's adherence to the guidebook. Because staff were not following the guidebook when approving additional care, VHA had no assurance that staff evaluated ongoing treatment by non-VA acupuncturists and chiropractors or that the reauthorized services were appropriate for veterans seeking care.

To determine whether VHA appropriately reauthorized requests for additional care, the audit team reviewed a total of 80 acupuncture and chiropractic claims (49 acupuncture and

¹⁰ The MISSION Act requires VA to provide the same "continuing medical education material" to non-VA providers that is available to VA providers to "ensure that all medical professionals treating veterans have access to the same materials."

¹¹ This report uses the term "approval authority" or "approver" in lieu of OCC's term "delegation of authority" for appointed staff (designated by the facility's chief of staff) who are authorized to perform reviews to determine the clinical appropriateness of services requested in a non-VA care consult.

31 chiropractic authorizations) from veterans who had already had 12 or more visits and whose additional care appeared to be reauthorized under an initial authorization rather than a continuation of care request.¹² Of the 80 requests, 28 (more than one-third) were for care not reauthorized in accordance with the *OCC Field Guidebook* because facility staff did not document evaluations of prior non-VA care or approvers did not document clinical justifications for additional care.¹³

What the OIG Recommended

The OIG made six recommendations to the under secretary for health related to adding automated payment system controls, auditing the payment process, retrospectively auditing non-VA medical documentation, making continuing education material related to medical documentation available to non-VA providers, documenting review of prior care before approving more care, and documenting clinical justification for non-VA care.

Management Comments

The acting under secretary for health concurred in principle with recommendation 1 and concurred with recommendations 2 through 6, and the action plans are responsive to the intent of the recommendations. The acting under secretary reported that VHA's use of the Plexis Claims Manager system for third-party reimbursements had been replaced by the Electronic Claims Adjudication Management System (eCAMS) and the Community Care Reimbursement System (CCRS) for the new Community Care Network contract in all regions except one, which will migrate to the new system by the end of FY 2022. For recommendation 1, he reported that eCAMS already contains controls that address the OIG's recommendation, and the OCC is including the third-party administrator in its monitoring of payments processed by CCRS. CCRS ensures payments are only for allowed treatments, and the third-party administrators have implemented controls to stop payments for claims that exceed date ranges or the number of visits allowed. The acting under secretary for health considered this recommendation fully implemented and asked the OIG to consider closing it. Before closing this recommendation, the OIG will require evidence demonstrating the stated controls are in place. The OIG will monitor the implementation of all planned actions and will close recommendations when VHA provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

The acting under secretary for health also provided technical comments, which the OIG addressed following each finding. In its technical comments, VHA stated that the FSC had shared its secondary review process for inpatient and high-dollar claims and that it conducts

¹² This was not a statistical sample.

¹³ The audit team did not project these results because this sample was selected judgmentally.

reviews of sampled claims. As discussed in finding 1, FSC's Plexis Claims Manager system automatically paid all claims that were issued from one year of the authorization date.

VHA also stated that the third-party administrator contracts are the source for documentation standards for non-VA providers, rather than VHA Handbook 1907.01, which the OIG cited in this report. The OIG acknowledges that the third-party administrator contracts also require that healthcare claims must conform to Medicare billing requirements and clarified that in the report. As already reflected in the report, these billing requirements mean that the claims must meet the American Medical Association (AMA) Current Procedural Terminology (CPT) standards.

Notwithstanding OCC and third-party administrator responsibilities for non-VA provider medical documentation, the OIG does not read VHA Handbook 1907.01 as limiting the requirement for the AMA CPT code use to VA providers alone. Rather, the handbook seems broadly to require the use of the AMA CPT codes and code assignment, in accordance with Centers for Medicare & Medicaid Services, when documenting care in veterans' health records. Further, VHA's *HIM Clinical Coding Program Guide*, which provides procedures to be used in conjunction with VHA Handbook 1907.01, requires that the facility Health Information Management manager or coding supervisor conduct retrospective reviews for codes submitted for payment under the Care in the Community program and "ensure that the clinical services identified in the clinical documentation were performed." In sum, the guide states that VHA uses CPT codes, and explains that one of the purposes for coding is reimbursement. The OIG has added VHA's *HIM Clinical Coding Program Guide* to footnotes 24 and 35 and updated the report text referenced by footnote 35. At the start of and during the audit, the OIG briefed VHA officials about its methodology and criteria, and VHA agreed that the OIG's methodology and criteria were reasonable for the purpose of this audit.

VHA further reiterated that payments depend on authorization, not on receiving supporting documentation from the non-VA provider. The OIG discusses this issue in finding 1. Appendix D includes the full text of the acting under secretary for health's comments.



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Abbreviations

AMA	American Medical Association
CCRS	Community Care Reimbursement System
CPT	Current Procedural Terminology
eCAMS	Electronic Claims Adjudication Management System
FSC	Financial Services Center
FY	fiscal year
HIM	Health Information Management
OCC	Office of Community Care
OIG	Office of Inspector General
VHA	Veterans Health Administration



Introduction

Over the past seven years, legislation has increased veterans' access to private, local providers of medical services, including acupuncture and chiropractic care.¹⁴ In addition, VA has promoted acupuncture and chiropractic treatments as an alternative to opioid use for pain management.¹⁵ Yet greater use of these treatments has increased the need for controls over every aspect of community-provided care to ensure payments are authorized and supported as well as reauthorized in accordance with guidance.

The VA Office of Inspector General (OIG) conducted this audit to determine whether the Veterans Health Administration (VHA) ensured the payments it made to non-VA acupuncture and chiropractic providers were authorized and supported, including whether VHA staff followed guidance during the reauthorization process.

Community Care Legislation

The Veterans Access, Choice, and Accountability Act of 2014 (the Choice Act) established the framework for increasing veterans' access to care in the community. The act based eligibility on wait times for appointments and distance from the nearest medical facility.¹⁶ The MISSION Act continued veterans' ability to seek care locally with some adjustments to eligibility requirements.¹⁷ For example, instead of the Choice Act's distance requirements, the MISSION Act has drive-time eligibility requirements. According to both laws, the services need to be authorized by a VA medical facility before being delivered by a non-VA provider.¹⁸

Non-VA Care Including Acupuncture and Chiropractic Treatments

VHA's Office of Community Care (OCC) manages VA programs that allow veterans to receive medical care from non-VA providers, including acupuncturists and chiropractors. Veterans have

¹⁴ The Veterans Access, Choice and Accountability (Choice) Act of 2014, Pub. L. No. 113–146, § 101 (2014); the VA MISSION Act of 2018, Pub. L. No. 115–182, § 132 (2018).

¹⁵ VA's Opioid Safety Initiative, starting in October 2013, championed the use of complementary and alternative medicine practices as a viable support treatments for veterans with chronic pain.

¹⁶ VA's Patient-Centered Community Care program was established on September 3, 2013, before the Veterans Choice Program, and it allowed veterans to seek health care from non-VA providers. The Patient-Centered Community Care Program was administered by two third-party administrators. In October 2014, VA expanded the contracts with the two third-party administrators to include responsibility for the Veterans Choice Program.


¹⁷ MISSION Act of 2018.

¹⁸ The Choice Act of 2014 states, "In the case of an eligible veteran... the Secretary shall... [provide the care at VA or] authorize that such care or services be furnished to the eligible veteran under this section for a period of time specified by the Secretary." The MISSION Act of 2018 states, "[The] covered veteran may only receive care or services under this section upon the authorization of such care or services by the Secretary."

increasingly used these kinds of treatments through both VA medical facilities and community providers.

Standards for Care

Before making a referral for non-VA acupuncture or chiropractic treatments, a VA provider evaluates a veteran’s clinical needs and refers the veteran for the appropriate category of care or subspecialty. The provider stipulates the type and amount of care using what VA calls standardized episodes of care (see figure 2); this report refers to them as “standards for care.” According to VHA’s description, these standards include a set of evidence-based practices.



SEOC ADMINISTRATOR Physical Medicine and Rehabilitation
 VERSION 1.11.1 **Chiropractic Initial 1.0.2**

Duration: 90 days

Procedural Overview:

1. Initial outpatient evaluation and outpatient re-evaluation as clinically indicated on the consult
2. Plain film x-ray of the region of complaint specified on the consult if not yet performed at the VA and is clinically indicated.
 - a. Plain film x-ray imaging only when medically necessary based on widely-accepted indications such as clinical suspicion of fracture, dislocation, or other significant pathology. X-ray is not authorized for biomechanical/postural assessment, and/or determining manipulative technique approach
3. Authorized up to twelve (12) chiropractic visits. Chiropractic services include: chiropractic manipulative treatment, manual therapy, therapeutic exercise, and/or neuromuscular re-education

Payable Services:

Clinical Service	Visits/Units	Frequency	Description	Billing Codes
35-Chiropractic	999	N/A	Initial outpatient evaluation and outpatient re-evaluation as clinically indicated on the consult.	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215
35-Chiropractic	12	N/A	Authorized up to twelve (12) chiropractic visits. Chiropractic services include: chiropractic manipulative treatment, manual therapy, therapeutic exercise, and/or neuromuscular re-education	97110, 97112, 97124, 97140, <u>98940</u> , <u>98941</u> , <u>98942</u> , <u>98943</u>

Figure 2. Detailed example of standards for care.

Source: The audit team based this figure on VHA’s OCC Standardized Episodes of Care website.

Note: This excerpt provides details of specific procedure codes a non-VA chiropractic provider is authorized to bill. By stating that “999 units” of evaluation and management treatments are allowed, VHA is not restricting how many times a non-VA provider can bill for these codes. The “12” in the payable services table represents the number of visits allowed by this standard for care.

Authorization and Payment Process

In communication with the veteran, VHA medical facility providers determine if community care is appropriate for the patient’s needs.¹⁹ This determination is entered in the patient’s VA medical record as a consult (referral). If the provider determines that acupuncture or chiropractic services in the community are appropriate, he or she initiates a request for those services, annotated with the appropriate standards for care. The facility’s administrative staff then determine if the veteran meets the eligibility requirements and forward the request to the community care office in the same facility.

Facility staff review the request and contact the veteran to discuss potential providers.²⁰ After a provider is selected, community care office staff issue an authorization to the non-VA provider, which is also forwarded to the third-party administrator responsible for paying the community provider. Then, administrative staff in the local community care office assist the veteran with scheduling an appointment unless the veteran decides to schedule it directly. Figure 3 depicts the process.

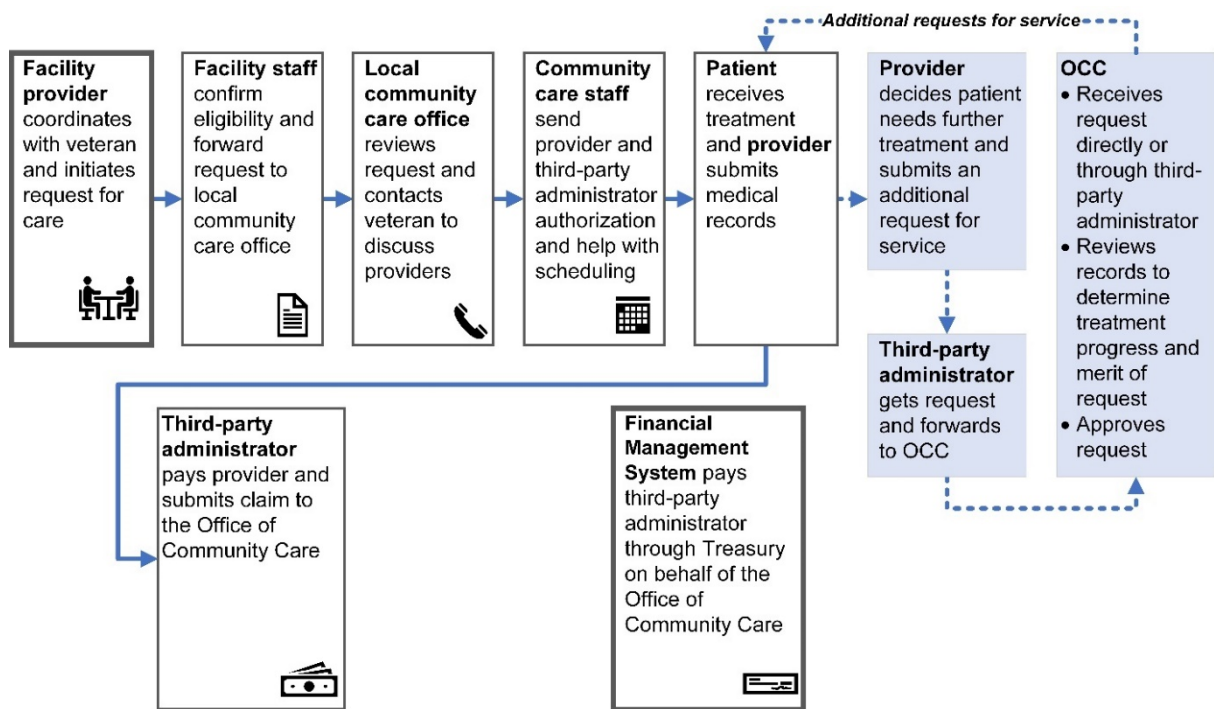


Figure 3. Referral, authorization, and payment process.

Source: OIG analysis of VHA Office of Community Care Field Guidebook.

¹⁹ If a veteran was eligible based on mileage to the nearest VA facility, the third-party administrators could authorize the care without coordinating with VA.

²⁰ VA entered into contracts with third-party administrators to help deliver care as required under the Choice Act of 2014 and the MISSION Act of 2018. The third-party administrators were responsible for establishing a network of providers to deliver health care to eligible veterans.

VHA's Community Care Operating Model states that after the local community care office has sent the authorization to the community provider, the appointment can be scheduled. After completing the appointment(s), the provider submits medical documentation to VHA, and claims for payment go from third-party administrators to the Financial Services Center (FSC). FSC is an enterprise center of the VA Franchise Fund, which provides common administrative services to VA and other federal government clients. For OCC, this includes reimbursing third-party administrators for community care payments. If the provider does not submit medical documentation, VHA contacts the provider and requests the documentation.

Process for Approving Requests for Additional Non-VA Care

According to the *OCC Field Guidebook*, when community providers deem additional non-VA care is necessary beyond VHA's initial authorization, they must submit a request for additional care to the VA community care office or through the third-party administrator.²¹ Additional care may be approved on an existing approved authorization with a defined standard for care up to 365 days from the date of initial authorization. With the request, the non-VA provider must submit supporting medical documentation showing the progress of treatment. Then, VHA staff with approval authority must review the medical documentation.²² Staff in the local community care office must review and process these requests within three days of receipt and coordinate a clinical review when appropriate.²³

VHA Medical Documentation Standards

VHA's Health Information Management (HIM) program office is responsible for ensuring health records are accurate and developing VHA coding procedures. VHA policy required non-VA providers' medical documentation to meet American Medical Association (AMA) Current

²¹ *VA Office of Community Care Field Guidebook*. The *OCC Field Guidebook* is frequently changed and updated. Governing guidance during the review period includes the following: In a version dated November 12, 2017, the required process for submitting a request for additional care was on page 3 of 4 in chapter 6.2.1. In a version dated February 26, 2018, the requirement was on pages 1–8 in chapter 3. In a version dated June 13, 2019, the requirement was on pages 1–5 of 10 in chapter 3. In a version dated April 30, 2020, the requirement was on pages 63, 98, and 105–109 of 111 in chapter 3. In a version dated December 8, 2020, the requirement was on pages 77–78, 84, 128, 157, and 238 of 248 in chapter 3. This report uses the term “request for additional care” in lieu of OCC’s terms “secondary authorization request” or “request for services.”

²² This report uses the term “approval authority” or “approver” in lieu of OCC’s term “delegation of authority.” Approval authorities are appointed staff, designated by the facility’s chief of staff, who are authorized to perform clinical reviews to determine the clinical appropriateness of services requested in a community care consult.

²³ A clinical review would be appropriate and required if a veteran submitted the request.

Procedural Terminology (CPT) and Centers for Medicare & Medicaid Services guidelines.²⁴ AMA CPT code guidelines describe terms and identify codes for reporting medical services and procedures performed by physicians.²⁵ The third-party administrator contracts also require that healthcare claims conform to Medicare billing requirements, and these requirements mean practitioners should use treatment codes that meet the AMA CPT guidelines.²⁶

²⁴ VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015. According to the handbook, “The medical facility Director, or designee, is responsible for establishing policies and processes in compliance with this Handbook, to include ensuring ... Non-VA medical care is documented,” and “the latest United States editions of the American Medical Association’s CPT ... must be used to provide uniform disease and operation terminology.” For billing purposes, a treatment is represented by a CPT code. VHA Guidebook, *HIM Clinical Coding Program Guide Version 1.4*, chap. 5, sec. m, September 7, 2018.

²⁵ “CPT Code Overview and Code Approval,” AMA, accessed November 16, 2020, <https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval>.

²⁶ “CPT Purpose & Mission,” AMA, accessed June 25, 2021, <https://www.ama-assn.org/about/cpt-editorial-panel/cpt-purpose-mission>.

Results and Recommendations

Finding 1: VHA Improperly Paid Acupuncture and Chiropractic Claims

The OIG determined that VHA paid for non-VA acupuncture and chiropractic care that was not authorized or supported by medical documentation. The audit team estimated that improper payments amounted to about \$136.7 million for acupuncture and chiropractic care during fiscal year (FY) 2018 and FY 2019.²⁷ The unauthorized payments occurred because neither the OCC nor the FSC ensured the payment system had effective controls. The unsupported payments revealed that non-VA care providers lacked understanding of medical documentation required to meet VHA policy standards, which persisted because VHA staff did not retroactively review samples of the documentation for deficiencies.²⁸ Consequently, VHA made improper payments with community care funds.

Medical documentation helps ensure that veterans get the care they need through treatment authorized by VHA, which is especially important in managing community care. Without it, VHA lacked assurance that non-VA acupuncturists and chiropractors provided veterans the care for which VHA paid.

Finding 1 is supported by the following determinations regarding VHA's payment of unauthorized and unsupported claims:

- VHA paid unauthorized acupuncture and chiropractic claims.
- Providers submitted and VHA paid acupuncture and chiropractic claims unsupported by medical documentation.
- Paying for unauthorized and unsupported acupuncture and chiropractic claims led to about \$136.7 million in improper payments.

²⁷ The Payment Integrity Information Act of 2019, Pub. L. 116-117 (2019); Office of Management and Budget Circular A-123, app. C, "Requirements for Payment Integrity Improvement," June 26, 2018. The act and the circular define improper payments as any payments that should not have been made. For this audit, this includes payments not authorized and those not supported by medical documentation. These totals include about \$16 million that is included in more than one category of unsupported or unauthorized acupuncture or chiropractic care. On March 5, 2021, OMB updated Office of Management and Budget Circular A-123, app. C, "Requirements for Payment Integrity Improvement." Under this update, unsupported claims would be classified as unknown payments, meaning the agency is unable to determine whether they are proper or improper. Since the audit work for this report was substantially complete prior to the March 5, 2021, revised circular, this report uses the language of the 2018 version and characterizes these payments as improper.

²⁸ VHA Handbook 1907.01; VHA Guidebook, *HIM Clinical Coding Program Guide Version 1.4*, chap. 5, sec. m.

What the OIG Did

The audit team analyzed the authorization and support for a statistical sample of 180 acupuncture and 180 chiropractic claims from non-VA community care providers randomly selected from FY 2018 and FY 2019. Most of the audit team's sampled claims included only one date of service, but some included multiple dates. In addition, the claims included various procedure codes, which the audit team categorized as acupuncture, chiropractic, evaluation and management, or other. These samples were selected from about 607,000 acupuncture claims totaling \$114 million and about 883,000 chiropractic claims totaling \$89 million. The audit team retrieved the authorizations and medical documentation from VHA's electronic health records.²⁹ If audit team members did not locate the medical documentation in the electronic health records, they contacted staff at the respective VA medical facility, who in turn contacted the non-VA providers.

To determine whether the claims were authorized, the audit team reviewed electronic health records to determine if there were authorizations for the claim dates in question. If claims were authorized after December 7, 2018, when standards for care started restricting care to certain treatment codes, the audit team also assessed whether the treatments were allowed.³⁰ The team interviewed OCC and FSC staff to determine why payments were made for unauthorized care.

The OIG contracted with medical coding specialists to help determine whether the care was supported by medical documentation. The coding specialists evaluated the medical documentation to determine whether it followed AMA and Centers for Medicare & Medicaid Services guidelines as required.³¹ The team discussed the insufficient documentation with VHA's acupuncture and chiropractic subject matter experts. In addition, the team interviewed OCC and HIM program office officials to determine why documentation was not sufficient. Appendixes A and B detail the audit scope and methodology and the sampling methodology.

VHA Paid Unauthorized Acupuncture and Chiropractic Claims

The audit team found that VHA paid for care that was not authorized, including more visits than allowed and dates of service after the authorized period. There were also authorized claims that contained treatment codes that were not allowed by standards for care. In particular, the changes

²⁹ The audit team used both the Joint Legacy Viewer and the third-party administrator portals.

³⁰ Acupuncture Initial 1.0.3, Acupuncture Continuation of Initial 1.1.1, Acupuncture Chronic Care Management 1.2.1, Chiropractic Initial 1.0.2, Chiropractic Continuation of Initial 1.1.1, and Chiropractic Pain Management 1.2.1. On December 7, 2018, VHA updated standards for care requirements, restricting the types of treatments for which non-VA acupuncturists and chiropractors can bill VHA. The deputy under secretary for health for operations and management introduced the requirement to use standards for care by issuing a memorandum for care purchased in the community on April 19, 2017, and the requirement was reinforced by additional memorandums on January 8, 2018, and January 2, 2019.

³¹ VHA Handbook 1907.01.

VHA made to standards for care on December 7, 2018, restricted the types and number of treatment codes that could be billed on acupuncture and chiropractic claims. For example, acupuncturists were only allowed to bill for two rounds of acupuncture needle insertions.

Of the acupuncture and chiropractic claims submitted for FY 2018 and FY 2019, the audit team estimated that 51,200 acupuncture claims (8 percent) and 83,300 chiropractic claims (9 percent) were not authorized by VA as required by the Choice and MISSION Acts and the contracts with the third-party administrators. The audit team considered a claim unauthorized for one or more of the following four conditions:

- The number of visits on the claim exceeded the number authorized.
- The date of the claimed service was after the allowable dates on the authorization.
- The third-party administrator authorized claims for veterans who did not actually meet mileage requirements.³²
- The claim included both acupuncture and chiropractic treatments when the authorization was for only one of these types of care.

In addition, when VHA updated the standards for care to restrict treatments, non-VA providers submitted claims with disallowed treatments. Among the claims from which the audit team drew its samples, an estimated 241,000 acupuncture claims and 332,000 chiropractic claims were initiated on or after December 7, 2018. Of these, the OIG estimated that 113,000 acupuncture claims (47 percent) and 163,000 chiropractic claims (49 percent) contained at least one treatment code billed by the non-VA provider and paid by VA that was not allowed by the standards for care.

These errors were allowed to continue because there was a lack of system controls and inadequate oversight, as detailed below.

Automated Payment System Controls Did Not Stop Unauthorized Payments

The claims-processing system did not flag or prohibit unauthorized visits or unallowable treatments in claims submitted by non-VA providers. According to FSC staff, the claims-processing system was designed to automatically pay claims that were issued within one year of the authorization date and did not restrict payments to the number of visits or specific dates allowed under the authorization. In addition, the OCC said that the payment system was

³² VA's Denver Acquisition & Logistics Center, *TriWest Healthcare Alliance Corporation P00009*, March 26, 2015; *Health Net Services LLC Contract Modification P00005*, October 30, 2014. Both contracts allowed the third-party administrators to authorize care on behalf of VHA for veterans who lived more than 40 miles from a medical facility.

limited by the authorization data that were available to the FSC, which did not include the number of visits authorized or allowable codes under standards for care. As a result, the payment system provided reimbursements for visits that were not allowed by authorizations and for treatments that were not allowed by the acupuncture and chiropractic standards for care. It is important that VHA apply sound controls to its current and future claims-processing systems.

Recommendation 1 is for the OCC to implement automated payment system controls for non-VA claims that go beyond the number of authorized visits and cutoff dates or that include treatment codes that deviate from accepted standards for care.

Internal Audits by the OCC Did Not Focus on Unauthorized Claims

Federal internal control guidance emphasizes that management should establish internal controls to ensure the entity's objectives are met and to monitor the quality of its performance.³³ The Office of Business Integrity and Compliance within the OCC is responsible for ensuring optimal use of VA resources in purchasing care in the community by conducting internal audits for the prevention and detection of fraud, waste, and abuse. Aside from claims reviewed as part of annual improper payment audits, the OCC's internal audits did not focus on the risk of paying for visits and treatments that exceeded authorizations through the Plexis Claims Manager payment system.³⁴ Further, the OCC stated that the FSC performs a secondary review of inpatient and high-dollar claims as well as a quarterly review of a random sample of claims. Assessing whether visits and treatments exceeded authorizations could mitigate the payment of unauthorized visits and treatments for non-VA services.

Recommendation 2 addresses the need for the OCC to conduct ongoing payment system audits to identify and minimize payments of unauthorized claims.

Providers Submitted and VHA Paid Acupuncture and Chiropractic Claims Unsupported by Medical Documentation

VHA policy required non-VA providers' medical documentation to meet AMA CPT and Centers for Medicare & Medicaid Services guidelines.³⁵ These guidelines describe the critical elements providers must include when billing any treatment code. Further, third-party administrators require care providers to have medical documentation that substantiates all authorized billed services. The administrators issue documentation requirements for all treatments. Community

³³ Government Accountability Office (GAO), *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

³⁴ The Plexis Claims Manager payment system was used to process the acupuncture and chiropractic claims evaluated during this audit.

³⁵ VHA Handbook 1907.01; VHA Guidebook, *HIM Clinical Coding Program Guide Version 1.4*, chap. 5, sec. m.

care providers who do not meet documentation standards when submitting claims for reimbursement may have their claims rejected as unsupported.

The audit team found that non-VA acupuncturists and chiropractors submitted and VHA paid acupuncture and chiropractic claims that lacked appropriate supporting medical documentation. Figure 4 breaks down the audit team’s estimates of claims with codes for treatments that were missing support, were insufficiently supported, and were adequately supported.³⁶

³⁶ “Missing support” means the medical documentation was not available for review. “Insufficiently supported” means the medical documentation did not meet all coding guideline elements.

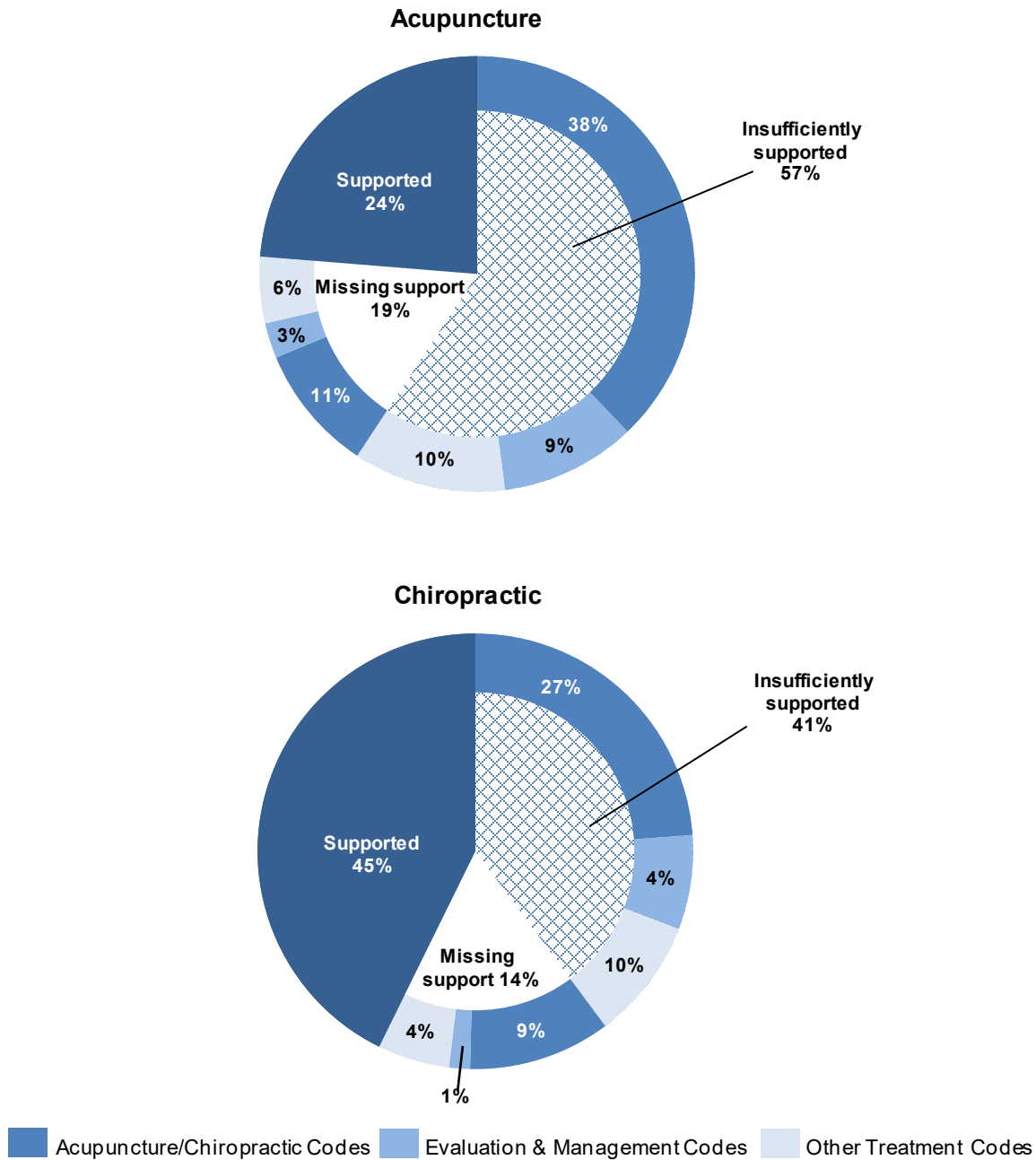


Figure 4. Codes on claims for acupuncture and chiropractic claim treatments.

Source: Coding specialists' analysis of sampled claims and medical documentation.

Notes: Each pie chart is divided into three categories—supported, missing support, and insufficiently supported. Only claim treatments with sufficient documentation count as supported. Missing support and insufficiently supported are comprised of acupuncture/chiropractic codes, evaluation and management codes, and other treatment codes as indicated by the colors above. Due to rounding, the percentages do not sum.

The coding specialists found that deficiencies in the support for acupuncture claims primarily involved a lack of procedural detail and insufficiently documented evaluation and management services. The audit team estimated that 38 percent of the treatment codes on acupuncture claims

involved procedures for which medical documentation lacked required details, such as where and how many needles were placed, the number of minutes the provider was face-to-face with the patient for each acupuncture code billed, whether the needles were reinserted, or whether electronic stimulation was used. Another 11 percent had missing documentation.

The team also estimated that 12 percent of the treatment codes on acupuncture claims were for evaluation and management services that were insufficiently supported or missing medical documentation; the majority of these were for established patients.³⁷ To bill for an evaluation and management service, a provider must document a separate and distinct service, such as the evaluation of a new injury. Furthermore, the documentation requirements are different for each of the evaluation and management codes, and the documentation must satisfy all requirements for the billed code(s).³⁸ In this audit, almost every use of evaluation and management codes the team examined had missing or insufficient documentation.

The coding specialists also found significant documentation deficiencies in the chiropractic claims evaluated. Specifically, the audit team estimated that 27 percent of treatment codes on chiropractic claims were for chiropractic procedures where medical documentation lacked detail on which region of the spine was treated or the date of the initial visit for treatment. Another 9 percent had missing documentation. The audit team also estimated that 5 percent of treatment codes on chiropractic claims were for evaluation and management services that were also not supported by any or adequate medical documentation.³⁹

Both non-VA acupuncturists and chiropractors billed other treatment codes not classified as acupuncture, chiropractic, or evaluation and management (for example, a physical therapy code for manual manipulation). Based on the coding specialists' work, the OIG team estimated that 10 percent of the treatment codes billed on acupuncture claims were for other procedures that did not have sufficient medical documentation, and 6 percent of the codes were for other treatments where the documentation was missing. The team also estimated that 10 percent of the treatment codes billed on chiropractic claims were for other procedures not sufficiently supported by medical documentation, and 4 percent of the treatment codes were for other treatments where the documentation was missing.

Although the absence of a single required element makes the medical documentation incomplete for billing purposes, such documentation may be sufficient from a clinical standpoint. The OIG did not assess in this audit whether the problems with documentation affected care delivery.

³⁷ The audit team estimated that 97 percent of evaluation and management treatment codes on acupuncture claims were not supported because the documentation was missing or insufficient.

³⁸ When reviewing evaluation and management documentation, the coding specialists applied the Centers for Medicare & Medicaid Services 1995 and 1997 *Documentation Guidelines for Evaluation and Management Services*. If the treatment code was acceptable by either set of guidelines, it was considered supported.

³⁹ The audit team estimated that 78 percent of evaluation and management treatment codes on chiropractic claims were not supported because the documentation was missing or insufficient.

Claims Are Paid Before Non-VA Providers Submit Medical Documentation

Both third-party administrator contracts state, “All submitted claims must have sufficient medical documentation to support the payment of the claim.” However, to comply with timely payment requirements, the third-party administrators pay the claims, and VHA in turn reimburses the third-party administrators, before receiving all supporting medical documentation.⁴⁰ Therefore, non-VA providers who furnished medical notes documenting billed treatments received no immediate feedback on whether the notes were complete or accurate before payment. According to HIM, this is not unusual throughout the industry. In addition, for the vast majority of the acupuncture and chiropractic treatments that had missing or illegible documentation, the non-VA paid providers did not submit medical documentation to VHA after being contacted.

VHA Does Not Review Provider Medical Documentation for Supported Charges

In September 2018, VHA instituted a requirement that HIM facility coding supervisors oversee retrospective reviews of sampled community care claims at each medical facility.⁴¹ These reviews are meant to verify that the billed treatments are supported by medical documentation. If the HIM coding supervisor or designee determines the billed treatments are not supported, the local community care staff are supposed to follow up with the non-VA providers, although the guidance does not specify what the billing-related follow-up should entail.⁴²

During this audit, the team communicated medical documentation issues, and in August 2020, the HIM program office issued more guidance on the retrospective reviews, instructing facilities to refer any coding inaccuracies to their local Payment Operations and Management offices.⁴³ However, HIM officials who spoke with the audit team said they believed staff at facilities were generally not conducting these types of reviews. In fact, officials said only two facilities had

⁴⁰ According to the MISSION Act, VA must pay providers within 45 calendar days for a paper claim and 30 days for an electronic claim. The audit team did not evaluate the process facilities use to retrieve notes from non-VA providers, including follow-up attempts, which differs by facility.

⁴¹ VHA Guidebook, HIM Clinical Coding Program Guide Version 1.4, chap. 5, sec. m.

⁴² VHA Guidebook, HIM Clinical Coding Program Guide Version 1.4. According to the contracts, the third-party administrators were also required to establish a quality assurance plan to monitor, evaluate, and appropriately address quality assurance, performance measurement, and other quality and safety issues. However, the deputy chief of community care contract administration stated there were no quality assurance plan reports about the reimbursement of the claims, and VHA took over responsibility of medical documentation collection in October 2018, making it impractical for the third-party administrators to review whether medical documentation supported payments.

⁴³ HIM Office of Health Informatics, HIM Practice Brief, *Community Care—Validating and Recording Coded Data*, August 2020.

access to the claims information in FY 2019, which means retrospective reviews could not have been conducted. In November 2020, a HIM official told the audit team about 25 facilities had the information they needed to conduct audits. Also, in November 2020, another HIM official said HIM planned to develop a report with claims data necessary for the reviews. In May 2021, the HIM program office said this report was still under development. This claims data report would help facility staff perform retrospective reviews to address the medical documentation findings in this audit.

In addition, VHA did not have a process for how it would act on the information in these reviews. In November 2020, HIM and OCC officials began discussing steps they could take, but these conversations had not produced results as of May 2021.

The OIG's third recommendation addresses the need for VHA not only to ensure facilities are conducting post-payment audits of billed acupuncture and chiropractic services to verify that non-VA providers are properly supporting their claims but also to develop processes for corrective actions based on audit results.

VHA Did Not Make Acupuncture and Chiropractic Continuing Education Materials Available to Community Providers

The MISSION Act requires VA to develop and implement a program to teach VA employees and contractors how to administer non-VA programs, establish a method to evaluate the effectiveness of this program at least annually, create a system to assess the quality of medical services delivered by community providers, and institute a program to provide continuing medical education material to non-VA providers.⁴⁴ Specifically, the MISSION Act requires VA to provide the same “continuing medical education material” to non-VA providers that is available to VA providers to “ensure that all medical professionals treating veterans have access to the same materials.”⁴⁵

In February 2021, the OCC and HIM did provide medical documentation submission requirements for care coordination, but nothing specific to acupuncture and chiropractic care. Then, in May 2021, HIM officials said it was not their role to educate non-VA providers and that their role would be limited to relaying results of non-VA care claims reviews to the OCC for action. Further, according to HIM, non-VA providers are required to follow industry documentation and billing standards, and non-VA providers, as a routine part of their scope of practice, should know these standards. However, the errors made by non-VA providers when billing for acupuncture and chiropractic services reflected a lack of understanding of or compliance with the documentation requirements.

⁴⁴ MISSION Act of 2018, § 102, 122, 123.

⁴⁵ MISSION Act of 2018, § 123.

The OIG’s fourth recommendation calls on VHA to make VA’s continuing education material related to documenting acupuncture and chiropractic services available to non-VA providers.

Paying for Unauthorized and Unsupported Acupuncture and Chiropractic Claims Led to About \$137 Million in Improper Payments

The OIG estimated that VHA improperly paid non-VA providers about \$85.4 million for acupuncture claims and about \$51.3 million for chiropractic claims in FY 2018 and FY 2019 for both initial and ongoing care. This means funds were spent on care that was not authorized or supported (table 1).

Table 1. Improper Payments for Unauthorized and Unsupported Acupuncture and Chiropractic Care, FY 2018 and FY 2019 (in Millions of Dollars)

Reason payment was improper	Acupuncture	Chiropractic	Total
Claim not authorized	8.0	8.2	16.1
Treatment not authorized	2.5	4.0	6.5
Medical documentation missing or illegible	21.3	12.7	33.9
Treatment lacked sufficient medical documentation	61.4	34.8	96.2
Improper for more than one reason	-7.8	-8.3	-16.0
Estimated total	85.4	51.3	136.7

Source: VA OIG statistical projections based on analysis of medical coding specialist’s evaluation results and unauthorized claims.

Note: Differences are due to rounding. Some payments were improper for more than one reason. To avoid counting these payments as improper more than once, the audit team subtracted payments that were included in more than one category.

On the basis of the FY 2018 and FY 2019 questioned costs, the risk of overpayments would total an estimated \$341.7 million through the end of FY 2022, when cost savings could be realized from implemented actions.⁴⁶

Paying for unauthorized and unsupported acupuncture and chiropractic care contributes to a larger problem of VA spending more than it estimates for non-VA care. In June 2019, the

⁴⁶ The OIG extrapolated the questioned costs from FY 2018 and FY 2019 through FY 2022 based on when effective actions could address the problems identified in this audit. Although the corrective actions to address the OIG recommendations may be implemented by the end of FY 2022, it is likely VHA may not realize benefits from these corrective actions until then. The audit team extrapolated \$136.7 million through the end of FY 2022 by multiplying it by 2.5.

Government Accountability Office reported that VA exceeded its estimates for spending on non-VA care in FY 2017 and FY 2018, causing VA to reallocate funding from other sources.⁴⁷ Making improper payments risks fraud, waste, or abuse of taxpayer dollars that should be used to benefit eligible veterans, and exceeding spending estimates reduces funds available for other priorities. Funding that was budgeted to serve veterans through other programs needs to be transferred to non-VA care when budgeted estimates are exceeded. Appendix C presents estimated monetary benefits of implementing the OIG's recommendations.

Finding 1 Conclusion

The OIG estimates that VHA will have paid for about \$341.7 million through FY 2022 for non-VA acupuncture and chiropractic care that was unauthorized or was not supported by medical documentation. The payment system lacked automated flags to mitigate unauthorized payments. Furthermore, medical documentation, VHA's primary support for community care payments, was prone to problems with providers delivering sufficient documentation and with HIM staff reviewing documentation. Ensuring that veterans get appropriate care through the treatment authorized by VHA is especially important in managing community care. Updating automated controls, monitoring payments to ensure they are authorized, performing medical documentation audits, and making acupuncture and chiropractic continuing education material available to non-VA providers will help ensure that providers are not paid for excessive visits and unallowable treatments that may not advance veterans' well-being and appropriately support their charges.

Recommendations 1–4

The OIG made four recommendations to the under secretary for health:

1. Ensure the Office of Community Care implements automated payment system controls to reject non-VA claims that exceed the number of authorized visits or cutoff dates or includes treatment codes that deviate from established standards for care.
2. Ensure the Office of Community Care conducts ongoing payment system audits to identify and minimize improper payments of unauthorized claims.
3. Direct the Health Information Management program office in coordination with the Office of Community Care and facility chiefs of staff to ensure facilities are conducting post-payment audits of billed acupuncture and chiropractic services to verify non-VA providers are properly supporting their claims and to develop processes for corrective actions based on audit results.

⁴⁷ GAO, Estimating Resources Needed to Provide Community Care, GAO-19-478, June 12, 2019.

4. Ensure the Office of Community Care and the Health Information Management program office, in coordination with the offices of Acupuncture and Chiropractic services, make any current and future continuing education material related to documenting acupuncture and chiropractic services available to non-VA providers.

Management Comments

The acting under secretary for health concurred in principle with recommendation 1 and concurred with recommendations 2 through 4. The acting under secretary reported that the Plexis Claims Manager system for third-party reimbursements has been replaced by the Electronic Claims Adjudication Management System (eCAMS) and the Community Care Reimbursement System (CCRS) for the new Community Care Network contract in all VHA regions except one.

In response to recommendation 1, the acting under secretary for health stated that eCAMS already contains controls that address the OIG's recommendations, and the OCC is including the third-party administrator in its monitoring of payments processed by CCRS. CCRS ensures that treatments are allowed by the standards for care, and the third-party administrators have implemented controls to ensure claims do not exceed the number of visits allowed or cutoff dates. Further, he stated that the last region will be migrated to the new reimbursement system by the end of FY 2022. The acting under secretary stated that the OCC believes integration of both automated and manual controls is needed for effective monitoring. VHA considered recommendation 1 fully implemented and asked the OIG to consider closing it.

To address recommendation 2, the acting under secretary for health reported that the OCC will begin payment system audits when it finishes documenting the internal controls within the payment systems. He stated that the OCC is using a "three lines of defense model" where they conduct monthly reviews of payments from two payment systems for non-VA care, and the third-party administrators also review claims to ensure the claims are authorized. For recommendation 3, the acting under secretary for health stated that the HIM and OCC program offices will establish a plan for regular post-payment audits of billed outpatient services, such as for acupuncture and chiropractic services. In addition, the plan will address resources needed for the reviews, and it will include corrective actions based on non-VA provider billing issues. VHA plans to complete recommendations 2 and 3 by March 2022.

Regarding recommendation 4, the acting under secretary for health reported that the HIM and OCC program offices, with assistance from acupuncture and chiropractic services, will ensure educational material is made available to non-VA providers. VHA plans to implement recommendation 4 by November 2021.

The acting under secretary for health also provided technical comments, which the OIG addressed below. VHA comments and action plans may be found in full in appendix D.

OIG Response

The corrective action plans are responsive to the intent of the recommendations. Before closing recommendation 1, the OIG will seek evidence that controls from VHA's payment system or the third-party administrators are sufficient to mitigate the risks of paying for unauthorized visits or treatments that are not allowed by the standards for care. The OIG will monitor implementation of planned actions for all of the recommendations and ensure that VHA provides sufficient evidence that audits of the payment system used to reimburse third-party administrators for improper payments are being planned or conducted, that post-payment audits of acupuncture and chiropractic claims have been completed, that there is a corrective action plan to address the findings of those audits, and that continuing education material has been shared with non-VA acupuncturists and chiropractors.

The acting under secretary for health provided the OIG with eight technical comments. In comment 1, VHA stated that its Plexis Claims Manager system is a reimbursement system rather than a claims adjudication system. Therefore, the OIG clarified the report to reflect that the Plexis Claims Manager system is a reimbursement system. Regarding comment 2, the OIG acknowledges that the OCC shared the FSC's secondary review process for inpatient and high-dollar claims and that the FSC conducts reviews of sampled claims and added that to the report. As discussed in finding 1, the FSC's Plexis Claims Manager system automatically paid all claims that were issued from one year of the authorization date, and it did not consider the number of visits, specific dates, or treatment codes allowed under the authorization or standards for care.

In its comment 6, the acting under secretary for health stated that payments depend on authorization, not on receiving supporting documentation from the non-VA provider. In the report, the OIG acknowledges that payment does not depend on receiving medical documentation from non-VA providers in the sections "Claims Are Paid Before Non-VA Providers Submit Medical Documentation" and "VHA Does Not Review Provider Medical Documentation for Supported Charges." As discussed above, practitioners are still required to provide medical documentation appropriate to the services provided under their contracts, regardless of whether VHA pays claims before receiving medical documentation.

The remaining five comments addressed the OIG's references to VHA Handbook 1907.01 and the source of the medical documentation standards for non-VA care providers. VHA posits that Handbook 1907.01 "does not address documentation submission requirements for non-VA providers because those guidelines would be contained in the contract" and "[i]t is the responsibility of OCC and/or TPA [third-party administrator] to ensure that the documentation submitted by non-VA providers is complete as specified in the contract." Further, VHA states that VHA Handbook 1907.01 only addresses inclusion of non-VA medical care documentation in veterans' health records and does not speak to whether the documentation is sufficient.

Regarding the source of the standards in comments 4, 5, and 8, the OIG acknowledges that the third-party administrator contracts also require that healthcare claims conform to Medicare billing requirements and added that to the report introduction. As reflected in the report, these billing requirements mean that the claims must meet the AMA CPT standards. CPT standards identify critical elements that providers must include when billing any treatment code, and third-party administrator contracts require non-VA practitioners to provide medical documentation appropriate to the services rendered. The audit team understands this to mean that the medical documentation submitted by non-VA providers must show that the critical elements associated with the billed CPT code have been met.

In comments 3, 4, 5, 7, and 8, VHA stated that the VHA Handbook 1907.01 only addresses the inclusion of non-VA medical care documentation in the health record and not the standards for which that care should be documented. In the report, the OIG highlights the following language from the handbook: “the medical facility Director, or designee, is responsible for establishing policies and processes in compliance with this Handbook, to include ensuring Non-VA medical care is documented.”⁴⁸ The handbook also states that “the latest United States editions of the American Medical Association’s CPT ... must be used to provide uniform disease and operation terminology ... [and code] assignment must be in accordance with ... Center[s] for Medicare and Medicaid Services ... guidelines.”⁴⁹ The OIG does not read these references to limit the requirement to use the AMA CPT codes to VA providers alone; rather, it seems broadly to require using the AMA CPT codes and code assignment, in accordance with Centers for Medicare & Medicaid Services, when documenting care in veterans’ health records. Further, VHA’s *HIM Clinical Coding Program Guide*, which provides procedures to be used in conjunction with VHA Handbook 1907.01, requires that the facility HIM manager or coding supervisor conduct retrospective reviews for codes submitted for payment under the Care in the Community program and “ensure that the clinical services identified in the clinical documentation were performed.” The guide states that VHA uses CPT codes and explains that one of the purposes of coding is for reimbursement. The OIG has added VHA’s *HIM Clinical Coding Program Guide* to footnotes 24 and 35 and updated the report text referenced by footnote 35 to “VHA policy required non-VA providers’ medical documentation to meet American Medical Association (AMA) and Centers for Medicare & Medicaid Services guidelines.”

At the start of and during the audit, the OIG briefed VHA officials about its methodology and criteria, and VHA agreed that the OIG’s methodology and criteria were reasonable for the purpose of this audit.

⁴⁸ VHA Handbook 1907.01, pp. 8–9.

⁴⁹ VHA Handbook 1907.01, p. 63.

Finding 2: VHA Staff Did Not Follow Guidance When Reauthorizing Non-VA Acupuncture and Chiropractic Care

VHA facility staff with approval authority did not follow the *OCC Field Guidebook* when reauthorizing acupuncture and chiropractic care.⁵⁰ Specifically, facility staff with approval authority issued new authorizations rather than documenting an evaluation of prior non-VA care as the guidebook requires. This noncompliance persisted because the OCC has no mechanism to ensure facility staff follow the *OCC Field Guidebook*. Further, the audit team found that in some cases veterans directly requested care through VA. The guidebook was not clear on how to handle these types of requests, and OCC clinical integration officials (staff responsible for national oversight of care coordination) said the guidebook was not applicable in these circumstances because local community care staff do not make the determination to authorize more care. This resulted in approvers not documenting an evaluation of prior non-VA care. Although VHA's OCC created and updates the guidebook, facility leaders are responsible for ensuring their staff follow the procedures. When VHA staff do not follow the guidebook in processing requests for additional care, they risk not properly evaluating whether treatments already provided were effective or are still needed.

What the OIG Did

To assess whether facility staff followed the *OCC Field Guidebook*, the audit team reviewed additional-care requests for veterans who had already had 12 or more visits with a non-VA acupuncturist or chiropractor.⁵¹ Among these, the team focused on authorized requests that appeared to be granted under an initial authorization rather than a request for additional care. These included 49 acupuncture authorizations and 31 chiropractic authorizations for a total of 80. The team reviewed prior authorizations and corresponding consults as well as the patient record and third-party administrator portals. The team also interviewed OCC officials to determine why continuing care was not authorized in accordance with guidance. The audit team did not project these results because it judgmentally sampled authorizations that were connected to sampled claims.

⁵⁰ “The Office of Community Care has designed the [OCC] Field Guidebook to serve as a single guiding artifact for VA staff on how to purchase care in the community,” and it is considered a “living document” that is frequently changed and updated. VHA uses a delegation of authority memo to identify staff with the authority to conduct clinical reviews and determine the clinical appropriateness of non-VA care requests, including initial and additional care requests.

⁵¹ The audit team selected 12 because that is the number of visits allowed by the initial acupuncture and chiropractic standards for care that were in place for most of FY 2019. Authorizations processed by the third-party administrators because the veteran met mileage requirements were not included because VA was not the approval authority.

VHA Staff Approved Requests for Additional Non-VA Care without Documenting the Evaluation of Prior Non-VA Care

Veterans can continue receiving non-VA acupuncture and chiropractic care after the number of visits from their initial authorization has been exhausted. Doing so requires (1) a non-VA provider to submit a request and supporting medical documentation and (2) the facility's approving officials to conduct and document a clinical review of the information that supports approval. During the clinical review, VA reviewers evaluate the appropriateness of ongoing care. Clinical reviews of additional-care requests by qualified, appointed approving officials are important for veterans' continuity of care.⁵² Specifically, these reviews ensure that veterans receive the right care, in the right setting, at the right time, and for the right clinical reasons. Another route to approval is for veterans themselves to request additional care directly; however, the guidebook does not indicate how facility staff are to document reviews of such requests.

The audit team determined that facility staff did not authorize requests for additional acupuncture and chiropractic care in accordance with the *OCC Field Guidebook* or document justification for additional care for 28 of 80 requests (35 percent) for veterans who already had 12 or more visits, as described in table 2.

⁵² *OCC Field Guidebook*.

Table 2. Approval Issues in Authorizing Additional Non-VA Care

Category of approval issue	Errors
1. There was no form requesting additional care in the patient record or third-party administrator portal, yet new authorizations were created.	12 (15%)
2. The patient record contained a form requesting additional care and supporting documentation from the non-VA provider, but there was no evidence of review by facility authorizing officials. Nonetheless, new authorizations were created.	5 (6%)
3. The request for additional care was denied, yet new authorizations were created.	5 (6%)
4. The veteran requested additional care directly from VA, but there was no documentation by a VA provider of clinical review or justification for extending care. Nonetheless, new authorizations were created.	6 (8%)
Total	28 (35%)

Source: VA OIG analysis of approval of requests for additional non-VA care.

Note: Percentages are rounded.

No Request Form

For category 1, the audit team did not find a request form for additional services in the records evaluated. Facility staff with approval authority initiated new consults without evaluating prior non-VA care as required by the *OCC Field Guidebook* for 12 of the tested authorizations. This noncompliance persisted because facilities did not enforce the guidebook requirements created by the OCC. Clinical integration officials from the OCC, who act as liaisons between community providers and VHA staff, told the audit team that the program office had no means of ensuring that approving officials followed the guidebook because the approving officials report up the supervisory chain to the chiefs of staff at their respective facilities.

Request Form Not Reviewed or Request Denied

For categories 2 and 3, the audit team found that a request form was not acted upon or the request was denied. For the five errors in category 2, the non-VA providers submitted medical documentation, but facility staff did not document their required review of it. Rather, they

initiated new consults to continue the care. The *OCC Field Guidebook* requires a clinical review within three days that is documented in the consult. The guidebook also says that the review requirement for continuing non-VA care would be fulfilled if the provider who originated the new consult also had approval authority, in which case the consult would serve as documentation of the clinical review. However, the audit team could not find evidence that these providers also had approval authority.

For the five cases in category 3, facility staff rejected the requests, yet authorized new care with an initial consult anyway. When VA facility staff deny requests for additional care for lack of medical documentation, they should notify the non-VA providers, who have the option to resubmit requests with more documentation.⁵³ The audit team did not find evidence that the requests were resubmitted by the non-VA providers.

The *OCC Field Guidebook* requires staff with approval authority to evaluate non-VA care before approving requests for additional services. When the guidebook is not followed, VHA has no assurance that continued non-VA acupuncture and chiropractic care is effective or appropriate.

Recommendation 5 addresses the need for facility chiefs of staff to require those with designated authority to follow OCC requirements for documenting their review of prior care.

Requests by Veterans

For six authorizations (category 4), veterans requested care directly from VA rather than the non-VA provider initiating the request. The audit team did not find documentation in the patient records of reviews of prior non-VA care or clinical assessments before approving additional care for these six. The *OCC Field Guidebook* did not clearly indicate how to process such requests. In addition, OCC clinical integration officials said a veteran may request additional non-VA care through a VA provider without a request form from the community care provider and explained that the guidebook was not applicable in these circumstances. However, without consulting the community care provider or having documented proof of treatment progress, facility staff cannot validate the effectiveness and necessity of continued care. In these circumstances, the burden of documentation falls on VA providers. OCC clinical integration officials agreed VA providers should document a clinical assessment to determine if additional non-VA care is appropriate and refer veterans for that care. When VA providers do not evaluate prior care or assess the veterans themselves, they impede efforts to ensure continuity of care.

Recommendation 6 addresses the need for facility chiefs of staff to require VA providers to document their clinical assessments when referring veterans who have made direct requests for additional care to non-VA providers.

⁵³ *OCC Field Guidebook*.

Finding 2 Conclusion

The OIG found that in approving requests for additional services, VHA facility staff did not follow the *OCC Field Guidebook*'s requirement for a documented evaluation of past care. Therefore, there is a risk that additional non-VA care will be approved with no evaluation of prior care. VA medical facilities must enforce requirements to follow the guidebook and the standardized clinical review process when approving additional non-VA care and ensure that VA providers document their clinical justifications for additional care requests initiated by veterans. Until then, VHA will lack assurance that veterans are receiving appropriate non-VA acupuncture and chiropractic care.

Recommendations 5–6

The OIG made the following recommendations to the under secretary for health:

5. Direct facility chiefs of staff to require those authorized to approve non-VA care to document review of prior care before approving additional services.
6. Instruct facility chiefs of staff to require VA providers to document their clinical justification for additional care requested by a veteran.

Management Comments

The acting under secretary for health concurred with recommendations 5 and 6. In response to these recommendations, he stated that the OCC will ensure the requirements to review prior care and document clinical justification are communicated to VA providers. Further, he stated that the corrective actions are targeted to be completed by March 2022.

OIG Response

The corrective action plans are responsive to the intent of the recommendations. The OIG will monitor implementation of the planned actions and will close recommendations when VHA provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

Appendix A: Scope and Methodology

Scope

The audit team performed its audit work from January 2020 to August 2021 to determine whether payments made to community acupuncture and chiropractic providers were authorized and supported by medical documentation. The audit included a universe of approximately 607,000 community care acupuncture claims estimated at \$114 million in VA payments and 883,000 community care chiropractic claims for which VA paid about \$89 million from October 1, 2017, through September 30, 2019.

Methodology

After becoming aware of questionable billing practices, the audit team developed its objective with the assistance of data scientists. The OIG's data scientists extracted acupuncture and chiropractic data from VA's Corporate Data Warehouse. In coordination with the audit team, the data scientists analyzed VA payments for non-VA acupuncture and chiropractic care and discerned patterns of questionable billing practices, such as billing for visits that exceeded the number allowed and billing for potentially excessive evaluation and management services.

To achieve the objective, the audit team reviewed the Veterans Choice Program contracts and interviewed officials from the OCC, the FSC, and HIM. Additionally, the audit team used a medical coding contractor to review and determine the sufficiency of medical documentation from community providers in supporting billed charges.

For the purposes of this audit, the universe was obtained from Choice data provided by the VA FSC and retrieved from the VA Plexis Claims Manager system. The audit team reviewed a statistical sample of 180 acupuncture and 180 chiropractic community care claims from the identified universe. Appendix B details the statistical sampling methodology.

Medical Claim and Treatment Authorization Review

To determine whether the payment of a claim was authorized, the audit team used electronic health records and third-party administrator portals to review the combined 360 claims for an authorization that covered the claim date. The audit team considered claims unauthorized if the visit number on the claim exceeded the number authorized, the date of the claim was after the allowable dates on the authorization, VHA did not authorize the claim but the third-party administrator did for veterans who were not eligible based on mileage from a VA care facility, or the claim included both acupuncture and chiropractic treatments when only one of those types of treatments was authorized. In addition, for claims that were authorized on or after December 7, 2018, the audit team verified that the treatments billed and paid were allowed by

the acupuncture and chiropractic standards for care. The audit team interviewed OCC and FSC staff to determine why payments were made for unauthorized care.

Evaluation of Medical Documentation Review

The OIG enlisted an independent contractor to evaluate medical documentation for the claims in the sample to determine whether the documentation supported billed charges. The OIG's contractor used two analysts to independently review documentation collected and provided by the OIG for 180 community acupuncture claims and 180 community chiropractic claims. A third analyst then reviewed each previous analyst's work and made a final decision when the other analysts did not agree on the sample. The contractor reported the errors in a spreadsheet provided by the OIG. The team discussed the insufficient documentation with VHA's acupuncture and chiropractic subject matter experts as well as OCC and HIM representatives. The OIG shared the contractor's evaluation with these officials, who were given an opportunity to review the results and underlying documentation. In addition, the team interviewed OCC and HIM program office officials to discuss risk mitigation efforts for documentation that did not support acupuncture and chiropractic claims.

Community Provider and Veteran Requests for Additional Non-VA Care Review

During the planning phase of the audit, the OIG's data scientists identified questionable billing activity among certain providers; these providers billed significantly more treatments daily than their peers. Therefore, the team sampled providers from this subpopulation. The team included any provider who billed more than 40 acupuncture or 40 chiropractic procedures in one day in this high-usage-days population and then sampled from that. The results of this analysis did not reveal any additional indicators of fraud, but the results did reveal a pattern of community providers requesting additional services.

Specifically, the audit team found denied or overlooked requests for additional services during the review of the high-usage-days sample. The audit team determined that this might be an issue and developed a plan to look at the previously mentioned acupuncture and chiropractic samples. A subsample was selected from the combined sample of claims for veterans who had already had 12 or more visits with the non-VA acupuncturist or chiropractor that appeared to be authorized with an initial authorization rather than by a request for additional care, as required.⁵⁴ The audit team selected 12 because that is the number of visits allowed by the initial acupuncture and chiropractic standards for care that were in place for most of FY 2019. This sample was further filtered to include only those claims that had less than 60 days between appointments. The audit

⁵⁴ Authorizations processed by the third-party administrators because the veteran was eligible based on mileage to the nearest VA facility that provided the service were not included because VA was not the approval authority.

team judgmentally selected 60 days because it would be reasonable to initiate a new authorization after that time. This resulted in 80 authorizations associated with 80 claims.

The audit team looked at these 80 claims for an approved request form, provider approval notes in an existing consult, or a provider note documenting clinical review of a request or medical records provided by the community care provider. In the absence of such documentation, the audit team marked the claims as containing an error. The team presented the audit methodology and exceptions to OCC officials and interviewed OCC officials to determine why continuing care was not authorized in accordance with guidance.

Internal Controls

As required by generally accepted government auditing standards, the audit team reviewed the five internal control components and 17 principles of (1) the OCC authorization process and (2) the FSC claims reimbursement process related to the audit objective.⁵⁵ The team identified the following three components and six principles associated with the audit objective and proposed recommendations 1–4 in finding 1 and recommendations 5–6 in finding 2 to address the deficiencies identified in the control environment, control activities, and monitoring:

- Control Environment, Principle 2—Exercise Oversight Responsibility
- Control Environment, Principle 3—Establish Structure, Responsibility, and Authority
- Control Activities, Principle 10—Design Control Activities
- Control Activities, Principle 11—Design Activities for the Information System
- Control Activities, Principle 12—Implement Control Activities
- Monitoring, Principle 16—Perform Monitoring Activities

Fraud Assessment

The audit team assessed the risk that fraud and noncompliance with provisions of laws, regulations, and contracts, significant in the context of the audit objectives, could occur during this audit. The team exercised due diligence in staying alert to any fraud indicators by

- soliciting the OIG’s Office of Investigations for indicators, and
- evaluating medical documentation with the assistance of a medical coding specialist.

The OIG did not identify any instances of fraud or potential fraud during this audit.

⁵⁵ GAO, *Standards for Internal Control in the Federal Government*.

Data Reliability

The OIG Data Analytics Division provided the audit team with Plexis Claims Manager claims data. The audit team performed the data reliability steps detailed in the next paragraph for all the claims from the statistical sample.

The audit team assessed the completeness and accuracy of the payment data fields in each sample by reconciling the payment data within the Plexis Claims Manager system to payment data retrieved from the Financial Management System. In addition, during the authorization review, the audit team ensured that dates, names, and other claim information matched with the electronic health records and other source documentation. The OIG concluded the data were valid and sufficiently reliable to support the audit's objectives and conclusions.

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on the audit objectives. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

Appendix B: Statistical Sampling Methodology

Approach

To accomplish the objective, the audit team reviewed a statistical sample of 180 acupuncture community care claims and 180 chiropractic community care claims. The team used statistical sampling to quantify the extent to which payments made to community acupuncture and chiropractic providers for claims were unauthorized or not supported by medical documentation.

Population

The review population included 607,432 acupuncture community care claims with a total of \$113,915,516 in paid charges and 882,923 for chiropractic community care claims with a total of \$89,256,684 in paid charges. Additional samples were required for the acupuncture sample based on conversations with the Office of Investigations. The audit team removed samples for any claims related to providers under criminal investigation and replaced those claims with others from the same acupuncture universe.

Sampling Design

The audit team selected a statistical sample of 180 community care acupuncture claims and 180 community care chiropractic claims. The details of each are as follows:

- 45 claims where the claim was after a veteran's 12th visit with the same provider and the provider billed for an evaluation and management service (Population A)
- 45 claims where the claim was a veteran's 12th visit or prior and the provider did not bill for an evaluation and management service (Population B)
- 45 claims where the claim was after a veteran's 12th visit with the same provider and the provider did not bill for an evaluation and management service (Population C)
- 45 claims where the claim was a veteran's 12th visit or prior and the provider billed for an evaluation and management service (Population D)

Table B.1. Acupuncture Sample

Population	Number of claims, Plexis Claims Manager	Amount of claims, Financial Management System (\$)	Sampled items
A	79,643	17,651,415	45
B	244,290	39,845,776	45
C	113,754	17,635,038	45
D	169,745	38,783,287	45
Total	607,432	113,915,516	180

Source: VA OIG sampled universe of acupuncture community care claims paid by the Plexis Claims Manager system from October 1, 2017, through September 30, 2019.

Table B.2. Chiropractic Sample

Population	Number of claims, Plexis Claims Manager	Amount of claims, Financial Management System (\$)	Sampled items
A	51,124	7,357,538	45
B	483,508	41,739,419	45
C	208,671	17,234,878	45
D	139,620	22,924,849	45
Total	882,923	89,256,684	180

Source: VA OIG sampled universe of chiropractic community care claims paid by the Plexis Claims Manager system from October 1, 2017, through September 30, 2019.

Weights

The estimates in this report were calculated using weighted sample data. Samples were weighted to represent the population from which they were drawn. The team used the weights to compute estimates. For example, the team calculated the error rate point estimates by summing the sampling weights for all sample records that contained the error, then dividing that value by the sum of the weights for all sample records.

Projections and Margins of Error

The point estimate (e.g., estimated error) is an estimate of the population parameter obtained by sampling. The margin of error and confidence interval associated with each point estimate are a measure of the precision of the point estimate that accounts for the sampling methodology used. If the audit team 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.

The OIG statistician employed statistical analysis software to calculate the weighted population estimates and associated sampling errors. This software uses replication or Taylor series approximation methodology to calculate margins of error and confidence intervals that correctly account for the complexity of the sample design.

The sample size was determined after reviewing the expected precision, potential error rate, and logistical concerns of the sample review. Although precision improves with larger samples, the rate of improvement does not significantly change as more records are added to the sample review.

Figure B.1 shows the effect of progressively larger sample sizes on the margin of error.

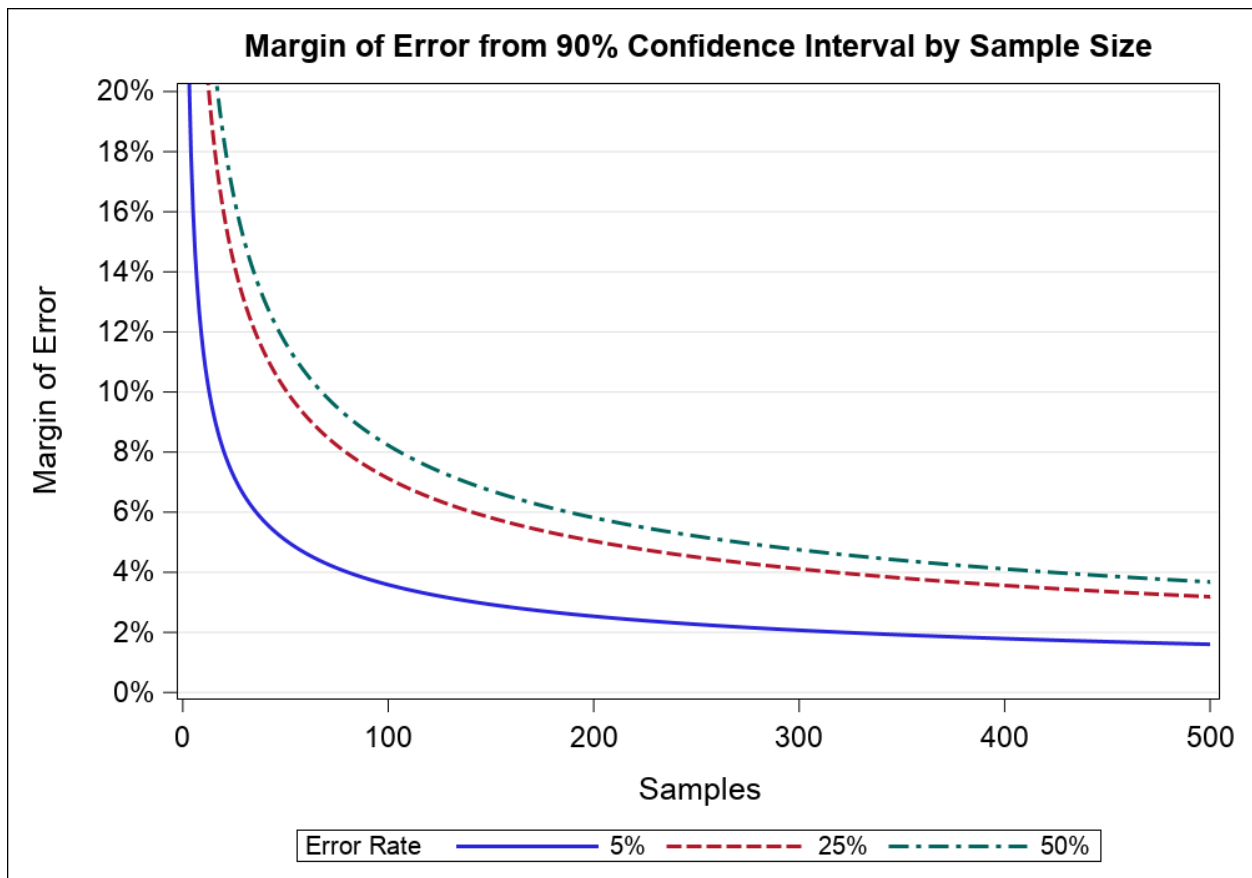


Figure B.1. Effect of sample size on margin of error.

Source: VA OIG statistician's analysis.

Projections

Table B.3. Unauthorized Acupuncture Claims

Description	Estimate	Margin of error	Confidence interval lower limit 90 percent	Confidence interval upper limit 90 percent	Sample results	Sample size
Number of unauthorized acupuncture claims	51,200	20,600	30,500	71,800	19	180
Percentage of unauthorized acupuncture claims	8%	3%	5%	12%	19	180
Total acupuncture claims with treatment restrictions	240,600	40,000	200,600	280,500	70	180
Acupuncture claims with unauthorized treatments	112,600	32,100	80,500	144,700	32	180
Percentage of acupuncture claims with unauthorized treatments	47%	11%	36%	58%	32	70

Source: VA OIG unauthorized acupuncture claim projections based on a sampled universe of acupuncture Choice claims paid by the Plexis Claims Manager system from October 1, 2017, through September 30, 2019.

Note: For appendix tables B.3–B.9, numbers in the estimate column are rounded. Numbers in the columns for margin of error, lower limit, and upper limit do not add to the totals shown; they are based on statistical formulas because they represent a measure of uncertainty for the point estimates.

Table B.4. Unauthorized Chiropractic Claims

Description	Estimate	Margin of error	Confidence interval lower limit 90 percent	Confidence interval upper limit 90 percent	Sample results	Sample size
Number of unauthorized chiropractic claims	83,300	30,600	52,600	114,000	24	180
Percentage of unauthorized chiropractic claims	9%	3%	6%	13%	24	180
Total chiropractic claims with treatment restrictions	331,800	65,000	266,800	396,800	72	180
Chiropractic claims with unauthorized treatments	162,500	47,000	115,600	209,500	44	180
Percentage of chiropractic claims with unauthorized treatments	49%	12%	37%	61%	44	72

Source: VA OIG unauthorized chiropractic claim projections based on a sampled universe of chiropractic Choice claims paid by the Plexis Claims Manager system from October 1, 2017, through September 30, 2019.

Table B.5. Percentages of Supported, Missing or Illegible, and Not Sufficiently Supported Treatments on Acupuncture Claims

Description	Estimate	Margin of error	Confidence interval lower limit 90 percent	Confidence interval upper limit 90 percent	Sample results	Sample size
All supported treatments	24	3	21	27	226	953
All unsupported treatments	76	3	74	79	727	953
All treatments with missing or illegible medical documentation	19	2	17	22	162	953
All treatments not sufficiently supported	57	3	54	60	565	953
Acupuncture treatments with missing or illegible medical documentation	11	2	9	13	90	953
Acupuncture treatments not sufficiently supported	38	3	35	40	361	953
Evaluation and management treatments	12	2	10	14	125	953
Evaluation and management treatments with missing or illegible medical documentation	3	1	2	3	25	953
Evaluation and management treatments not sufficiently supported	9	1	7	10	96	953
Evaluation and management treatments on acupuncture claims that are not supported because the documentation was missing or insufficient	97	3	94	100	121	125
Other treatments with missing or illegible medical documentation	6	2	5	8	47	953
Other treatments not sufficiently supported	10	2	8	12	108	953

Source: VA OIG unauthorized acupuncture claim projections based on a sampled universe of acupuncture Choice claims paid by the Plexis Claims Manager system from October 1, 2017, through September 30, 2019.

Table B.6. Percentages of Supported, Missing or Illegible, and Not Sufficiently Supported Treatments on Chiropractic Claims

Description	Estimate	Margin of error	Confidence interval lower limit 90 percent	Confidence interval upper limit 90 percent	Sample results	Sample size
All supported treatments	45	4	41	49	418	937
All unsupported treatments	55	4	51	58	515	937
All treatments with missing or illegible medical documentation	14	2	11	16	157	937
All treatments not sufficiently supported	41	4	37	44	358	937
Chiropractic treatments with missing or illegible medical documentation	9	2	7	11	95	937
Chiropractic treatments not sufficiently supported	27	3	24	30	214	937
Evaluation and management treatments	5	1	5	6	98	937
Evaluation and management treatments with missing or illegible medical documentation	1	0	0	1	14	937
Evaluation and management treatments not sufficiently supported	4	1	3	4	63	937
Evaluation and management treatments on chiropractic claims that are not supported because the documentation was missing or insufficient	78	8	70	86	77	98
Other treatments with missing or illegible medical documentation	4	1	3	6	48	937
Other treatments not sufficiently supported	10	2	8	13	81	937

Source: VA OIG unauthorized chiropractic claim projections based on a sampled universe of chiropractic Choice claims paid by the Plexis Claims Manager system from October 1, 2017, through September 30, 2019.

Table B.7. Improper Acupuncture Payments (in Millions of Dollars)

Description	Estimate	Margin of error	Confidence interval lower limit 90 percent	Confidence interval upper limit 90 percent	Sample results	Sample size
Improper payments for acupuncture claims due to claim not authorized	8.0	2.8	5.2	10.8	95	953
Improper payments for acupuncture claims due to treatment not authorized	2.5	1.1	1.4	3.6	61	953
Improper payments for acupuncture claims due to missing or illegible medical documentation	21.3	4.2	17.1	25.5	162	953
Improper payments for acupuncture claims due to treatment not sufficiently supported by medical documentation	61.4	5.2	56.2	66.6	565	953
Overlap in acupuncture improper payments	-7.8	-3.0	-4.8	-10.7	-102	953
Estimated total acupuncture improper payments	85.4	7.9	77.5	93.3	781	953

Source: VA OIG improper acupuncture payment projections based on a sampled universe of acupuncture Choice claims paid by the Plexis Claims Manager system from October 1, 2017, through September 30, 2019.

Table B.8. Improper Chiropractic Payments (in Millions of Dollars)

Description	Estimate	Margin of error	Confidence interval lower limit 90 percent	Confidence interval upper limit 90 percent	Sample results	Sample size
Improper payments for chiropractic claims due to claim not authorized	8.2	2.1	6.0	10.3	120	937
Improper payments for chiropractic claims due to treatment not authorized	4.0	1.3	2.7	5.3	75	937
Improper payments for chiropractic claims due to missing or illegible medical documentation	12.7	2.7	10.0	15.3	157	937
Improper payments for chiropractic claims due to treatment not sufficiently supported by medical documentation	34.8	4.2	30.6	39.0	358	937
Overlap in chiropractic improper payments	-8.3	-2.3	-6.0	-10.6	-103	937
Estimated total chiropractic improper payments	51.3	6.0	45.3	57.3	607	937

Source: VA OIG improper chiropractic payment projections based on a sampled universe of chiropractic Choice claims paid by the Plexis Claims Manager system from October 1, 2017, through September 30, 2019.

**Table B.9. Improper Acupuncture and Chiropractic Payments
(in Millions of Dollars)**

Description	Estimate	Margin of error	Confidence interval lower limit 90 percent	Confidence interval upper limit 90 percent
Claim not authorized	16.1	2.1	14.0	18.3
Treatment not authorized	6.5	1.0	5.4	7.5
Missing or illegible medical documentation	33.9	3.0	30.9	37.0
Treatment not sufficiently supported by medical documentation	96.2	4.1	92.1	100.2
Improper for more than one reason	-16.0	-2.3	-13.8	-18.3
Estimated total	136.7	6.0	130.6	142.7

Source: VA OIG improper acupuncture and chiropractic payment projections based on a sampled universe of acupuncture and chiropractic Choice claims paid by the Plexis Claims Manager system from October 1, 2017, through September 30, 2019.

Appendix C: Monetary Benefits in Accordance with Inspector General Act Amendments

Recommendations	Explanation of Benefits	Better Use of Funds	Questioned Costs
1-2	Unauthorized acupuncture claims		\$8.0 million
1-2	Unauthorized treatments on acupuncture claims		\$2.5 million
1-2	Unauthorized chiropractic claims		\$8.2 million
1-2	Unauthorized treatments on chiropractic claims		\$4.0 million
3-4	Missing medical documentation for acupuncture claims from non-VA providers*		\$21.3 million
3-4	Medical documentation that does not sufficiently support acupuncture claims from non-VA providers*		\$61.4 million
3-4	Missing medical documentation for chiropractic claims from non-VA providers*		\$12.7 million
3-4	Medical documentation that does not sufficiently support chiropractic claims from non-VA providers*		\$34.8 million
NA	Overlap of dollars included in more than one category		-\$16 million
	Subtotal FY 2018 and FY 2019		\$136.7 million
	Estimated FY 2020 through FY 2022		\$205.0 million
	Total	\$0	\$341.7 million

Source: The OIG team’s questioned costs are based on payment projections of errors found in a sampled universe of acupuncture and chiropractic Choice claims paid by the Plexis Claims Manager system from October 1, 2017, through September 30, 2019.

Notes: (1) Amounts are rounded and may not sum. (2) The OIG considered the approximately \$136.7 million in questioned costs for FY 2018 and FY 2019 to be improper payments. The Payment Integrity Information Act of 2019 and Office of Management and Budget Circular A-123, app. C (OMB M-18-20), define improper payments as any payments that should not have been made. For this audit, this includes payments not supported by medical documentation or not authorized.

* These categories of questioned costs were also considered unsupported costs and are presented separately as required by the Inspector General Act of 1978. In March 2021, OMB updated the Office of Management and Budget Circular A-123, app. C, “Requirements for Payment Integrity Improvement,” March 5, 2021. Under this update, the missing medical documentation and medical documentation that did not sufficiently support the claims would be classified as unknown payments, meaning the agency is unable to determine whether they are proper or improper. The OIG extrapolated the questioned costs from FY 2018 and FY 2019 through FY 2022 based on when effective actions could address the problems identified in this audit. Although the corrective actions to address the OIG recommendations may be implemented by the end of FY 2022, it is likely VHA may not realize benefits from these corrective actions until then.

Appendix D: Management Comments

Department of Veterans Affairs Memorandum

Date: September 16, 2021

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report, VHA Improperly Paid and Reauthorized Non-VA Acupuncture and Chiropractic Services (2020-01099-R5-0001) (VIEWS 5739669)

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) subject draft report. The Veterans Health Administration (VHA) concurs with recommendations two through six and concurs in principle with recommendation one. VHA provides an action plan in the attachment.
2. VHA appreciates OIG's comprehensive review of reimbursements processed by the Financial Services Center (FSC) using the Plexis Claims Manager. In discussion with OIG, page ii-iii, 8 section, *VHA Improperly Paid Acupuncture and Chiropractic Claims*, explains that the system was designed to automatically pay claims issued within 1 year of the authorization date, instead of restricting payments to the number of visits or specific dates allowed under the authorization.
3. VHA is pleased to share that utilization of the Plexis Claims Manager for Third Party Reimbursements will be replaced by the Community Care Reimbursement System (CCRS) for the new Community Care Network contract.
4. The Office of Health Informatics recommend removing the reference to VHA Handbook 1907.01 in this footnote. The interpretation and reference to VHA Handbook 1907.01 has been applied inappropriately because the handbook only provided specific guidance on the inclusion of Non-VA medical care documentation and not whether the documentation is sufficient or insufficient in the context of corresponding paragraph. The reference to VHA Handbook 1907.01 regarding use of American Medical Association Current Procedural Terminology codes is referencing the codes and terminology utilized by the facility, not services from Non-VA care providers.

Technical Comments

Comment 1

Draft location: Page 13 and Page 25

Current language: However, the deputy chief of community care contract administration stated there were no quality assurance plan reports about the adjudication and accuracy of the claims or the payment process, and VHA took over responsibility of medical documentation collection in October 2018, making it impractical for the third-party administrators to review whether medical documentation supported payments. (pg. 13)

As required by generally accepted government auditing standards, the audit team reviewed the five internal control components and principles of the (1) OCC authorization process and (2) the Financial Services Center (FSC) claims adjudication process related to the audit objective.(pg. 25)

Comment and justification: FSC utilizes The Plexis Claims Manager (PCM) system to process claims. PCM is a reimbursement system, and not a claims adjudication system. For purposes of accuracy, VHA

respectfully asks OIG to consider revising the noted sections to reference the PCM system as a reimbursement system instead of a claims adjudication process.

Comment 2

Draft location: Page iii and Page 9

Current language: Furthermore, the audit team determined that OCC did not monitor the payment process by performing internal audits specific to when visits and treatments exceeded authorizations for the Plexis Claims Manager payment system. (pg. iii)

The audit team found no evidence that previous OCC related internal audits focused on the risk of paying for visits and treatments that exceeded authorizations through the Plexis Claims Manager payment system. Assessing whether visits and treatments exceeded authorizations could mitigate the payment of unauthorized visits and treatments for non-VA services. (pg. 9)

Comment and justification: In discussion with OIG, the FSC shared information regarding the current quality assurance process for PC3 claims, which includes a second level review from a senior FSC processor for inpatient and high dollar claims. FSC Internal Controls, Auditing, and Risks Division (ICARD) conducts a quarterly review of a random sampling of claims.

Comment 3

Draft location: Page iii, Footnote 8, and associated paragraph (pg. iii, para 2, lines 1-4)

Current language:

Footnote: 8. VHA Handbook 1907.01, Health Information Management and Health Records, March 19, 2015. According to the handbook, “The medical facility Director, or designee, is responsible for establishing policies and processes in compliance with this Handbook, to include ensuring ... Non-VA medical care is documented,” and “the latest United States editions of the American Medical Association’s CPT ... must be used to provide uniform disease and operation terminology.” For billing purposes, a treatment is represented by a Current Procedural Terminology code.

Comment and justification:

VHA respectfully asks OIG to consider removing the reference to VHA Handbook 1907.01 in this footnote. For purposes of accuracy, the referenced VHA Handbook 1907.01 provides specific guidance on the inclusion of Non-VA medical care documentation, and not whether the documentation is sufficient or insufficient as indicated in the referenced paragraph above.

VHA Handbook 1907.01 references AMA Current Procedural Terminology (CPT) codes and terminology used by the facility, and is not a reference to Non-VA care provider services.

VHA asks OIG to consider revising the referenced comment for the purposes of accuracy, to avoid unintentional misrepresentation, and inaccurate reader interpretation.

Comment 4

Draft location: Page 4-5, paragraph 3

Current language:

VHA’s Health Information Management (HIM) program office is responsible for ensuring health records are accurate and developing VHA coding procedures. VHA policy required non-VA providers’ medical documentation to meet American Medical Association (AMA) and Centers for Medicare & Medicaid Services guidelines.²⁴ AMA’s Current Procedural Terminology code guidelines describe terms and identify

codes for reporting medical services and procedures performed by physicians.²⁵ The Centers for Medicare & Medicaid Services also requires practitioners to use treatment codes that meet the AMA's Current Procedural Terminology guidelines.²⁶

Comment and justification:

VHA respectfully asks OIG to consider removing footnote 24 and the reference to footnote 24 for purposes of accuracy (also see comments above for footnote 8). This reference is applicable to VA's process for submitting claims to third party insurance companies for reimbursement. The handbook does not specifically identify the requirements for community providers to submit medical documentation. Documentation requirements are covered in the Third-Party Administrators (TPA) contract. For purposes of clarity, VHA also asks OIG to consider adding a sentence that states VHA documentation guidelines are based on industry standards (Joint Commission, CMS, etc.). The AMA publishes the CPT code set, which only requires documentation to sufficiently describe the services provided, rather than a specific format. The Health Insurance Portability and Accountability Act (HIPAA) requires covered entities to adhere to industry standards for coding and billing guidelines when submitting claims. For purposes of accuracy, VHA asks OIG to consider revising the 4th sentence to read "The Centers for Medicare & Medicaid Services also requires practitioners to use treatment codes that meet Medicare and Medicaid services and The Joint Commission guidelines."²⁶

Comment 5

Draft location: Page 6, Footnote 28.

Current language:

²⁸VHA Handbook 1907.01. VHA Guidebook, *HIM Clinical Coding Program Guide Version 1.4*, chap. 5, section m, September 7, 2018.

Comment and justification:

VHA Handbook 1907.01 does not specifically identify the documentation requirements for community providers to submit back to VA. It is the responsibility of OCC and/or TPA to ensure that the documentation submitted by non-VA providers is complete as specified in the contract. VHA respectfully asks OIG to consider removing the reference to VHA Handbook 1907.01 for purposes of accuracy.

Comment 6

Draft location: Page 6, paragraph 3, 2nd bullet

Current language:

Providers submitted and VHA paid acupuncture and chiropractic claims unsupported by medical documentation.

Comment and justification:

VHA recommends noting that payments are dependent on authorization, which includes clinical review and approval, prior to services being performed. Payment is not dependent on supporting documentation from the community provider. VHA does not withhold provider payments for a lack of documentation, but attempts to obtain provider documentation for rendered community care. VHA asks OIG to consider revising this statement for purposes of clarity and to avoid reader confusion.

Comment 7

Draft location: Page 9, paragraph 5, lines 1-2 and footnote 35.

Current language:

Medical documentation produced by non-VA acupuncturists and chiropractors must comply with the AMA's Current Procedural Terminology code guidelines.³⁵

³⁵ VHA Handbook 1907.01.

Comment and justification:

VHA Handbook 1907.01 is not an accurate reference to the requirement for non-VA providers to submit medical documentation because VHA Handbook 1907.01 does not associate clinical documentation compliance requirements with AMA's CPT Code guidelines. VHA Handbook 1907.01 provides clinical documentation principles in line with industry standards such as The Joint Commission. Assigning codes based on clinical documentation is a separate action. Billing, collections, and payments should not be catalyst for clinical documentation. The referenced document does not address documentation submission requirements for non-VA providers because those guidelines would be contained in the contract. For these reasons, VHA respectfully asks OIG to remove the reference to VHA Handbook 1907.01 for purposes of accuracy.

Comment 8

Draft location: Page 9, paragraph 5, lines 3-6.

Current language:

Further, third-party administrators require care providers to have medical documentation that substantiates all authorized billed services. The administrators issue documentation requirements for all treatments.

Comment and justification:

For purposes of accuracy, VHA asks OIG to consider referencing TPA's medical documentation requirements utilized as the guiding documentation principle, and underlying requirements not met throughout this report instead of VHA Handbook 1907.01.

The OIG removed point of contact information prior to publication.

(Original signed by)

Stephen L. Lieberman, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, VHA Improperly Paid and Reauthorized Non-VA Acupuncture and Chiropractic Services

(2020-01099-R5-0001)

Recommendation 1. The Under Secretary for Health will ensure the Office of Community Care implement automated payment system controls to reject non-VA claims that exceed the number of authorized visits or cutoff dates, or include treatment codes that deviate from established standards for care.

VHA Comments: Concur in Principle

The Office of Community Care (OCC) concurs in principle with this recommendation and must point out that the scope and findings of the audit were based on review of claims reimbursed during fiscal years (FY) 2018 and 2019 using the Plexis Claims Management (PCM) system. PCM system is limited to Community Care Network (CCN) Region 5. Region 5 will use the PCM system until the current contract ends in FY 2022 and the CCN contract is implemented in this region. Claims for all other regions are now processed using one of two new systems: Electronic Claims Adjudication Management System (eCAMS) for Veteran Care Agreements (VCA) claims and the Community Care Reimbursement System (CCRS) for CCN claims.

VHA OCC believes that an integration of both automated and manual controls are needed in our current environment to effectively monitor for care not authorized by the referral and to accommodate processing activities in both VHA and Third Party Administrator (TPA) environments.

VHA's eCAMS already contains automated controls which process payments to non-VA care providers after checking for authorization appropriateness. The system includes capabilities to reject claims that exceed the number of authorized visits or cutoff dates, or which include treatment codes that deviate from established standards for care.

For CCRS and CCN claims, a different monitoring approach is being used. This is because CCRS is not designed or utilized as a claims adjudication system. Before authorizing a reimbursement to the TPA, CCRS automated controls check that a claim has a matching referral/authorization, confirms that the provided service is supported by the authorized standard episode of care (SEOC), and the service was performed within the referral's indicated dates of service. In addition, OCC is conducting post-payment reviews that focus on excessive reimbursements and analyze data for potential improper payments. This type of review supplements the CCRS automated controls. Within the TPA environments, TPAs have introduced measures to eliminate the payment of claims that have exceeded the number of visits, have dates outside of the authorized dates of service, and have treatment codes that deviate from the SEOC. Both TPAs provided staff training and work process instructions to identify and remediate these issues. Both TPAs have instituted a recurring quality assurance review of these types of claims.

VHA OCC considers this recommendation complete and asks OIG to consider closure.

Status: Complete

Recommendation 2. The Under Secretary for Health will ensure the Office of Community Care conduct ongoing payment system audits to identify and minimize improper payments of unauthorized claims.

VHA Comments: Concur

VHA OCC agrees that ongoing payment system audits to identify and minimize the improper payment of care not authorized by the referral are important controls within the payment system environment. OCC is in the process of documenting internal controls within the payment systems. Once controls are documented, OCC will initiate ongoing audits to assess the internal controls and payments systems. Any failures or control deficiencies will be reported to payment system managers for remediation.

As part of OCC's approach to the three lines of defense model, OCC is also conducting monthly qualitative reviews in eCAMS as a supplemental control for improper payments. This review focuses on overall adjudication accuracy and includes claim level analysis of authorized visits, dates of service, authorization mismatches and general authorization appropriateness. Post-payment reviews are also conducted for CCRS. OCC will explore expanding the nature of these reviews to include identification of improper payments of care not authorized by the referral. Finally, both TPAs have instituted a recurring quality assurance review of claims for care not authorized by the referral and will be providing these results to OCC.

Status: In progress

Target Completion Date: March 2022

Recommendation 3. The Under Secretary for Health will Direct the Health Information Management program office in coordination with the Office of Community Care and facility chiefs of staff to ensure facilities are conducting post-payment audits of billed acupuncture and chiropractic services to verify non-VA providers are properly supporting their claims, and to develop processes for corrective actions based on audit results.

VHA Comments: Concur

VHA OCC understands the importance of conducting post-payment audits of community care providers' records for services rendered to Veterans. These audits are a fundamental way to monitor the billing, coding, and documentation practices of non-VA health care providers to prevent fraud and abuse within the VHA payment system. The Health Information Management program office, in coordination with the OCC will develop an approach and plan for regularly conducting post-payment audits of billed outpatient services, such as for acupuncture and chiropractic services. The plan will address the resourcing needed for conducting audits, which may include coordination with additional program offices. The plan will outline approaches for scoping, sampling, and taking corrective actions inclusive of non-VA provider-specific billing and documentation issues.

Status: In progress

Target Completion Date: March 2022

Recommendation 4. The Under Secretary for Health will ensure the Office of Community Care and the Health Information Management program office, in coordination with the offices of Acupuncture and Chiropractic services, make any current and future continuing education material related to documenting acupuncture and chiropractic services available to non-VA providers.

VHA Comments: Concur

VHA's Health Information Management Office, the Integrative Health Coordinating Center (which oversees acupuncture), and the Chiropractic Program within Rehabilitation and Prosthetic Services, will ensure any current and future provider education materials related to documenting acupuncture and

chiropractic services are made available to the OCC for dissemination to non-VA providers. OCC will make the education material available to these providers via the VA OCC public facing website and will ensure that providers are made aware of the availability of these education materials.

Status: In progress

Target Completion Date: November 2021

Recommendation 5. The Under Secretary for Health will Direct facility chiefs of staff to require those authorized to approve non-VA care to document review of prior care before approving additional services.

VHA Comments: Concur

VHA OCC will clarify guidance regarding the approval of requests for additional services to include documentation prior to care approval. This guidance will address the necessity to review prior care and document clinical justification. Any additional guidance will be communicated to providers, updated in procedures and trainings.

Status: In progress

Target Completion Date: March 2022

Recommendation 6. The Under Secretary for Health will Instruct facility chiefs of staff to require VA providers to document their clinical justification for additional care requested by a veteran.

VHA Comments: Concur

VHA OCC will clarify guidance regarding the approval of requests for additional services to include documentation prior to care approval. This guidance will address the necessity to review prior care and document clinical justification. Any additional guidance will be communicated to providers, updated in procedures and trainings.

Status: In progress

Target Completion Date: March 2022

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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