



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Audits and Evaluations*

VETERANS HEALTH ADMINISTRATION

Improvements Needed to  
Reduce Duplicate Payments  
by VHA and Medicare and  
Ensure VHA Has Authorized  
Community Medical Services

REVIEW

REPORT #21-03630-250

DECEMBER 8, 2022



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## Executive Summary

VA provides health care for eligible veterans at its nationwide medical facilities. If veterans cannot receive the health care they need from these facilities or if veterans meet certain wait time, distance, or other criteria, they can instead receive care from providers in their communities. Community care may be covered by VA and by other insurance, such as Medicare, Tricare, or private health insurance.<sup>1</sup> When the Veterans Health Administration (VHA), which oversees veterans' health care for VA, authorizes community care for a veteran who is eligible for both VHA and Medicare benefits, VHA is responsible for paying for that care even when Medicare also covers the same service. If VHA pays for care it has not authorized, it may be able to seek collection of overpayments.<sup>2</sup> However, when VHA has authorized care and both VHA and Medicare made payments for the same services, the duplicate payments will generally be recoverable by Medicare because VHA is responsible for paying for care that it authorizes.<sup>3</sup>

Potential duplicate payments by Medicare and VHA have been a long-standing issue. In 1979, the General Accounting Office reviewed a sample of Medicare-eligible veterans in Florida and California, identified duplicate claim payments, and recommended better coordination between the two agencies.<sup>4</sup> However, as of May 2022, VA and the Centers for Medicare and Medicaid Services had not yet developed a data-sharing agreement or process to prevent or identify duplicate claim payments.

The VA Office of Inspector General (OIG) conducted this review to determine whether community care providers are receiving potential duplicate payments for the same healthcare services from VHA and Medicare and to determine whether VHA paid any of these claims without authorization. In this review, the VA OIG collaborated with the Department of Health and Human Services (HHS) OIG—which is currently conducting its own review of duplicate Medicare payments—to better understand duplicate payments and confirm that they had occurred.

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<sup>1</sup> Medicare is a health insurance program for people aged 65 years or older, people younger than 65 years with certain disabilities, or people of all ages with end-stage renal disease. The Centers for Medicare and Medicaid Services oversees the Medicare program and is an agency within the Department of Health and Human Services (HHS). Tricare is a healthcare program for uniformed service members, retirees, and their families.

<sup>2</sup> Unauthorized care is for treatment that VHA did not approve before it was provided or that was provided outside the authorized dates of service.

<sup>3</sup> 38 C.F.R. § 17.1535; 42 C.F.R. §§ 411.7 and 411.8; 38 U.S.C. § 1703(a)(3).

<sup>4</sup> General Accounting Office, *Duplicate Payments for Medical Services by VA and Medicare Programs (HRD-80-10)*, October 22, 1979.

## What the Review Found

The OIG determined that VHA and Medicare made potential duplicate claim payments for community care services. Most of the sample claims reviewed by the OIG were for treatment that had been authorized by VHA, so VHA should pay for the services. Because VHA and the Centers for Medicare and Medicaid Services do not share healthcare claims data, neither agency is aware of claims paid by the other agency. Without an interagency system, the risk of duplicate payments is increased, and it is difficult to determine which agency should pay the claim and which agency can collect overpayments.

### VHA and Medicare Made Duplicate Payments

Before the MISSION Act of 2018 consolidated community care programs under the Veterans Community Care Program, VA-authorized community care was provided under the Patient-Centered Community Care (PC3) program and the Veterans Choice Program (Choice).<sup>5</sup> The Choice program ended on June 6, 2019. However, some PC3 contracts were extended through March 31, 2022, to ensure continuity of care for veterans until the consolidated Veterans Community Care Program was fully implemented.

VHA and Medicare made potential duplicate payments (hereafter referred to as duplicate payments) on 140,869 unique PC3 or Choice claims for community care provided from January 1, 2017, through September 30, 2019.<sup>6</sup> For these types of claims, VHA paid over \$103 million, and Medicare paid over \$79.8 million. This is less than 1 percent of all PC3 and Choice payments. For Veterans Community Care Program claims, VHA made duplicate payments on 285,956 unique claims for community care provided from October 1, 2019, to March 31, 2021. This is less than 1 percent of all Veterans Community Care Program claims. VHA paid over \$204 million, and Medicare paid about \$163.6 million.<sup>7</sup>

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<sup>5</sup> VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182 (2018).

<sup>6</sup> Claim payments by VHA and Medicare were considered to be duplicate if they had matching social security numbers; were for the same or overlapping dates of service; were billed by the same provider; and were for the same service for professional, durable medical equipment, or outpatient claims. For inpatient and home health agency claims, claims were considered to be duplicate if they had matching social security numbers; were for the same or overlapping dates of service; and were submitted by different inpatient hospitals or by the same home health agency. These claims are referred to as “duplicate payments” in this report.

<sup>7</sup> The review team collaborated with the HHS OIG to discuss the criteria the VA OIG applied to identify duplicate payments and to confirm that VHA and Medicare made payments for claims for the same services. The HHS OIG plans to issue their own report on the duplicate payments, which will include determining how many claims in the VA OIG review team’s universe were for the exact same dates of service or for overlapping service dates and how many claims had been cancelled or repaid since the VA OIG completed its data analyses.

## VHA Authorized Most Community Care Services It Paid For

In the sample reviewed, the OIG determined that VHA had authorized most of the duplicate claim payments that were made under the PC3 and Choice programs. Because VHA is responsible for paying for the community care that it authorizes, in situations where both VHA and Medicare made payments and VHA authorized the service, Medicare rather than VA can initiate recovery of the duplicate payment from the provider who billed both entities.<sup>8</sup> Of the 140,869 duplicate claim payments for PC3 or Choice claims, the team reviewed a sample of 100 claims for which VHA paid over \$422,000.<sup>9</sup> The team found that for 93 of the 100 claims (for which VHA paid about \$397,000), VHA appropriately authorized and documented authorizations for the treatment.<sup>10</sup> The team could not identify authorizations for five claims.<sup>11</sup> For two other claims, the team found documentation in the veterans' medical records demonstrating that care had been authorized; however, the team did not find VA Form 10-0386 (VHA Choice Approval for Medical Care) in the medical records or the third-party administrator portals.<sup>12</sup> The team concluded that VHA had authorized most of these duplicate claim payments made under the PC3 and Choice programs, and Medicare could recover the duplicate payments.

The team did not conduct an authorization analysis for Veterans Community Care Program claims but would expect these claims to have the same proportion of, and reasons for, unauthorized care as the sampled PC3 and Choice claims. At the time of this review, the Veterans Community Care Program was still being implemented, and HealthShare Referral Manager was a relatively new system used to document authorizations.<sup>13</sup> According to VHA officials, the authorization process for PC3 and Choice claims was cumbersome and contained opportunities for error. As a result of VHA's continuous process improvement, pre-authorizations for the new Veterans Community Care Program are now completed in HealthShare Referral Manager, a VA-managed system integrated with other key systems for

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<sup>8</sup> 42 C.F.R. § 411.8.

<sup>9</sup> This sample was selected from 99,758 potentially unauthorized claims for which VHA paid over \$72 million. For these claims, the review team was unable to locate claim authorization information by searching VHA's Corporate Data Warehouse. According to VHA officials, authorizations should have been located there. For more information on the review's methodology, see appendix A.

<sup>10</sup> For this sample, in addition to the review team's initial search of VHA's Corporate Data Warehouse for claim authorization information, the team also searched for claim authorization information in veterans' medical records and the third-party administrator portals and compared the claim service date to the authorization period for all records associated with the same veteran.

<sup>11</sup> Appendix B summarizes these overpayments.

<sup>12</sup> VHA staff documented authorizations for community care using VA Form 10-0386.

<sup>13</sup> The HealthShare Referral Manager is a secure web-based system that VHA uses to generate and submit referrals and authorizations to community providers and is the primary platform VHA community care staff at facilities use for implementing, assessing, and updating community care documentation.

claims payment. See appendix A for additional information on the OIG team’s authorization analysis.

According to VHA officials, for PC3 and Choice referrals to community care, VHA staff should document the authorization and then upload it to the veteran’s electronic medical record, as well as to the third-party administrator portal. Authorization information also should have been stored in VHA’s Corporate Data Warehouse. VHA did not follow these documentation procedures, which increased the risk of overpayments or payments for unauthorized services. VHA needs to make sure all nonemergent community care services are preauthorized and appropriately documented to minimize payments for unauthorized community care claims as they move forward using the HealthShare Referral Manager to document authorizations.

### **Providers Billed VHA and Medicare for the Same Healthcare Service**

The review team identified duplicate payments by matching claims for the same or overlapping service dates for the same service and for claims submitted by different inpatient hospitals or by the same home health agency. Duplicate payments may have happened because VHA guidance did not clarify how healthcare providers should bill dual-eligible veterans who have both VA and Medicare benefits, so providers may have billed VHA and Medicare for the same service on the same or overlapping service dates. The review team requested documentation of guidance given to community care providers for billing both VHA and Medicare. VHA officials provided the team with VA Form 10-7080 (Approved Referral For Medical Care), which VHA community care staff are supposed to give to community providers. This form indicates providers should submit bills to the third-party administrator but does not include any details on dual-eligible veterans.

### **VHA and Medicare Do Not Have a System or Process to Identify or Manage Duplicate Payments**

As of May 2022, VHA and Medicare do not have access to the other agency’s claims data to determine whether a claim has already been paid by the other agency. A process to share such data has been a point of discussion between VHA and Medicare for decades. In addition, the Medicare Secondary Payer Manual notes that the Centers for Medicare and Medicaid will annotate Medicare individual files with possible VA involvement using information supplied by VA each month.<sup>14</sup> However, this process was never implemented, and the Medicare manuals were never updated. In addition to not sharing data on dual-eligible patients, neither VHA nor

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<sup>14</sup> The Centers for Medicare and Medicaid Services, chap. 5, “Medicare Secondary Payer Manual,” Pub. No. 100-05, January 2022.

Medicare currently has a process to manage duplicate payments; instead, both agencies relied on either providers or veterans to initiate requests to cancel duplicate payments.

## **VHA Has Not Previously Conducted Reviews to Identify Duplicate Payments**

Until the beginning of fiscal year 2021, VHA had not conducted any reviews of duplicate payments made by it and Medicare. In 2021, VHA reviewed claims from 2019 and identified potential duplicate claims, but VHA staff stated they sometimes had trouble determining who should pay for care. As of March 2022, VA had established a one-time data-sharing agreement with Medicare to confirm the duplicate payments VA identified.<sup>15</sup>

## **What the OIG Recommended**

The OIG made three recommendations to the under secretary for health, including working with the Centers for Medicare and Medicaid Services to establish a data-sharing agreement with VA to minimize duplicate claim payments. The OIG also recommended identifying overpayments made for care provided to dual-eligible veterans that was not authorized by VHA and ensure documentation and care are completed or that VA seeks reimbursement for any unauthorized care. Finally, the OIG recommended making sure all nonemergent community care is preauthorized and that documentation for all authorizations is complete and properly stored before treatment is provided.

## **VA Comments and OIG Response**

The under secretary for health concurred in principle with recommendation 1 and concurred with recommendations 2 and 3, and provided an action plan detailing steps for implementation. The full text of the under secretary's comments appears in appendix C.

The proposed corrective measures in VHA's action plans are responsive to the recommendations. The OIG will follow up on the implementation of the planned actions and will close the recommendations when documentation has been provided illustrating corrective actions have been implemented.



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<sup>15</sup> VA did not evaluate whether care was authorized.

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## Abbreviations

FY	fiscal year
HHS	Department of Health and Human Services
OCC	Office of Community Care
OIG	Office of Inspector General
PC3	Patient-Centered Community Care
VHA	Veterans Health Administration



## Introduction

VA provides health care for eligible veterans at its nationwide medical facilities through the Veterans Health Administration (VHA). If these facilities cannot provide veterans with the health care they need or if veterans meet certain wait time, distance, or other criteria, they can instead receive care from their community providers. For many veterans, community care may be covered by VA and by other insurance, such as Medicare, Tricare, or private health insurance.<sup>16</sup> The number of VHA and Medicare dual-eligible enrollees remained around 5.6 million from fiscal year (FY) 2017 to FY 2020 (table 1).

**Table 1. VHA and Medicare Dual Enrollees**

FY 2017	FY 2018	FY 2019	FY 2020
5,586,113	5,656,985	5,651,970	5,595,617

*Source: VHA Medicare and Medicaid Analysis Center.*

When VHA authorizes community care for a veteran who is eligible for both VA and Medicare benefits, VHA is responsible for paying for the care provided even when Medicare also covers the same service. Although guidance from both VHA and Medicare states that each payer can pay for different healthcare services provided to program beneficiaries at the same visit, a provider should not receive duplicate payments for the same service.<sup>17</sup> When VHA has not authorized care, it could seek collection of payments for the care that were made in error.<sup>18</sup> However, when VHA has authorized care and both VHA and Medicare made payments for the same services, the duplicate payments will generally be recoverable by Medicare because VHA is responsible for paying for VHA-authorized care.<sup>19</sup>

Potential duplicate payments are a long-standing issue. Neither VHA nor Medicare have published reports that explore the scope of duplicate payments for veterans' care or presented recommendations to prevent duplicate payments. In 1979, the General Accounting Office reviewed a sample of Medicare-eligible veterans in Florida and California and identified duplicate claim payments. Recommendations from this audit included (1) identifying how frequently duplicate payments were occurring throughout the nation for all medical services;

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<sup>16</sup> Medicare is a health insurance program for people aged 65 years or older, people younger than 65 years with certain disabilities, or people of all ages with end-stage renal disease. The Centers for Medicare and Medicaid Services is an agency within the Department of Health and Human Services (HHS) and oversees the Medicare program. Tricare is a healthcare program for uniformed service members, retirees, and their families.

<sup>17</sup> On March 29, 2022, the VA Preventing Duplicate Payments Act of 2022 was introduced in the US House of Representatives. This act would require policies and procedures to prevent duplicate payments for the same medical services by VA, HHS, and the Department of Defense.

<sup>18</sup> Unauthorized care is for treatment that VHA did not approve before it was provided or that was provided outside the authorized dates of service.

<sup>19</sup> 38 C.F.R. § 17.1535; 42 C.F.R. §§ 411.7 and 411.8; 38 U.S.C. § 1703(a)(3).

(2) improving coordination between VHA and Medicare on claims-processing activities for patients who may be eligible for medical benefits from both programs; (3) developing a standardized claim form that would require authorized providers to certify that no other federal program would be billed for the same costs for the same services; and (4) issuing timely reminders and sanctions to providers when dual billing and payments were identified.<sup>20</sup> In response to these recommendations, agency officials noted that they would work together to discuss duplicate payment problems and would exchange information to determine the frequency of this problem. However, as of May 2022, VA and the Centers for Medicare and Medicaid Services had not yet developed a data-sharing agreement or process to prevent or identify duplicate claim payments.

The VA Office of Inspector General (OIG) conducted this review to determine whether community care providers are receiving potential duplicate payments for the same healthcare services from VHA and Medicare and to determine whether VHA paid any of these claims without authorization. In this review, the VA OIG collaborated with the Department of Health and Human Services (HHS) OIG—which is currently conducting its own review of duplicate Medicare payments—to better understand duplicate payments and confirm that they had occurred.

## Authorization of Community Care by VHA

VHA’s Office of Integrated Veteran Care manages programs under which veterans receive medical care from non-VA providers.<sup>21</sup> According to the *Office of Community Care (OCC) Field Guidebook*, authorized care is defined as VHA-approved care initiated by a VA provider requesting services in the community because the veteran meets at least one of the eligibility criteria.<sup>22</sup> Until the MISSION Act of 2018 consolidated community care programs, authorized community care was provided under the Patient-Centered Community Care (PC3) program and the Veterans Choice Program (Choice program).<sup>23</sup> The Choice program ended on June 6, 2019.

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<sup>20</sup> General Accounting Office, *Duplicate Payments for Medical Services by VA and Medicare Programs (HRD-80-10)*, October 22, 1979.

<sup>21</sup> In July 2022, VHA reported it had integrated the Office of Veterans Access to Care and its Office of Community Care into one office called Integrated Veteran Care to help VHA better coordinate care while also streamlining and simplifying access processes. Although the Office of Community Care was the program oversight office at the time of this review, the OIG refers to the Office of Integrated Veteran Care throughout this report because the consolidation of the two offices occurred before publication of this report.

<sup>22</sup> *Office of Community Care Field Guidebook*, chap. 3, “How to Perform Coordination of Care,” accessed October 19, 2021, <https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx>; *Office of Community Care Field Guidebook*, chap. 2, “Eligibility, Referral, and Scheduling,” accessed May 5, 2022, <https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx>. Eligibility for the Choice program was based on wait times for appointments and distance from the nearest medical facility. (This is an internal website not publicly accessible.)

<sup>23</sup> VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182 (2018).

However, some PC3 contracts were extended through March 31, 2022, to provide uninterrupted care in the community to veterans until the consolidated Veterans Community Care Program was fully implemented.

## **PC3 and Choice Programs**

Under the PC3 program, VHA used a nationwide network of providers for community care when services were not readily available or accessible at the veteran's local VA medical facility. The Choice program, which included Choice First, was a temporary program established under the Veterans Access, Choice, and Accountability Act of 2014, which enabled eligible veterans to receive medical care in the community if they met requirements, such as wait times and distance from a VA medical facility.<sup>24</sup> Choice First covered eligible veterans when services were not available within VA or through existing Department of Defense or Indian Health facilities, and Choice covered eligible veterans who resided more than 40 miles from their closest VA medical facility.

VHA contracted with third-party administrators to manage the PC3 and Choice programs. For authorized care, administrators were responsible for paying the providers, and VHA then reimbursed the administrators and billed veterans' private health insurance for treatment of conditions unrelated to military service.

According to VHA staff, they created authorizations for PC3, Choice, and Choice First referrals to community care, except for authorizations for veterans whose eligibility for the Choice program was based on distance (more than 40 miles) from a VA medical facility. Third-party administrator staff created the 40-mile distance authorizations and were contractually obligated to validate the distance eligibility. The administrator also was responsible for documenting authorizations in the administrator portal and notifying VHA each time this occurred. According to VHA officials, for PC3, Choice, and Choice First referrals to community care, VHA staff documented the authorization by completing VA Form 10-0386 (VHA Choice Approval for Medical Care) and then uploading it to the veteran's electronic medical record, as well as to the third-party administrator portal. Authorization information also should have been stored in VHA's Corporate Data Warehouse.

## **New Veterans Community Care Program**

The MISSION Act of 2018 consolidated existing community care programs into the Veterans Community Care Program, a permanent program that relies on third-party administrators

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<sup>24</sup> The Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (August 7, 2014); MISSION Act. The Veterans Access, Choice, and Accountability Act of 2014 was the founding legislation for the Veterans Choice Program. The program's end date was June 6, 2019, in accordance with the MISSION Act of 2018.

contracted by VHA to manage the networks of community care providers.<sup>25</sup> According to VHA guidance, VHA medical facility staff create authorizations for services.<sup>26</sup> All requests for care—with the exception of community emergency department care—should be coordinated and authorized by VA medical facility staff using the VA Community Care-Coordination Plan Note in the Computerized Patient Record System and in the HealthShare Referral Manager.<sup>27</sup> According to VHA officials, the authorization process for PC3 and Choice was cumbersome and contained opportunities for error. As a result of VHA’s continuous process improvement, pre-authorizations for the new Veterans Community Care Program are now completed in HealthShare Referral Manager, a VA-managed system integrated with other key systems for claims payment.

## Claim Payment Responsibilities

Per Medicare guidance, if veterans have both Medicare and veterans’ benefits, they can obtain treatment under either program.<sup>28</sup> However, for VA to pay for healthcare services, the veteran must go to a VA medical facility, or VA must authorize services in a non-VA facility. VA is responsible for paying for authorized services rendered by non-VA providers pursuant to applicable federal laws and regulations and consistent with VA’s contracts with third-party administrators.<sup>29</sup> If both VA and Medicare could properly pay the cost of a service that VA has authorized, VA (not Medicare) is obligated to pay for it. Under Medicare rules, services paid for by another government entity (in this case, VA) are excluded from Medicare coverage.

Medicare is never the secondary payer after VA, and the veteran must choose which benefit to use to pay for healthcare services.<sup>30</sup> Medicare and VHA may both pay for services in a non-VA hospital when VHA authorizes some but not all services during the hospital stay; in this case, Medicare may pay for the Medicare-covered services that were not authorized by VHA.

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<sup>25</sup> MISSION Act.

<sup>26</sup> *Office of Community Care Field Guidebook*, chap. 3, sec. 3.4, How to Coordinate Authorized Care, accessed October 19, 2021. (This is an internal website not publicly accessible.)

<sup>27</sup> The Computerized Patient Record System is a Veterans Health Information Systems and Technology Architecture computer application that enables staff to enter, review, and continuously update all the information connected with any patient. The HealthShare Referral Manager is a secure web-based system that VHA uses to generate and submit referrals and authorizations to community providers and is the primary platform that VHA facility community care staff use for implementing, assessing, and updating community care documentation. Community emergency department care should be documented through VHA’s Emergency Care Authorization Tool.

<sup>28</sup> Centers for Medicare and Medicaid Services, “Medicare and Other Health Benefits: Your Guide to Who Pays First,” accessed April 25, 2022, <https://www.medicare.gov/sites/default/files/2021-10/02179-Medicare-and-other-health-benefits-your-guide-to-who-pays-first.pdf>.

<sup>29</sup> 38 C.F.R. § 17.1535; 42 C.F.R. §§ 411.7 and 411.838; U.S.C. 1703(a)(3). Per U.S.C. 1703(a)(3), “A covered veteran may only receive care or services under this section upon the authorization of such care or services by the Secretary.”

<sup>30</sup> A secondary payer does not have primary payment responsibility for a healthcare claim. Another entity has the responsibility of paying first.

In addition, Medicare policy states “generally, an authorization issued by Veterans’ Administration (VA) binds VA to pay in full for the items and service provided.” This policy also states, “no payment is made under Medicare for such authorized services.”<sup>31</sup>

If VHA has authorized care, then VHA is responsible for paying for the care, and duplicate payments will generally be recoverable by Medicare. If VHA has not authorized care, then VA could recover payments that were made for the unauthorized care.

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<sup>31</sup> Centers for Medicare and Medicaid Services, sec. 50.1.1, rev. 198, “Medicare Benefit Policy Manual,” November 6, 2014.

## Results and Recommendations

### **Finding: VHA and Medicare Did Not Have a Data-Sharing System or Process to Avoid Duplicate Claim Payments and Identify VHA-Authorized Community Care**

The OIG determined that for community care that was provided from January 1, 2017, through September 30, 2019, VHA and Medicare made potential duplicate claim payments (hereafter referred to as duplicate payments) for 140,869 unique PC3 or Choice claims.<sup>32</sup> The review team identified duplicate payments by identifying claims with matching social security numbers and dates of service and with both VHA and Medicare payments. Of these 140,869 claims, 99,758 initially appeared to be unauthorized by VHA.<sup>33</sup> The OIG identified unauthorized claims as those where VHA did not approve treatment before it was provided or where the authorization did not cover the period of care. From the 99,758 potentially unauthorized claims, the team reviewed a sample of 100 claims for which VHA paid over \$422,000.<sup>34</sup>

The team found that for 93 of the 100 claims (for which VHA paid about \$397,000), VHA appropriately authorized and documented authorizations for the services. For these claims, Medicare may be able to recover the duplicate payments. The team could not find authorizations for five claims (for which VHA paid over \$15,700). For two other claims (for which VHA paid over \$9,600), the team determined the care was authorized but not properly documented. VHA concurred with the team's findings for the seven claims and either did not follow procedures for authorizing or for documenting authorizations before treatment was provided.

Additionally, the OIG identified 285,956 duplicate Veterans Community Care Program claims for community care that was provided from October 1, 2019, through March 31, 2021. The review team did not determine whether these duplicate payments were for authorized care because the Veterans Community Care Program was still being implemented, and HealthShare Referral Manager was a relatively new system for documenting authorizations. According to the

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<sup>32</sup> The review team considered claim payments by VHA and Medicare to be duplicate if they had matching social security numbers; were for the same or overlapping dates of service; were billed by the same provider; and were for the same service for professional, durable medical equipment, or outpatient claims. For inpatient and home health agency claims, claims were considered to be duplicate if they had matching social security numbers; were for the same or overlapping dates of service; and were submitted by different inpatient hospitals or by the same home health agency. These claims are referred to as "duplicate payments" in this report.

<sup>33</sup> For the 99,758 claims totaling over \$72 million, the review team was unable to locate claim authorization information by searching VHA's Corporate Data Warehouse. According to VHA officials, authorizations should have been located there.

<sup>34</sup> For this sample, in addition to the review team's initial search of VHA's Corporate Data Warehouse for claim authorization information, the team also searched for this information in veterans' medical records and the third-party administrator portals and compared the claim service date to the authorization period for all records associated with the same veteran.

team's analysis, most of the PC3 and Choice claims reviewed were for preauthorized treatments, and the team concluded that treatments for most of the Veterans Community Care Program claims would likewise have been preauthorized and that the reasons for unauthorized treatment would be the same. The OIG plans to evaluate the HealthShare Referral Manager, including the completeness of authorization documentation for community care services, in a future review.

For all three Office of Integrated Veteran Care programs, the OIG determined that VHA and Medicare made duplicate payments for 426,825 unique PC3, Choice, and Veterans Community Care Program claims for community care that was provided from January 1, 2017, through March 31, 2021. VHA paid over \$307 million for these claims, and Medicare paid over \$243 million. Generally, Medicare could recover the duplicate payment from entities that billed both agencies, as VHA's claim payments for community care services were mostly authorized by VHA.

The OIG determined VA and the Centers for Medicare and Medicaid Services currently do not have a process to share healthcare claims data to prevent or identify instances of duplicate claim payments. Without such a mechanism in place, the agencies cannot know which claims the other agency has paid. The lack of an interagency system increases risk of duplicate payments by VHA and Medicare and hinders each agency's ability to deny claims the other agency should pay. VHA should coordinate with the Centers for Medicare and Medicaid Services to develop appropriate data-sharing processes to identify claims that are eligible for reimbursement through VHA and Medicare and to limit the risk of duplicate payments when these claims have been paid by VHA. In addition, the director for VA's Office of Business Oversight, Program Integrity Office indicated until the beginning of FY 2021, VA had not conducted a review of duplicate payments by VHA and Medicare.

The following determinations formed the basis for this finding and led to the OIG's recommendations:

- VHA and Medicare made duplicate claim payments.
- VHA authorized most community care services it paid for.
- Providers billed VHA and Medicare for the same healthcare services.
- VHA and Medicare do not have a system or process in place to identify duplicate payments.
- VHA has not previously conducted reviews to identify duplicate payments by VHA and Medicare.

## **What the OIG Did**

The review team interviewed Office of Integrated Veteran Care leaders to gain a better understanding of how community care claims were processed under the PC3 and Choice

programs. In addition, Office of Integrated Veteran Care staff demonstrated how to view referrals and authorizations generated under the Veterans Community Care Program in the HealthShare Referral Manager. For all three programs, the team requested guidance on the documentation required for authorizing care. The team also requested and received guidance given to community providers on billing VHA and Medicare for the same services. VHA also sent *OCC's Field Guidebook* to the review team.

To identify potential duplicate payments, the team reviewed services provided to veterans under the PC3 and Choice programs from January 1, 2017, through September 30, 2019. A second analysis was conducted in January 2022 to determine whether potential duplicate claim payments occurred under the Veterans Community Care Program for services provided between October 1, 2019, and March 31, 2021. PC3 and Choice claims were retrieved as of October 5, 2020, and Veterans Community Care Program claims were retrieved as of January 10, 2022.<sup>35</sup> To identify duplicate payments, the team matched claims data from VA's Financial Services Center and Corporate Data Warehouse for PC3 and Choice program claims and claims data from OCC's Program Integrity Tool to claims data from VHA's Medicare and Medicaid Analysis Center.<sup>36</sup> For the purposes of this review, claims payments by VHA and Medicare were considered to be duplicate if they had matching social security numbers, were for the same or overlapping days of service, were billed by the same provider, and were for the same service for professional, durable medical equipment, or outpatient claims. For inpatient and home health agency claims, claims were considered to be duplicate if they had matching social security numbers, were for the same or overlapping dates of service, and were submitted by different inpatient hospitals or by the same home health agency. With inpatient hospitals one patient would not be expected to be in two different places on the same or overlapping dates of service for the same service. For home health agency claims there should not be a claim for the same patient on overlapping dates of service submitted by the same home health agency.

To identify potentially unauthorized care for PC3 and Choice program claims, the team first searched VHA's Corporate Data Warehouse for all 140,869 duplicate payments under the PC3 and Choice programs for claim authorization information. This included searching for data elements from VA Form 10-0386 that would support that treatment was authorized before being provided. For authorizations that were identified, the team compared the claim service date to the

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<sup>35</sup> The universe of Veterans Community Care Program claims included some PC3 claims. The deputy under secretary for health for operations and management issued a memorandum on December 20, 2018, stating that the PC3 contract was the preferred routing for referrals until the Community Care Network contracts, under the new Veterans Community Care Program, were fully implemented. Use of the PC3 contracts ended completely as of March 31, 2022.

<sup>36</sup> VHA's Medicare and Medicaid Analysis Center is a field office within the Chief Strategy Office. The director is the information custodian for the Centers for Medicare and Medicaid Services. OCC's Program Integrity Tool collects data from multiple sources to identify fraud, waste, and abuse. The data are subsequently transmitted for storage in VA's Corporate Data Warehouse.

authorization period and to the data of the claims for all records associated with the same beneficiary (same social security number). Next, for a sample of 100 of the 99,758 claims for which the team could not identify authorization information in VHA's Corporate Data Warehouse, the team manually searched veterans' medical records and the third-party administrator portals to determine whether authorizations were documented elsewhere.<sup>37</sup> For additional information on the review's methodology, please refer to appendix A.

## **VHA and Medicare Made Duplicate Payments**

As of October 5, 2020, VHA, under the PC3 and Choice programs, made duplicate payments on 140,869 unique claims for community care that was provided from January 1, 2017, through September 30, 2019. VHA paid over \$103 million, and Medicare paid over \$79.8 million. This is less than 1 percent of all PC3 and Choice payments.

As of January 10, 2022, VHA, under the Veterans Community Care Program, made duplicate payments on 285,956 unique claims for community care that was provided between October 1, 2019, and March 31, 2021. VHA paid over \$204 million, and Medicare paid about \$163.6 million. This is less than 1 percent of all Veterans Community Care Program payments.

To confirm that duplicate payments were made, the review team shared the universe of the identified potential duplicate PC3, Choice, and Veterans Community Care Program claims with HHS OIG staff.<sup>38</sup>

## **VHA Authorized Most Community Care Services It Paid For**

The OIG concluded that VHA authorized most of the duplicate claim payments made under the PC3 and Choice programs for the sample reviewed. Because VHA is responsible for paying for the community care that it authorizes, in situations where both VHA and Medicare made payments and VHA authorized the service, Medicare can seek to recover the duplicate payment from the provider.<sup>39</sup>

In a few cases, VHA paid for services without documentation to show the service was appropriately authorized or with incomplete documentation to authorize the services. According to regulations, authorizations should be made before services are provided, except in emergency

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<sup>37</sup> According to VHA officials, authorizations for PC3 and Choice should have been in VHA's Corporate Data Warehouse, veterans' medical records, or the third-party administrator portals.

<sup>38</sup> The review team collaborated with the HHS OIG to discuss the criteria the VA OIG applied to identify duplicate claim payments and to confirm that VHA and Medicare made payments for claims for the same services. The HHS OIG plans to issue their own report on duplicate payments, which will include determining how many claims in the VA OIG review team's universe were for the exact same date of service or for overlapping service dates and how many claims had been cancelled or repaid since the VA OIG completed its data analyses.

<sup>39</sup> 42 C.F.R. § 411.8.

situations.<sup>40</sup> According to a VHA official, authorization information should be stored in VHA’s Corporate Data Warehouse. However, officials also acknowledged that *OCC’s Field Guidebook* was a living document, and instructions for how to document authorizations changed over time. Because of this, authorization information might instead be in two other places—the veterans’ medical records or the third-party administrator portals.

Of the 140,869 duplicate payments for PC3 and Choice claims, the review team initially identified 99,758 claims (71 percent) without documentation of VHA authorization in the Corporate Data Warehouse. For these claims, the review team was unable to locate claim authorization information after searching VHA’s Corporate Data Warehouse, even though, according to a VHA official, authorizations should have been located there. However, when the team reviewed a sample of 100 of these claims, authorizations were found in the veterans’ medical records or the administrator portals for 93 of the claims.<sup>41</sup> The team could not find authorizations for five claims. For two other claims, the team found documentation of authorization in notes included in the veterans’ medical records but could not find VA Form 10-0386 in the medical records or the administrator portals. VHA concurred with the review team’s findings for these seven claims. For additional details, see table 2 (errors are indicated in red and are italicized).

**Table 2. Results of PC3 and Choice Sample Review**

Observation	Total
Services appropriately authorized and documented	93
Amount VHA paid	\$397,000
Valid authorization	93%
Authorized but without appropriate documentation	2
Amount VHA paid	\$9,700
Inappropriate authorization documentation	2%
No valid authorization for treatment	5
Amount VHA paid	\$15,700
Without valid authorization	5%
<b>Total (number of claims)</b>	<b>100</b>

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<sup>40</sup> 38 C.F.R. §§ 17.54(a), 17.1535(c), and 17.4020(a).

<sup>41</sup> The team worked with the OIG’s statistical operations group to pull a sample of claims for each of the following types of service: professional, inpatient and skilled nursing facility, outpatient and home health aide, and mismatched (when the service provided did not appear to match the authorized service). To estimate the overall error rate and the overall sum of unauthorized payments, the team would have needed to review 200 sample claims at a minimum. In consultation with the OIG statisticians, the team decided not to review more than 100 claims because the identified issues resulting in unauthorized services would have been the same. Therefore, the sample results are not projected to the universe of claims.

Observation	Total
Amount VHA paid	\$422,000

*Source: VA OIG analysis of a sample of duplicate claims from January 1, 2017, through September 2019. Numbers are rounded.*

According to VHA officials, for PC3, Choice, and Choice First referrals to community care, VHA staff should document the authorization and then upload it to the veteran’s electronic medical record, as well as to the administrator portal. Authorization information should also have been stored in VHA’s Corporate Data Warehouse. Many of VHA systems’ data and information, including claims data, should be extracted from the source systems and stored in the Corporate Data Warehouse.

VHA staff did not always follow these documentation procedures, which increased the risk of overpayments or payments for unauthorized services. VHA needs to make sure all nonemergent community care treatments are preauthorized and appropriately documented to minimize payments for unauthorized community care claims as they move forward using the HealthShare Referral Manager to document authorizations.<sup>42</sup> In addition, the five claims with no valid authorization are improper payments because the care was not authorized before treatment, so the claims should not have been paid.<sup>43</sup> Appendix B provides additional information on improper payments.

### **Providers Billed VHA and Medicare for the Same Healthcare Service**

The review team identified duplicate payments by matching claims for the same service or for claims submitted by different hospitals or by the same home health agency on the same or overlapping service dates. Duplicate payments may occur because VHA guidance does not specify how to bill dual-eligible veterans. The review team requested documentation of guidance given to community care providers for billing both VHA and Medicare. In response, VHA officials provided the team with VA Form 10-7080 (Approved Referral For Medical Care), which VHA community care staff give to community providers. The form indicates that providers should submit bills to the third-party administrators but does not include specific information about how to bill services for dual-eligible veterans to limit the risk of duplicate payments. In addition, according to a VHA official, third-party administrators are supposed to inform providers of billing processes, to include that the administrator’s payment should be

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<sup>42</sup> The OIG analyzed provider data for professional services to determine if there was a pattern of providers billing VHA and the Centers for Medicare and Medicaid Services for the same service. Provider clusters were identified by aggregating VHA and the Centers for Medicare and Medicaid Services duplicate paid claims by the volume of duplicate claims by provider. The analysis was sent to the VA OIG Office of Investigations Healthcare Fraud Division to identify potential fraud, but they found nothing actionable in the data provided.

<sup>43</sup> OMB Circular A-123, app. C, “Requirements for Payment Integrity Improvement,” March 5, 2021. An improper payment is defined as any payment that should not have been made or was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements.

considered payment in full. According to the director of VA's Office of Business Oversight, Program Integrity Office, the veteran can choose to use VHA or Medicare benefits for community care. When both agencies receive a bill, it is unclear whether the veteran intended to use VHA or Medicare benefits. Also, according to the deputy director of VHA Business Integrity and Compliance, community providers generally have patients' insurance information and might bill all possible sources, including Medicare, to ensure they receive payment in full, even if they should not be doing so.

## **VHA and Medicare Do Not Have a System or Process to Identify or Manage Duplicate Payments**

In addition to not sharing data on dual-eligible patients, neither VHA nor Medicare currently has a process to manage duplicate payments; instead, both agencies either relied on providers or veterans to initiate requests to cancel duplicate payments. As of May 2022, VHA does not have access to Medicare data to determine whether a claim has already been paid, and Medicare does not have access to VHA's data. A process to share such data has been identified as a possible recommendation and has been a point of long-standing challenge. For example, a 1979 report by the General Accounting Office identified duplicate claim payments by VHA and Medicare and recommended better coordination between the agencies and a standardized claim form to minimize duplicate payments.<sup>44</sup>

In addition, the Medicare Secondary Payer Manual from January 2022 notes that Centers for Medicare and Medicaid Services will annotate Medicare individual files with possible VA involvement using information supplied by VA each month.<sup>45</sup> When a Medicare beneficiary is identified as possibly entitled to VA benefits, the private insurance company should contact the provider to determine whether a claim has been or will be submitted to VA for payment.<sup>46</sup> However, when the review team asked VHA officials if any monthly VA data were supplied to the Centers for Medicare and Medicaid Services, the VHA officials replied they did not send information to the centers.

The director of VA's Office of Business Oversight, Program Integrity Office provided information from a Centers for Medicare and Medicaid Services point of contact that the process described in the manual was never implemented. HHS OIG staff also confirmed with the Centers for Medicare and Medicaid staff that the process described in the manual was never implemented; the manual is currently under review, and these sections will be updated accordingly. The Centers for Medicare and Medicaid Services point of contact stated that in the

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<sup>44</sup> General Accounting Office, *Duplicate Payments for Medical Services by VA and Medicare Programs (HRD-80-10)*.

<sup>45</sup> Centers for Medicare and Medicaid Services, chap. 5, "Medicare Secondary Payer Manual," Pub. No. 100-05, January 2022.

<sup>46</sup> Centers for Medicare and Medicaid Services, "Medicare Secondary Payer Manual."

1990s, VA was going to administer a VA card to veterans who were also enrolled in Medicare so they could show the card to the healthcare provider to demonstrate entitlement to both VA and Medicare benefits and indicate whether the service was authorized by VA. VA was also supposed to enter into a data-matching agreement with Medicare. The VA card project and data-matching agreement were never implemented, and the Medicare manuals were never updated to remove this information.

HHS OIG staff are conducting a similar review for Medicare payments for veterans. HHS OIG staff collaborated with the VA OIG team to develop questions for the Centers for Medicare and Medicaid Services to understand the Medicare claims payment criteria and data. In their response, the Centers for Medicare and Medicaid Services staff stated that neither the agency nor the Medicare contractor independently identifies whether a beneficiary has both Medicare and VA benefits when a claim is submitted. The Centers for Medicare and Medicaid Services staff also stated that Medicare claims do not indicate whether the veteran is dual-eligible.

## **VHA Had Not Previously Conducted Reviews to Identify Duplicate Payments by VHA and Medicare Until 2021**

The director of VA's Office of Business Oversight, Program Integrity Office told the OIG team that VA's assistant secretary for management and chief financial officer suspected duplicate payments were happening with VHA and Tricare. According to VHA officials this occurred because there are no policies in place to address who is the primary payor when both agencies have the legal authority to pay for care.<sup>47</sup> VA staff conducted a review in May 2020 and substantiated this suspicion. As a result of this review, the assistant secretary asked VA staff to determine whether duplicate payments were also occurring with Medicare.

Further, according to the director, in the beginning of FY 2021, staff reviewed data for claims from 2019 to identify duplicate payments made by VHA and Medicare. VA staff indicated that in some instances they had trouble determining who should pay for care and when, but if VHA initiated and authorized the care, VHA is responsible for payment. As of March 2022, VA had established a one-time data-sharing agreement with Medicare to confirm the duplicate payments it identified.<sup>48</sup> However, this is not an ongoing data-sharing agreement and is just for one initiative. The director stated that VA officials reported they are working with Medicare staff on a long-term data-sharing solution to identify and recover duplicate payments, but they expect the solution will take several years to plan and implement.

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<sup>47</sup> The OIG did not verify this statement.

<sup>48</sup> VA did not evaluate whether care was authorized.

## Conclusion

As of October 5, 2020, for PC3 and Choice claims, and as of January 10, 2022, for the Veterans Community Care Program, VHA made duplicate payments on 426,825 unique claims for services provided from January 1, 2017, through March 31, 2021. VHA paid over \$307 million for these claims, and Medicare paid over \$243 million. VHA generally authorized the care for the treatment before it was provided; therefore, most overpayments would be recoverable by Medicare. In a few instances, VHA did not follow policy to preauthorize community care or document authorizations before treatment was provided.

Providers may be billing VHA and Medicare for the same service because VHA does not provide clear guidance about how providers should manage dual-eligible patients. In addition, VHA does not have a system or process in place with Medicare to determine whether community care providers received duplicate payments for the same healthcare service or to manage duplicate claim payments. Until the beginning of FY 2021, VHA had not conducted any reviews of duplicate Medicare payments. Establishing a data-sharing agreement, periodically reviewing duplicate payments, and establishing processes to manage duplicate payments could help minimize this risk. VHA should coordinate with the Centers for Medicare and Medicaid Services to develop appropriate data-sharing processes to permit both agencies to identify claims that are eligible for reimbursement through VHA and Medicare and to limit the risk of duplicate payments.

## Recommendations 1–3

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

1. Work with the Centers for Medicare and Medicaid Services to establish a data-sharing agreement with VA to limit potential duplicate claim payments.
2. Identify overpayments made for care provided to dual-eligible veterans that were not authorized by VHA and ensure either documentation of care is completed, or VA seeks reimbursement for any care without prior approval.
3. Make sure all nonemergent community care is preauthorized and that documentation for all authorizations is complete and properly stored before treatment is provided.

## VA Management Comments

The under secretary for health concurred in principle with recommendation 1, concurred with recommendations 2 and 3, provided an action plan detailing steps for implementation, and asked the OIG to close recommendations 2 and 3. Appendix C includes the full text of the under secretary's comments, which are summarized below.

To address recommendation 1, the Office of Integrated Veteran Care intends to support efforts already in progress to establish a data-sharing agreement with the VHA Office of Business

Oversight and the Centers for Medicare and Medicaid Services. For example, the Office of Integrated Veteran Care is actively developing data infrastructure in support of data-sharing opportunities with external stakeholders, such as the Centers for Medicare and Medicaid Services. However, because the Office of Integrated Veteran Care does not have the authority to ensure a sharing agreement is established, the under secretary concurred in principle with this recommendation.

For recommendation 2, according to VHA officials, VHA researched the claims identified by the OIG that did not have valid authorizations and located data to support that VA was aware of the episode of care in the community and/or intended to authorize the care even though authorization was not formally documented.

Regarding recommendation 3, the Office of Integrated Veteran Care noted that they have significantly improved their authorization process by using HealthShare Referral Manager for processing and managing community care referrals and authorizations.

## **OIG Response**

The corrective action plans provided by the under secretary for health are responsive to the intent of recommendations 1 through 3, but the OIG will need to see additional documentation to close recommendations 2 and 3. The OIG finds the planned actions responsive to recommendation 1 and acknowledges the steps VHA has taken to reduce duplicate payments between VHA and Medicare and to make sure community care treatment is authorized. The OIG will monitor implementation of all planned actions and will close recommendation 1 when VHA provides sufficient evidence demonstrating progress in addressing the intent of the recommendation and the issues identified. The OIG will close recommendation 2 when VHA provides information supporting that VA was aware of the unauthorized episodes of care and/or found intent to authorize the care. The OIG will close recommendation 3 when VHA provides evidence of quality assurance processes or controls that the Office of Integrated Veteran Care has implemented to ensure the HealthShare Referral Manager is generating authorizations for community care before care is provided.

## Appendix A: Scope and Methodology

### Scope

The team performed its work from December 2021 through August 2022. The scope of the review focused on community care services provided by both VHA and Medicare from January 1, 2017, through March 31, 2021, under the PC3, Choice, and Veterans Community Care programs.

### Methodology

The team reviewed public laws, regulations, policies, and guidance pertinent to the objective of this review of duplicate payments with VHA and Medicare. The team interviewed and communicated with VA staff about community care, policies, claims processing, authorizations, and oversight, including staff from the Office of Integrated Veteran Care's Clinical Integration team. These interviews helped the team to gain a better understanding of how community care claims were processed under the PC3 and Choice programs and under the Veterans Community Care Program and how authorizations for community care should be documented. The team also interviewed staff at VA's Office of Business Oversight, Program Integrity Office regarding their oversight responsibilities for duplicate VHA and Medicare claim payments; any past, ongoing, or planned reviews of duplicate payments; systems and processes in place to identify duplicate payments; and the potential data-sharing agreement with Medicare. The team did not conduct in-person site visits or interviews because of the COVID-19 pandemic.

The review was a collaborative effort with the VA OIG and the HHS OIG to determine whether VHA and Medicare made duplicate payments for the same service. Throughout the process, VA and HHS OIG staff discussed plans and progress of the audits. The VA OIG team sent two datasets to the HHS OIG team to compare VHA data against Medicare data to confirm that duplicate payments were made. The first dataset included PC3 and Choice claims for community care provided from January 1, 2017, through September 30, 2019. The second dataset comprised Veterans Community Care Program claims for community care provided from October 1, 2019, through March 31, 2021. The HHS OIG obtained a current snapshot of Medicare data to identify matching claims or claim status changes that had occurred after the VA OIG's data analyses were completed. The HHS OIG plans to issue their own report on the duplicate payments, which will include determining how many claims in the VA OIG review team's universe were for the exact same date of service or for overlapping service dates and how many claims had an updated status, such as being canceled or repaid, since the VA OIG completed its data analyses.

## Duplicate Claims

In October 2020, the review team identified potential duplicate claim payments for services provided from January 1, 2017, through September 30, 2019, under the PC3 and Choice programs.<sup>49</sup> The initial work did not include claims from the Veterans Community Care Program because the OIG did not have access to the data at the time the work was completed.<sup>50</sup> A second analysis was conducted in January 2022 to determine whether duplicate claim payments occurred under the new program for services provided between October 1, 2019, and March 31, 2021.

The team identified duplicate payments for professional, inpatient, outpatient, skilled nursing facility, home health agency, and durable medical equipment services. In addition, they identified mismatched authorization claims for which the category of care did not match between the authorization and the claim. For all claim types, the team matched veterans' social security numbers between VHA and Medicare claims to identify potential duplicate payments. The team also accounted for additional factors (see below) to ensure they were not counting duplicate services for professional, inpatient-skilled nursing facility, and outpatient claims. To identify duplicate claims, the OIG matched claims data from VA's Financial Services Center and Corporate Data Warehouse for PC3 and Choice program claims and claims data from OCC's Program Integrity Tool and the HealthShare Referral Manager for the Veterans Community Care Program claims to Medicare claims data from VHA's Medicare and Medicaid Analysis Center.<sup>51</sup> The team's review of claims included both service-connected and nonservice-connected claims.

For professional services, claim payments were considered duplicate if both VHA and Medicare paid the same provider for the same service for the same patient on overlapping dates of service. Additionally, the team added modifiers to ensure claims were not considered duplicates if they were for separate services (for example, if separate claims were submitted for the technical administration of an imaging procedure and the interpretation of the imaging; these services are legitimately reimbursed separately). Durable medical equipment claims were identified as

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<sup>49</sup> The review team considered claim payments by VHA and Medicare to be duplicate if they had matching social security numbers; were for the same or for overlapping dates of service; were billed by the same provider; and were for the same service for professional, durable medical equipment, or outpatient claims. For inpatient and home health agency claims, claims were considered to be duplicate if they had matching social security numbers; were for the same or overlapping dates of service; and were submitted by different hospitals or by the same home health agency. These claims are referred to as "duplicate payments" for the purposes of this report.

<sup>50</sup> MISSION Act. The MISSION Act consolidated several existing community care programs into one permanent program. The Choice program under the Veterans Access, Choice, and Accountability Act of 2014 ended on June 6, 2019.

<sup>51</sup> VHA's Medicare and Medicaid Analysis Center is a field office within the Chief Strategy Office. The director is the information custodian for the Centers for Medicare and Medicaid Services, and OCC's Program Integrity Tool collects data from multiple sources to identify fraud, waste, and abuse. The data are subsequently transmitted for storage in VA's Corporate Data Warehouse.

duplicates if the same item was purchased by the same supplier for overlapping dates of service for the same veteran.

Inpatient and skilled nursing claims were identified as duplicate if both VHA and Medicare paid claims for services to the same patient on overlapping dates of service. In this instance, a patient cannot be admitted to inpatient or skilled nursing stays at two different hospitals during the same period, regardless of the provider or types of services received.

Outpatient hospital claims were identified as duplicate if both VHA and Medicare paid claims for the same patient on overlapping service dates for similar services in any outpatient hospital setting. The team ensured that the veteran received similar services to ensure that the claim was not counted as two separate encounters at different outpatient hospitals. This was based on revenue codes. For example, a claim for a colonoscopy at one outpatient hospital and a later claim for an emergency room visit at a different outpatient hospital because the patient experienced complications from the colonoscopy would not be considered duplicate claims.

Home health agency claims were identified as duplicates if both VHA and Medicare paid claims for the same patient on overlapping dates of service by the same home health agency.

### **PC3 and Choice Claims: Potential Unauthorized Claims**

To identify potentially unauthorized care for the 140,869 duplicate claims under the PC3 and Choice programs, the review team first searched VHA's Corporate Data Warehouse for authorizations, including data elements from VA Form 10-0386 (VHA Choice Approval for Medical Care) because this form is used to document authorizations for care. This form is required as a progress note in the veteran's medical record and is uploaded to the third-party administrator's portal. When authorizations were identified, the team compared the claim service date to the authorization period for all records associated with the same beneficiary (same social security number).<sup>52</sup> For the 99,758 claims for which the team could not identify authorization information in VHA's Corporate Data Warehouse, the team searched veterans' medical records for a sample of 100 claims to determine whether authorizations were documented elsewhere. To find VA Form 10-0386 in the veteran's medical records, the team searched for the veteran's name, social security number, and date of care.

The team defined authorization coverage as any authorization record that matched a veteran's social security number and date of service. For PC3 and Choice claims, the team completed the following actions:

- Authorizations without complete date information were segmented separately and were not considered unauthorized.

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<sup>52</sup> According to VHA officials, authorizations for PC3 and Choice claims should have been in VHA's Corporate Data Warehouse, veterans' medical records, or the third-party administrator portals.

- For inpatient hospital, outpatient hospital, home health, and skilled nursing facility claims, the “date of service” was defined as the claim start date (“FROM DATE”).
- For professional and durable medical equipment claims, the “date of service” was defined as the claim end date (“THRU DT”) because Health Care Finance Administration claim lines occur on individual dates of service.<sup>53</sup>
- For Java Script Object Notation authorizations, authorization dates were defined as the period starting with the episode of care start date (EOCSTARTDT) and ending with the episode of care end date (EOCENDDT).<sup>54</sup>

For inpatient hospital and outpatient hospital claims, the team added an additional three-day grace period to the claim start date (“FROM DATE”) when comparing to the authorization start date for emergency room claims. Emergency room claims were identified using the UB 04 claim line files.<sup>55</sup> Claims were considered an emergency room claim if they had a claim line with “23” as the place of service (emergency room) or if they had a revenue code that began with “045.”

To confirm that care was unauthorized, the team sent to VHA claims for which the team could not find authorization documentation in VHA’s Corporate Data Warehouse, the veterans’ medical records, or third-party administrator portals.

To estimate the overall error rate and the overall sum of unauthorized payments, the team would have needed to review 200 sample claims at a minimum. In consultation with the VA OIG statisticians, the team decided not to review more than 100 claims because the identified issues resulting in unauthorized services would have been the same. Therefore, the sample results are not projected to the universe of claims.

## **Veterans Community Care Program Claims**

For the Veterans Community Care Program, the team did not conduct a review to determine whether the duplicate payments for 285,956 unique claims for community care services received by veterans between October 1, 2019, and March 31, 2021, were for authorized care. Because the team found that most of the claimed services were authorized before they were provided in the PC3 and Choice program analysis, the team determined that most of these Veterans Community Care Program claims were likely to have been authorized, and the reasons for unauthorized treatment would be the same. According to VHA officials and VHA guidance, for authorizations

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<sup>53</sup> The Health Care Finance Administration form is used by clinical practitioners and physicians to submit claims for professional services.

<sup>54</sup> Java Script Object Notation is a data file format used to retrieve data.

<sup>55</sup> The UB 04 uniform medical billing form is the standard claim form that any institutional provider can use for the billing of inpatient or outpatient medical and mental health claims.

under the new program, requests for care should be coordinated and authorized by VA medical facility staff using the HealthShare Referral Manager, except for authorizations for community emergency department care, which are instead documented through VHA's Emergency Care Authorization Tool. Community care providers should not provide any treatment before receiving an authorization from VHA. At the time of this review work, the HealthShare Referral Manager was a relatively new system, and the Veterans Community Care Program was still being implemented. The VA OIG plans to evaluate the HealthShare Referral Manager, including the completeness of authorization documentation for community care services.

## Internal Controls

The review team assessed internal controls of community care to prevent duplicate payments by VHA and Medicare. This included an assessment of the five internal control components: control environment, risk assessment, control activities, information and communications, and monitoring.<sup>56</sup> In addition, the team reviewed the principles of internal controls as associated with the objective. The team identified the following three components and five principles as significant to the objective.<sup>57</sup> The team identified internal control weaknesses during this review and proposed recommendations to address the following control deficiencies:

- Component 3—Control Activities
  - Principle 10: Selects and develops control activities
  - Principle 12: Deploys through policies and procedures
- Component 4—Information and Communication
  - Principle 13: Uses relevant information
  - Principle 15: Communicate externally
- Component 5—Monitoring Activities
  - Principle 16: Conducts ongoing and/or separate evaluations

## Fraud Assessment

The review team assessed the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant within the context of the review objectives, could occur during this review. The team exercised due diligence in staying alert to

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<sup>56</sup> Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

<sup>57</sup> Because the review was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that may have existed at the time of the review.

any fraud indicators by reviewing provider clusters and sharing these with the OIG's Office of Investigations.

The team did not identify any instances of fraud or potential fraud during this review.<sup>58</sup>

## Data Reliability

The team used computer-processed claims' payment data obtained from VA Financial Services and the OCC Program Integrity Tool accessed via VHA's Corporate Data Warehouse as well as Medicare payment data from the VA Medicare and Medicaid Analysis Center. To assess the reliability of the data, the team tested a randomly selected sample of 10 PC3 or Choice program claims identified as those for which VHA and Medicare had made duplicate payments. The team compared the claim records' unique data fields to documents retrieved from veterans' medical records and two third-party administrator (TriWest and HealthNet) online document portals by searching for the sample data fields' entries in the source records. The team verified data fields including the veteran's social security number, amount paid, and third-party administrator.

To assess the reliability of Veterans Community Care Program claims, the team tested 30 randomly selected claims for which VHA and Medicare made duplicate payments. The team compared the records' unique data fields to two third-party administrator (TriWest or Optum) online document portals. The team compared samples of the claims data to electronic document records for relevance, accuracy, and completeness.

The team relied on the validation of VA Medicare and Medicaid Analysis Center data having been completed by the VA information custodian to perform data-quality checks in accordance with VHA policy.<sup>59</sup> The team determined the data used in this review were reliable for the purposes of assessing whether VHA and Medicare made duplicate claim payments and whether VHA's duplicate paid claims were for unauthorized services.

## Government Standards

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

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<sup>58</sup> The OIG analyzed provider data to determine if there was a pattern of providers billing VHA and the Centers for Medicare and Medicaid Services for the same service. The analysis was sent to the VA OIG Office of Investigations Healthcare Fraud Division to identify potential fraud, but they found nothing actionable in the data provided.

<sup>59</sup> VHA Directive 1153, *VHA Access to and Use of Centers for Medicare and Medicaid Services and United States Renal Data System Data*, sec. 6, part b (3), November 23, 2021.

## Appendix B: Monetary Benefits in Accordance with Inspector General Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
2	Overpayments		\$15,700
	<b>Total</b>		<b>\$15,700</b>

*Note: The review team identified five claims with no valid authorization that are improper payments because the care was not authorized before treatment, so the claims should not have been paid.*

## Appendix C: VA Management Comments

### Department of Veterans Affairs Memorandum

Date: October 7, 2022

From: Under Secretary for Health (10)

Subj: OIG Draft Report, Improvements Needed to Reduce Duplicate Payments by VHA and Medicare and Ensure VHA Has Authorized Community Medical Services (2021-03630-AE-0180) (VIEWS 8532921)

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) draft report, Improvements Needed to Reduce Duplicate Payments by VHA and Medicare and Ensure VHA Has Authorized Community Medical Services. The Veterans Health Administration concurs with the recommendations and provides an action plan in the attachment.

*The OIG removed point of contact information prior to publication.*

(Original signed by)

Shereef Elnahal, M.D., MBA

Attachment

**VETERANS HEALTH ADMINISTRATION (VHA)**

**Action Plan**

**Improvements Needed to Reduce Duplicate Payments by VHA and Medicare and Ensure VHA Has Authorized Community Medical Services (2021-03630-AE-0180)**

**Recommendation 1. Work with the Centers for Medicare and Medicaid Services to establish a data-sharing agreement with VA to limit potential duplicate claim payments.**

**VHA Comments:** Concur in Principle. In collaboration with VHA Office of Business Oversight and Centers for Medicare and Medicaid Services (CMS), VHA Office of Integrated Care (IVC) intends to support efforts already in progress to establish a data-sharing agreement; however, VHA IVC does not have the authority to ensure a sharing agreement is established and therefore concurs in principle with this recommendation.

Of the sampled 100 claims identified by OIG as potential duplicates, 93 of those claims were authorized by VHA. VHA paid appropriately for authorized care; CMS made a duplicate payment. For the remaining seven claims, OIG found two of the seven claims had documentation in the medical record indicating the care was authorized even though VA Form 10-0386 was not in the record. For the other five claims, VHA IVC found authorization numbers for all five claims, but incomplete or missing documentation. Of note, the universe of claims in this audit were processed prior to nationwide implementation of the Health Share Referral Manager (HSRM) in January 2022.

Since the scope of this OIG audit, VHA IVC has significantly improved its authorization process by utilizing HSRM for processing and managing community care referrals and authorizations. HSRM standardizes referrals with consistent format and data between community providers and VHA via one unified system. HSRM allows for the centralization of facility level authorizations into one secure structure, improving care coordination and communication between community providers and VHA. This consolidated system for viewing and managing authorizations provides additional safeguards to the community care process and mitigates the risk of paying claims without proper authorization and documentation.

VHA IVC is actively developing data infrastructure in support of data sharing opportunities. Specifically, the IVC initiative Consolidated Data Sets (CDS), will result in consolidating disparate sources of claims data into one centralized database, thereby improving accessibility to and usefulness of claims data by external stakeholders such as CMS. Initial rollout of CDS is scheduled for November 2022. Once full deployment of CDS is complete, VHA IVC intends to request closure of this recommendation.

Status: In Progress

Target Completion Date: April 2023

**Recommendation 2; Identify overpayments made for care provided to dual-eligible veterans that was not authorized by VHA and ensure either documentation of care is completed, or VA seeks reimbursement for any care without prior approval.**

**VHA Comments:** Concur. VHA understands the importance for community care to be preauthorized and appropriately documented. VHA researched the identified claims without a valid authorization on file. While the report recognized a formal authorization may not have been located, VHA was able to locate data to support VA was aware of the episode of care in the community and/or found intention to authorize, even though the authorization was not properly documented. VHA requests closure of this recommendation as none of the samples were recoverable as VHA authorized the care, or the service was provided by a contractor whose contract has ended.

Status: Complete

**Recommendation 3: Make sure all nonemergent community care is preauthorized and that documentation for all authorizations are complete and properly stored before treatment is provided.**

**VHA Comments:** Concur. To better ensure documentation of care is complete, VHA IVC has significantly improved its authorization process by utilizing HSRM for processing and managing community care referrals and authorizations. HSRM was fully implemented in January 2022. All non-emergent community care referrals, excluding Contract Nursing Home, are processed electronically through the HSRM system. Once care is requested, community care eligibility is confirmed, and clinical review is performed by staff designated by the facility's Chief of Staff who have been given Delegation of Authority (DOA) to determine the requested services are clinically appropriate to be authorized for delivery in the community. Once the consult is deemed clinically appropriate by the DOA and determined to meet MISSION eligibility, a staff member in the facility community care office sends the referral through HSRM. Once the referral is submitted in HSRM, an authorization is generated electronically, and a VA authorization number is created. An offline referral form containing the details of the referral is generated in HSRM and stored electronically in the HSRM system. VHA requests closure of this recommendation as the issue of missing authorization documentation has been mitigated with the implementation of HSRM.

Status: Complete

*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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<b>Contact</b>	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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