



Department of Veterans Affairs Office of Inspector General

Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program

To Report Suspected Wrongdoing in VA Programs and Operations,

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Executive Summary

Results in Brief

The Fee Program provides essential medical services to veterans when certain services are unavailable at VA facilities, when services cannot be economically provided due to geographical inaccessibility, or in emergencies when delays may be hazardous to life or health. The Fee Program provides inpatient care, outpatient care, dental care, and pharmaceuticals to eligible veterans. During the 4-year period of fiscal years (FYs) 2005–2008, outpatient Fee Program costs have more than doubled, from about \$740 million to \$1.6 billion. In FY 2008, VA medical centers (VAMCs) paid about 3.2 million outpatient fee claims. The objective of this audit was to assess the accuracy of payments made for pre-authorized outpatient fee services.

Given the complexities associated with processing fee claims, the Veterans Health Administration (VHA) needs to take immediate action to strengthen controls over the Fee Program to ensure that payments are accurate and proper. Our results support that in FY 008, VAMCs made a significant number of improper payments (37 percent of paid claims), such as duplicate payments and payments for incorrect amounts. We also identified serious weaknesses in the controls needed to ensure that outpatient fee care is properly justified and authorized. We concluded that VHA lacks reasonable assurance that Fee Program funds were used as intended and in an effective and economical manner for 80 percent of outpatient care payments because VAMCs did not properly justify and authorize fee services as required by VHA policy. These errors occurred because VHA has not established an adequate organizational structure to support and control the complex, highly decentralized, and rapidly growing Fee Program.

The magnitude of the program's payment errors indicates VHA faces significant challenges to address these vulnerabilities and has an immediate need to improve controls over claims processing and the justification and authorization of fee services. In addition, VHA needs to obtain regulatory changes in the outpatient fee care program to ensure payments are consistent, reasonable, and proper.

VHA Needs To Strengthen Controls Over Outpatient Fee Care

VHA needs to strengthen controls over the outpatient Fee Program to reduce improper payments and ensure that VAMC officials properly justify and authorize fee care services. The audit found that VAMCs improperly paid 37 percent of outpatient fee claims by making duplicate payments, paying incorrect rates, and making other less frequent payment errors, such as paying for the wrong quantity of services. As a result, we estimate that in FY 2008 VHA overpaid \$225 million and underpaid \$52 million to fee providers, or about \$1.126 billion in overpayments and \$260 million in underpayments over 5 years. In addition, for 80 percent of fee claims, VAMCs did not

properly justify or authorize services as required by VHA policy, increasing the risk of additional improper payments.

VAMC fee staff made these payment, justification, and authorization errors because VHA has not established an adequate organizational structure to support and control the complex, highly decentralized, and rapidly growing fee program. Specifically, VHA has not developed current and comprehensive fee policies and procedures, identified core competencies and established mandatory training requirements for fee staff, and implemented clear oversight responsibilities and procedures for the Fee Program.

VAMCs waste scarce health care resources when they make improper payments. Improper payments inflate program costs unnecessarily, which impairs VHA's ability to make sound business decisions on allocating health care resources. Furthermore, when VAMCs do not properly justify and authorize fee services, VHA lacks assurance that fee care funds are used as intended and in an economical manner.

VAMCs Improperly Paid 37 Percent of Outpatient Fee Claims. In FY 2008, VAMCs paid about 3.2 million outpatient fee claims. Based on our review of 800 sampled claims paid during the 6-month period March 1, 2008–August 31, 2008, we found that VAMCs improperly paid 37 percent of fee claims. VAMCs made three types of payment errors—duplicate payments, incorrect rates, and other minor payment errors. Some fee claims contained multiple errors, thus the percentages for each specific error will not total 37 percent. Regardless of whether a claim contained multiple errors, we only counted each claim once.

VAMCs Made Duplicate Payments. We estimate that VAMCs improperly paid 12 percent of claims because fee staff paid for either the same services twice or paid the professional component of a service twice. For FY 2008, we estimate that these errors resulted in overpayments of \$156.8 million.

VAMCs Paid Incorrect Rates. We estimate that VAMCs improperly paid 26 percent of claims because fee staff used the wrong fee schedules and paid incorrect schedule rates, paid more than maximum allowable rates for dental and home health services, or paid outdated rates. In addition, VAMCs paid incorrect rates because fee staff did not know when the VAMCs had contracts in place or did not have access to contract rate information. For FY 2008, we estimate that these errors resulted in estimated total overpayments of \$47.8 million and underpayments of \$52 million.

VAMCs Made Other Minor Payment Errors. We estimate that 2 percent of paid claims were improper because VAMCs made other, less frequent errors, such as paying for more services than authorized. For FY 2008, these errors resulted in estimated overpayments of \$20.5 million.

VAMCs Improperly Justified and Authorized Services for 80 Percent of Outpatient Fee Claims. Proper justification and authorization of fee services ensures that before VAMC officials use non-VA health care resources, they consider if VAMC clinical resources are being effectively utilized and if requests for outpatient fee care are

necessary. VHA fee policy requires VAMCs to justify fee care by either conducting a cost analysis or by properly documenting the need for fee care in veterans' medical records. Except in emergencies, fee policy also requires VAMCs to pre-authorize fee care services. Our review found that for 80 percent of outpatient fee claims VAMCs did not follow requirements for justifying and authorizing fee services. Some fee claims contained multiple errors, thus the percentages shown below for each specific error will not total 80 percent. Regardless of whether a claim contained multiple errors, we only counted each claim once.

VAMCs Did Not Adequately Document Justifications for Use of Outpatient Fee Care.

For 72 percent of claims, VAMC requesting clinicians did not adequately document justifications for using fee care in veterans' medical records. Clinicians typically documented the diagnosis and treatment plan but no rationale for using fee care. In addition, fee staff did not conduct required cost analyses to determine if lower cost alternatives, such as transporting patients to other VA facilities, were available.

VAMCs Did Not Properly Authorize Outpatient Fee Care Services.

For 55 percent of claims, VAMC Chiefs of Staff or their formal designees did not pre-authorize fee services as required by VHA policy. Instead other VAMC staff, including clinic nurses, administrative personnel, and fee clerks, who had no delegated authority, authorized services.

An Organizational Structure To Support and Control the Fee Program Will Reduce Improper Payments, Justifications, and Authorizations

VAMCs made these payment, justification, and authorization errors because VHA has not established an adequate organizational structure to support and control the Fee Program. Specifically, VHA has not established current and comprehensive policies and procedures, core competencies or mandatory training requirements for fee staff, and clear oversight responsibilities and procedures for the Fee Program.

VHA Fee Policies and Procedures are Not Current and Comprehensive.

VHA Manual M-1, Chapter 18, "Outpatient Fee," is the primary policy for the Fee Program. However, significant portions of M-1 are outdated and reflect old organizational structures within VHA and the Fee Program, often making M-1 confusing to understand and apply. As a result, even though M-1 contains some important program requirements, VAMCs do not consistently follow it.

VHA's National Fee Program Office drafted new policies to replace M-1 and submitted them to VA General Counsel for review in Fall 2008. VA General Counsel returned the policies with additional revisions to the National Fee Program Office in May 2009, and as of June 2009, the policies had not been issued. In addition, we found that the draft policies do not sufficiently address requirements for VAMCs to justify and authorize fee care to ensure that fee care meets the legislative intent and is economical and efficient. Furthermore, VHA has not developed detailed written procedures suitable for fee staff to

use as their day-to-day instructions for processing claims and meeting VHA policy requirements.

VHA Has Not Identified Core Competencies for Fee Staff and Does Not Require Training. VHA has not identified core competencies that fee staff are expected to demonstrate, such as understanding how to apply the payment hierarchy. Furthermore, while the National Fee Program Office offers training for fee staff and supervisors, VHA does not require these employees to take the training. At the 8 sampled VAMCs, we found that only 96 (53 percent) out of 182 fee staff had attended an initial fee training course and 3 (38 percent) out of 8 supervisors had attended fee supervisor training.

VHA Has Not Established Clear Oversight Responsibilities and Procedures. According to VHA's organizational chart, the Chief Business Office (CBO) has overall responsibility for the Fee Program. However, the CBO and the National Fee Program Office, which is aligned under the CBO, do not conduct regular oversight reviews of the program, nor have they established any oversight procedures or performance metrics for the Fee Program (other than a performance measure of paying 95 percent of invoices within 30 days). VHA policy does not clearly establish oversight responsibilities and procedures for the CBO, program office, or other VHA entities, such as the Compliance and Business Integrity (CBI) Office.

VHA Needs Regulatory Changes To Address Payment of Outpatient Facility Charges

VHA needs a regulation that addresses the payment of outpatient facility charges in the Fee Program. VHA policies do not provide VAMCs explicit guidance on how to pay for outpatient facility charges, and we found wide variations in how VAMCs and fee staff paid these charges. This occurred because the Code of Federal Regulations (CFR) does not address outpatient facility charges as part of the Fee Program. Specifically, the CFR does not authorize VA to use the same payment methodologies used by the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) for paying facility charges (although the CFR does provide this authority for professional charges). Without regulatory authority that addresses how VHA should pay facility charges and provides a basis for developing clear policies and procedures for paying facility charges, VHA has no assurance that the amounts VAMCs pay for facility charges are consistent, reasonable, or proper.

Conclusion

The magnitude of the Fee Program's payment errors indicates VHA faces significant challenges to address these vulnerabilities and has an immediate need to improve controls over claims processing and the justification and authorization of fee services. Stronger controls will help minimize payment errors and ensure fee care services are required and cost-effective. The Fee Program's high payment error rate is evidence that without sufficient policy guidance, mandatory training, and routine oversight of the program,

VHA has little assurance that risks associated with the Fee Program are identified, managed, and controlled. VHA needs to immediately address regulatory constraints affecting the Fee Program and consider implementing interim guidance for how it will pay outpatient facility charges until a new regulation is implemented.

Recommendations

1. We recommended the Acting Under Secretary for Health revise and publish fee policies that establish clear requirements for how VAMCs should justify and authorize outpatient fee care.
2. We recommended the Acting Under Secretary for Health develop and publish detailed fee claim processing procedures that provide specific instructions on how to prevent duplicate payments, review justifications and authorizations, and perform cost analyses.
3. We recommended the Acting Under Secretary for Health develop and publish detailed procedures to ensure fee staff have access to all contract rate information needed to accurately pay fee claims.
4. We recommended the Acting Under Secretary for Health identify core competencies for fee staff and supervisors and develop and implement mandatory initial and periodic training to address the required competencies.
5. We recommended the Acting Under Secretary for Health establish clear oversight responsibilities for the Fee Program and implement oversight procedures to regularly monitor program compliance and performance.
6. We recommended the Acting Under Secretary for Health instruct the eight sampled VAMCs to initiate recovery of overpayments and reimbursement of underpayments identified by our audit.
7. We recommended the Acting Under Secretary for Health coordinate with VA General Counsel to obtain regulatory authority that addresses the payment of outpatient facility charges.
8. We recommended the Acting Under Secretary for Health develop and disseminate interim guidance to instruct VAMCs on how to pay outpatient facility charges.

Management Comments and OIG Response

The Acting Under Secretary for Health agreed with the findings, recommendations, and monetary benefits in the report and provided acceptable implementation plans (see Appendix E for the full text of the comments). He reported that VHA will update and publish fee policies and procedures that provide specific requirements on justifying and authorizing fee care and instructions on processing fee claims, to include access to all contract rate information needed to accurately pay fee claims. VHA will also identify core competencies for fee staff and supervisors and link these competencies to learning

objectives, as well as develop a plan to identify mandatory training requirements and a tracking system to assure compliance.

The Acting Under Secretary acknowledged that additional oversight of the Fee Program is required and reported that the CBO and the CBI office will address program oversight and monitor compliance with program requirements. The CBO has established a Field Assistance Office to provide technical assistance to field facilities in development of structured business practices and has started a number of pilot initiatives intended to improve program effectiveness. The CBI office will implement a compliance business oversight plan and has identified the Fee Program as a strategic goal in its Strategic Plan for FY 2010 and beyond.

Furthermore, the Acting Under Secretary reported that the CBO will work with the eight sampled VAMCs to develop an action plan for initiating recovery of overpayments and reimbursement of underpayments identified by the audit. He also stated that VHA is obtaining regulatory authority to address the payment of outpatient facility charges. He reported that VHA has completed the rewrite of the applicable CFR section, and the Office of General Counsel is currently reviewing the proposed changes. In the interim, VHA will develop a procedural guide to instruct VAMCs on how to pay outpatient facility charges.

In his response, the Acting Under Secretary expressed concern that some readers may misinterpret the OIG's discussion about improper justifications to mean that "VA was routinely purchasing unnecessary services," rather than not properly documenting justifications. He also stated his concern that the audit report did not identify information technology (IT) gaps as "key drivers in the erroneous payments" and reported that fee staff manually process many claims and few upgrades have been made to the VistA Fee system in the past 10 years. He added that the CBO is working to address IT challenges and that funding for these "technological needs is fundamental to the effective administration of the Fee Care Program."

Based on our further discussions with National Fee Program Office officials and the Acting Under Secretary's comments, we made minor revisions to the final report to clarify that justifications were not properly documented, which increases the risk that resources will not be used appropriately. However, our audit did not assess the clinical necessity of services, and we did not draw any conclusions on that issue.

We also wish to address the Acting Under Secretary's concern about IT issues. Although the scope of the audit did not directly address IT issues, we recognize the shortcomings of VHA's current automated infrastructure, and we are aware of the challenges fee staff encounter using the current system. However, we would caution against any implication that the issues identified by this audit are wholly solvable with a better IT system.

The audit evidence we obtained from document reviews, statistical analyses, in-depth interviews with fee staff and program officials, and observations of fee processes at the eight sample sites supports our conclusion that VHA lacks clear, updated policies and

procedures that reflect regulatory, organizational, and system changes that have occurred over the years. While we recognize the importance of technology and automation for the future success of the Fee Program, our audit recommendations focus on the *foundational* issues of establishing and defining policies, standardizing operational procedures and business practices, training and maintaining a competent professional staff, and developing a strong oversight program. Addressing these issues *prior* to any significant attempts to replace or upgrade an automated system will increase the likelihood of developing a successful automated infrastructure.

We consider the Acting Under Secretary's planned actions acceptable, and we will follow up on their implementation.

(original signed by:)
BELINDA J. FINN
Assistant Inspector General
for Auditing

Introduction

Purpose

The objective of this audit was to assess the accuracy of payments made for pre-authorized outpatient fee services.

Background

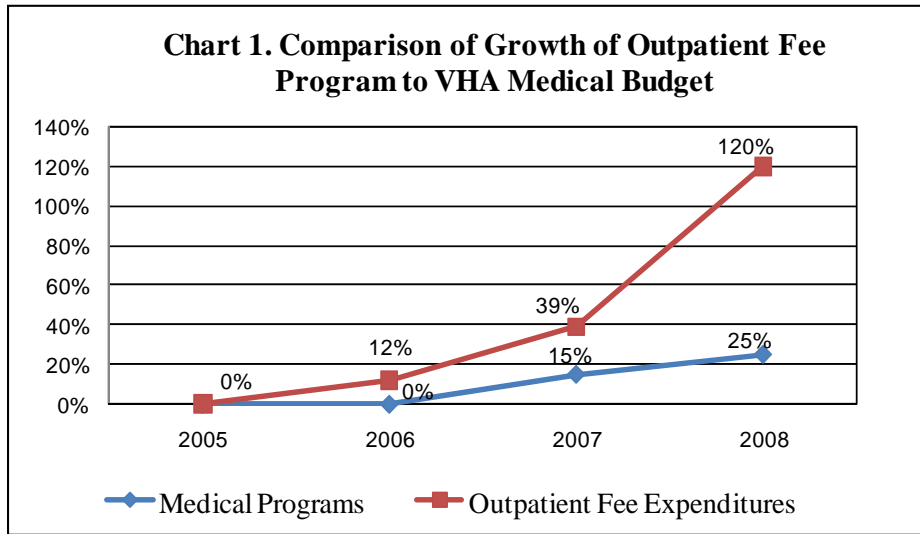
Description of the Fee Program. VHA uses the Fee Program to provide medical care to eligible veterans. Title 38 of the United States Code (USC), §1703, 1725, and 1728, authorizes VA to pay non-VA providers—through contracts or individual authorizations—for veterans' care when certain medical services are unavailable at VA facilities, when services cannot be provided economically due to geographical inaccessibility, or in emergencies when delays are hazardous to life or health. The Fee Program provides inpatient care, outpatient care, dental care, and pharmaceuticals. With the exception of some emergencies, outpatient fee care must be authorized prior to veterans receiving services from non-VA providers—VHA refers to this type of care as “pre-authorized” fee care.

Program Responsibilities. VHA's CBO, which is aligned under the Deputy Under Secretary for Health for Operations and Management, has primary responsibility for the Fee Program. The National Fee Program Office, located in Denver, CO, is a component of the CBO and provides policy and program support. In 2003, VHA had only two staff assigned to the program office to manage the Fee Program. In December 2007, VHA increased program management by hiring a Deputy Chief Business Officer for Purchased Care, and in August 2008 hiring a Director of Non-VA Purchased Care. As of February 2009, the program office had about 28 staff involved in various aspects of program management, including policy development, training, and technical support. In addition, VHA's Geriatrics and Extended Care Service and Office of Dentistry provide policy guidance for non-VA home health care and dental services. The Fee Program is highly decentralized and has no standard structure for how VAMCs or Veterans Integrated Service Networks (VISNs) organize and staff their local fee activities.

Program Workload and Expenditures. In FY 2008, 137 VAMCs had fee activities and processed an estimated 3.2 million outpatient fee claims.¹ Since FY 2005, outpatient Fee Program costs have more than doubled—from over \$740 million to about \$1.6 billion in FY 2008. By comparison, VHA's medical care budget increased from \$31.5 billion in FY 2005 to \$39.4 billion in FY 2008—an increase of 25 percent. VHA officials estimate Fee Program expenditures will increase by about 20 percent in FY 2009 to \$1.9 billion and attribute the growth to increased demand for care. Chart 1 compares the growth of

¹ These numbers do not include fee activities at VA facilities in Alaska, Hawaii, the Virgin Islands, and other United States territories. We excluded fee activities in these regions from our review due to their unique requirements. (See Appendix C for more detail.)

the Fee Program to the overall growth in VHA's medical budget from FY 2005 through FY 2008.



Program Policy and Procedures. Policy for outpatient fee care is contained in Title 38 CFR, Chapter 17, and VHA Manual M-1, Part I, Chapter 18, Change 3, “Outpatient Care – Fee,” dated July 20, 1995. VHA’s CBO Procedure Guide 1601.F, “Fee Service,” also contains limited policy and procedures for the management and operation of the Fee Program. In addition, VHA Handbook 1140.3, “Home Health and Hospice Care Reimbursement Handbook,” dated August 16, 2004, provides policy for home health care, and VHA Handbook 1130.1, “Criteria and Standards for Dental Program,” dated December 7, 1998, provides policy for non-VA dental services. VHA has also adopted many of the billing procedures and practices published by the CMS. For example, VHA uses the CMS Physician Fee Schedule and associated guidance to determine professional fees for non-VA physicians. Furthermore, VHA follows health insurance industry standards, such as using standardized claim forms (called “Uniform Bills” or UB forms).

Scope and Methodology. During the 6-month period between March 1, 2008 and August 31, 2008, 137 VAMCs paid about 1.6 million outpatient fee invoices. To assess the accuracy of payments made for pre-authorized outpatient fee services, we reviewed a statistical sample of 800 fee claims paid by 8 randomly selected VAMCs during the 6-month period.

We determined payment errors using criteria from the Improper Payments Information Act (IPIA) of 2002 in conjunction with the implementing guidance and criteria from Office of Management and Budget (OMB) Circular A-123, Appendix C, “Requirements for Effective Measurement and Remediation of Improper Payments.” For our review of claim payments, we used the same payment criteria the fee staff are required to use, as prescribed by the CFR and VHA policy. For professional services, we applied the payment methodology cited in Title 38 CFR, §17.56. For home health and dental services, we used the payment methods cited in VHA Handbooks 1140.3 and 1130.1 (see

Appendix B for more details on our scope and methodology and Appendix C for details on our sample design and results).

Results and Conclusions

VHA Needs To Strengthen Controls Over Outpatient Fee Care

VHA needs to strengthen controls over the outpatient Fee Program to reduce improper payments and ensure that VAMC officials properly justify and authorize fee care services. The audit found that VAMCs improperly paid 37 percent of outpatient fee claims by making duplicate payments, paying incorrect rates, and making other minor, less frequent payment errors, such as paying for the wrong quantity of services. As a result, we estimate that in FY 2008 VHA overpaid \$225 million and underpaid \$52 million to providers, or about \$1.126 billion in overpayments and \$260 million in underpayments over 5 years. In addition, for 80 percent of fee claims, VAMCs did not properly justify or authorize services as required by VHA policy.

VAMC fee staff made these errors because VHA has not established an adequate organizational structure to support and control the complex, highly decentralized, and rapidly growing fee program. Specifically, VHA has not developed current and comprehensive fee policies and procedures, identified core competencies and established mandatory training requirements for fee staff, and implemented clear oversight responsibilities and procedures for the Fee Program. VAMCs waste scarce health care resources when they make improper payments, and improper payments inflate program costs unnecessarily and impair VHA's ability to make sound business decisions on allocating health care resources. Furthermore, when VAMCs do not properly justify and authorize fee services, VHA lacks assurance that fee care funds are used as intended and in an economical manner and it increases the risk of additional improper payments.

VAMCs Improperly Paid 37 Percent of Outpatient Fee Claims

During the 6-month period, March 1, 2008–August 31, 2008, we estimate that VAMCs improperly paid 37 percent of outpatient fee claims. VAMCs made three types of payment errors—they made duplicate payments, paid incorrect rates, and made other minor payment errors. In some cases, we identified multiple errors on a single claim; consequently, the sum of all of the percentages shown for each specific type of error will not total 37 percent. To prevent double counting in calculating the overall estimated error rate, we only counted each claim once, regardless of whether the claim contained one or multiple errors.

VAMCs Made Duplicate Payments. We estimate that VAMCs improperly paid 12 percent of claims because fee staff made duplicate payments. As a result, we estimate that in FY 2008 VAMCs overpaid \$156.8 million. VAMCs made two types of duplicate payments—straight duplicate payments in which VAMCs paid for the same service twice and duplicate payments in which the VAMCs paid the professional component of a billed service twice. Straight duplicate payments affected about 4 percent of the claims and

resulted in estimated overpayments of \$133.7 million. The following example shows a straight duplicate payment.

Straight Duplicate Payment. A VAMC received two bills, one from a physician and the other from the physician's group practice, for the same service. The physician and the physician's group each billed the VAMC \$3,700. The VAMC paid the CMS Physician Fee Schedule rate of \$2,051.28 to both for a total payment of \$4,102.56. The VAMC should have only paid one bill to avoid a duplicate payment of \$2,051.28.

The second type of duplicate payment, paying the professional component twice, occurred more frequently and was more complex to identify. When billing for professional services, providers use Current Procedural Terminology (CPT) codes and modifiers. Certain types of procedures, such as radiology procedures, have both a professional component and a technical component. The professional component of the procedure, indicated by modifier 26, represents the physician's work, such as interpreting an x-ray, and associated overhead costs. The technical component of the procedure, indicated by modifier TC, represents the associated costs for equipment, supplies, and technicians, such as the radiology technician who takes an x-ray. Providers may bill for an unmodified CPT, or they may separately bill for the professional or technical component using a modifier. When combined, the rates for modifier 26 and modifier TC equal the rate paid for the unmodified CPT code, as in the example shown in Table 1.

Table 1. An Example of Payment Rates for an Abdominal Ultrasound

CPT Code	Modifier	Component	Price
76705	26	Professional	\$27.38
76705	TC	Technical	<u>\$53.93</u>
76705	Unmodified	Professional+Technical	\$81.31

Duplicate Payment of Professional Component. A hospital billed a VAMC for a veteran's abdominal ultrasound, CPT 76705. The physician radiology group also billed the VAMC for the professional component of the ultrasound, CPT 76705 with modifier 26. The VAMC paid the hospital \$81.31 for the procedure (\$53.93 for the technical component and \$27.38 for the professional component). Additionally, the VAMC paid the physician radiology group \$27.38 for the professional component, resulting in a duplicate payment.

We estimate that VAMCs improperly paid 7 percent of claims because they paid the full cost of the CPT codes (that is the unmodified code) plus the CPT codes with modifier 26 for the same services, thereby duplicating the payments for the professional portion of the services. As a result, we estimate that in FY 2008 VAMCs overpaid \$23.1 million for the professional component. The example below highlights the problem.

Fee staff made duplicate payments because they did not review Veterans Health Information Systems and Technology Architecture (VistA) Fee payment histories, which provide detailed information, such as dates of service, vendors, CPT codes, and amounts claimed and paid. By reviewing payment histories, fee staff will be able to determine if the VAMCs have already paid unmodified CPT codes or professional or technical components.

VAMCs Did Not Pay Correct Rates for Outpatient Fee Care. We estimate that VAMCs improperly paid 26 percent of claims because fee staff did not consistently apply the correct fee schedule rates. Specifically, VAMCs made three types of errors in determining the correct fee schedule rates—they paid incorrect rates for outpatient professional charges, exceeded maximum allowable rates for dental and home health services, and paid outdated rates. As a result, we estimate that in FY 2008 VAMCs made \$47.8 million in overpayments and \$52 million in underpayments.

VAMCs Incorrectly Paid Professional Charges. When paying for fee services, VAMCs may incur two types of costs—professional charges and facility charges. Professional charges are the fees paid to clinicians for services provided. According to Title 38 CFR §17.56, when a VAMC receives a bill for professional charges, it is required to determine the payment amount using a payment hierarchy. The hierarchy requires that VAMCs reimburse providers at the lowest rate between the billed amount, the CMS Physician Fee Schedule, and the VA Fee Schedule. A contract rate for the fee service supersedes the scheduled rates, even if it is higher. We estimate that VAMCs improperly paid 8 percent of claims because fee staff paid incorrect amounts by incorrectly applying the payment hierarchy, as highlighted in the following two examples.

CMS Physician Fee Schedule Rate. A physician billed the VAMC \$380 for ophthalmology services. The VAMC should have paid the CMS Physician Fee Schedule rate of \$282.54. Instead, the VAMC paid the billed rate of \$380, resulting in an overpayment of \$97.46.

Billed Rate. A fee provider billed a VAMC \$336 for a disability examination. The VAMC paid the provider \$248, but fee staff could not explain the basis for this amount. Since the CMS Physician Fee Schedule and VA Fee Schedule did not list rates for the specific professional service and no contract was in place, the VAMC should have paid the billed rate of \$336, resulting in an underpayment of \$88.

For FY 2008, these errors resulted in estimated overpayments of \$16.4 million and underpayments of \$49.2 million and primarily occurred because the National Fee Program Office did not adequately address the payment hierarchy in their training. In addition, fee staff often did not know when the VAMCs had contracts in place or did not have access to contract rate information. For example, five of the eight sampled VAMCs did not pay contract rates because the fee offices did not have copies of all contracts.

VAMCs Exceeded Maximum Allowable Rates for Dental and Home Health Care. According to VHA Handbook 1130.1, VAMCs should pay dental rates found in the National Dental Advisory Schedule for the applicable region of the country. Home health payment rates are subject to rules found in VHA Handbook 1140.3, which requires payment of home health care at a rate that does not exceed the Low Utilization Payment Adjustment (LUPA) rate schedule established by CMS. We estimate that VAMCs improperly paid 4 percent of claims because fee staff paid billed rates that exceeded maximum allowable rates under the dental and LUPA schedules, resulting in estimated overpayments of \$28.7 million in FY 2008. The example below shows this type of error.

Home Health Care. A home health vendor submitted a \$1,050 claim for seven home health services. However, according to the CMS LUPA rate schedule, the maximum allowable amount was \$77.35 per unit of service. Therefore, the VAMC should have paid a total of \$541.45 (7 home health services x \$77.35). Instead, the VAMC paid the billed amount of \$1,050, resulting in an overpayment of \$508.55.

The fee staff was unaware maximum rates existed and, therefore, paid claims exceeding the maximum allowable amount. Fee staff indicated that they were not provided with reimbursement rate information for home health and dental services. VHA's Geriatrics and Extended Care Service and Office of Dentistry provide policy guidance for non-VA home health care and dental services, and fee staff does not receive much training on program policies and payment methodologies for these services. The National Fee Program Office develops training for fee staff but is not involved in developing or issuing policy guidance for home health care and dental services.

VAMCs Paid Outdated Rates. CMS updates Physician Fee Schedule rates annually. When VA receives an update, it must develop a software patch to update the rates in the VistA Fee system, and each VAMC must install the patch into their local systems to implement the new rates. We estimate VAMCs improperly paid 14 percent of claims because fee staff paid outdated rates due to delays in developing the software patch. As a result, in FY 2008 VAMCs made estimated overpayments of \$2.7 million and underpayments of \$2.8 million.

On November 27, 2007, CMS issued Physician Fee Schedule rates that became effective January 1, 2008. Once CMS issued the Physician Fee Schedule rates, the National Fee Program Office coordinated with the VA Office of Information and Technology (OI&T) to initiate building an update patch to the VistA Fee system. On May 22, 2008, OI&T issued the patch to the VAMCs. None of the eight sites we visited from our sample updated the patch until early June 2008, more than 5 months after the rates became effective. Therefore, many CMS Physician Fee Schedule payments made to fee providers during the period January 1–June 13, 2008 were incorrect.

According to officials in the National Fee Program Office, this is a recurring issue, resulting from OI&T's development, test, and release control procedures for software

patches. This audit did not include a review of OI&T's procedures; therefore, we could not determine if the delays in updating VistA Fee were preventable.

VAMCs Made Other Minor Payment Errors. We estimate 2 percent of paid claims were improper because VAMCs made other, less frequent errors, such as paying for the wrong quantity of services. For FY 2008, these errors resulted in estimated overpayments of \$20.5 million. The following example shows this type of error.

Paid for More Services than Billed. A home health provider billed a VAMC for two skilled nursing visits at \$100 per visit. The VAMC paid the correct rate of \$100 per visit, but they paid for three visits instead of two. Therefore, the VAMC paid for more services than billed, resulting in an overpayment of \$100.

VAMCs Improperly Justified and Authorized Services for 80 Percent of Outpatient Fee Claims

We estimate VAMCs did not properly document justifications or authorize services as required by VHA policy for 80 percent of outpatient fee claims. Proper justifications and authorizations ensure that VAMC officials consider if VAMC clinical resources are being effectively utilized and if requests for outpatient fee care are necessary before they use non-VA health care resources. Justifications and authorizations, if properly performed and documented, provide assurance that VAMCs are making sound medical and business decisions allocating their health care resources.

VAMCs Did Not Adequately Document Justifications for Use of Outpatient Fee Care. A VA clinician initiates fee care by requesting a specific service for a veteran. CBO Procedure Guide 1601F requires fee staff to conduct a cost analysis to determine if the care may be provided more economically by VHA or through fee care. To conduct a cost analysis, the fee staff is required to compare the average cost of providing the same medical services at a VAMC to the cost at a non-VA facility, including transportation costs. The fee staff does not need to conduct a cost analysis if the requesting VA clinician documents in the veteran's medical record that VHA does not have the capability or capacity to provide the service or the service is geographically inaccessible for the veteran.

We estimate VAMC requesting clinicians did not adequately document justifications for using fee care in veterans' medical records for 72 percent of claims. Clinicians typically documented the diagnosis and treatment plan but no rationale for using fee care. Of the 26 clinicians we interviewed, 25 were not aware that they were required to document justifications for fee care based on capability, capacity, or accessibility. VAMC fee staff did not conduct cost analyses to determine if the care could be provided more economically. We interviewed 16 fee staff, and 12 told us they did not even review the requests; they assumed that if they received a request, it was justified.

VAMCs Did Not Properly Authorize Outpatient Fee Care Services. VHA Manual M-1 requires that the clinic director and the Chief of Medical Administration Service, more commonly known as the VAMC CBO, authorize non-VA fee care prior to a veteran receiving service to ensure the request is appropriate and that VAMC management is aware of how fee services are being utilized. M-1 defines “clinic director” as the person in charge of an outpatient clinic, outpatient service in a VAMC, or another designated VA clinician in a VAMC or clinic with fee-basis responsibility. According to the National Fee Program Office, in practice, Chiefs of Staff typically approve fee care and may delegate approval authority to other clinical staff, but those delegations should be in writing.

We estimate for 55 percent of claims, VAMC Chiefs of Staff or their formal designees did not pre-authorize services as required by VHA policy. Instead, a wide range of VAMC employees authorized services, including primary care physicians, nurses, administrative officers, and even fee staff. The following example highlights how controls to ensure proper authorization of fee care were not effective, increasing the risk of underutilizing available VA clinical resources.

Radiology Services. Because the VAMC's Community Based Outpatient Clinics (CBOCs) did not have Magnetic Resonance Imaging (MRI) systems, fee staff routinely approved MRI fee requests from CBOCs. Instead of approving the requests themselves, fee staff should have sent the requests to the Chief of Radiology for his approval. The Chief of Staff and the Chief of Radiology were unaware this practice was occurring and agreed that they needed to better monitor radiology services sent to fee providers because less expensive options that are equally effective may be available.

VAMCs did not comply with M-1 authorization requirements because Chiefs of Staff did not consistently delegate approval authority or clearly communicate delegation decisions. Without formal delegations, many clinical staff assumed they were allowed to authorize fee services. In many cases, fee staff had no way of knowing who had proper approval authority, and they assumed that if a request came to them, it was approved.

An Organizational Structure To Control and Support the Fee Program Will Reduce Improper Payments, Justifications, and Authorizations

The improper payments, justifications, and authorizations occurred because VHA had not established an adequate organizational structure to support and control the complex, highly decentralized, and rapidly growing fee program. Specifically, VHA has not developed current and comprehensive fee policies and procedures, identified core competencies and established mandatory training requirements for fee staff, and implemented clear oversight responsibilities and procedures for the Fee Program.

In July 2006, VHA's Fee Standardization Committee, a work group established by the National Leadership Board (NLB), identified similar weaknesses in the Fee Program.

The Committee made 37 recommendations to the NLB addressing various aspects of the Fee Program, including policies and procedures, core competencies and training, and standardization of business processes. The Committee did not make any recommendations addressing program oversight. According to an official who served on the Committee, VHA did not establish a coordinated process to track the status of recommendations or ensure that they were implemented. However, we found that the CBO has incorporated several of the recommendations into its strategic planning process.

VHA Fee Policies and Procedures are Not Current and Comprehensive. VHA does not have a centralized source of comprehensive, clearly written, current policies and procedures for the Fee Program. Instead, fee supervisors and staff rely on an assortment of resources including the CFR, Manual M-1, other VHA directives, procedure guides that contain some policy, technical guides for the VistA Fee system, training materials, and informal guidance, such as conference call minutes.

Fee Policy. VHA's primary policy source for the outpatient Fee Program is Manual M-1, Chapter 18, which addresses the regulatory requirements outlined in Title 38 CFR, Chapter 17. M-1 policy provides basic Fee Program requirements, including circumstances that justify the use of fee care and responsibilities for authorizing fee services. Since 1986, VHA has made several changes to Chapter 18 to reflect regulatory, organizational, and system changes. The most recent change was made about 14 years ago; consequently, significant portions of M-1 are outdated and reflect old organization structures within VHA and the Fee Program, often making M-1 confusing to understand and apply. As a result, even though M-1 contains some important program requirements, VAMC fee staff rarely use M-1 as a reliable source of information—instead they use the CBO Procedure Guide 1601F, which includes procedures and limited policy.

Officials in the National Fee Program Office are aware that M-1 contains outdated information and developed four new policy handbooks to replace M-1. Program officials submitted the draft handbooks to VA General Counsel for review in Fall 2008. VA General Counsel returned the policies to the National Fee Program Office in May 2009. As of June 2009, the policies have not been issued. Our review of the draft handbooks concluded they do not sufficiently establish policy for justifying the use of fee care and authorizing services, as discussed below.

- Justifications for Fee Care. The USC clearly indicates fee care is intended for situations when VAMCs are “not capable of furnishing economical hospital care or medical services because of geographical inaccessibility or are not capable of furnishing the care or services required.” The CBO Procedure Guide describes a “Requirement for Conducting a Cost Analysis,” yet the draft handbooks do not address the need to justify fee care through cost analyses or medical determinations. If VHA intends for the handbooks to replace M-1 as the primary source of Fee Program policy, then the handbooks should clearly address the legislative intent of the program and how VAMCs should meet this intent by properly justifying fee care.

- Authorizing Fee Care. Although M-1 contains policy on authorizing fee services, we found VAMCs did not comply with the policy because it reflects an outdated organizational structure within VHA and the Fee Program. One of the four draft handbooks intended to replace M-1 specifically addresses authorizations and describes documentation and timeline requirements for authorizations. However, the draft handbook does not define who may authorize the use of fee care, whether those individuals may delegate their authority, and, if so, how and to whom they may delegate.

Fee Procedures. CBO Procedure Guide 1601F is the primary source that fee staff refer to for specific procedures needed to meet Fee Program policy requirements. However, based on our review of the guide and interviews with fee staff, we found it does not provide fee staff sufficient step-by-step instructions on how to perform many of their required tasks. For example, the Guide does not provide specific instructions on how to review VistA Fee payment history records to avoid making duplicate payments. For cost analyses, the Guide only states that a cost analysis compares the average cost of providing medical services at a VA facility with the same services in a community non-VA facility; it does not provide instructions on how to actually conduct a cost analysis and obtain average cost data. As a result, the fee staff often does not perform required tasks, such as cost analyses, or they rely on miscellaneous instructions acquired on an ad hoc basis, including e-mail guidance from the National Fee Program Office, advice from other fee offices, handouts from training courses, and minutes from conference calls.

VHA Has Not Identified Core Competencies for Fee Staff and Does Not Require Training. Although the National Fee Program Office has recently added training staff and made more training available, VHA has not identified core competencies or established mandatory training requirements for fee staff and supervisors. Since the Fee Program is very complex and limitations with the VistA Fee system require significant judgment by fee staff to ensure correct payments, processing fee claims requires specialized knowledge and skills. Not only must fee staff and supervisors understand how to use electronic medical records and the VistA Fee system, but they must also have knowledge of VHA fee policies and procedures, CMS rules and regulations for reimbursing physicians and health care facilities, insurance billing concepts and standardized forms, and medical procedure and diagnostic coding.

Core Competencies. The National Fee Program Office has not identified the basic skills, knowledge, and abilities (commonly referred to as “core competencies”) that fee staff and supervisors are expected to demonstrate at their assigned grade and duty positions. Due to the specialized nature of fee claims processing, identifying core competencies would help the program office develop training modules that go beyond the basics and address specific topics and skill sets. For example, one of the competencies the fee staff should be able to demonstrate is to accurately apply the CMS Physician Fee Schedule when paying for professional services in different settings. However, the program office currently does not have a module that provides in-depth training on specific payment methodologies.

Mandatory Training. The VAMC fee staff is predominately lower-grade employees (General Schedule grades 4–6), who have little or no previous experience processing medical claims. Yet, VHA does not require fee staff and supervisors to attend initial or refresher training. Instead, each VAMC decides if fee staff will attend training. Only 53 percent (96 out of 182) of fee staff at the 8 sampled VAMCs had attended basic fee training, and 38 percent (3 out of 8) of all supervisors had attended fee supervisor training, which the National Fee Program Office offers on a regular basis in Denver and by request at VISNs and VAMCs.

Other VA programs require mandatory training for employees performing complex functions. For example, the Veterans Benefits Administration requires their new benefits claim processors to complete prerequisite training before attending a formal introductory course. After completion of the formal course, claim processors are required to complete additional follow-on training at their facilities.

VHA Has Not Established Clear Oversight Responsibilities and Procedures. A high rate of improper payments, justifications, and authorizations clearly indicates that VHA needs to establish robust oversight responsibilities and procedures for the Fee Program. Strong oversight includes procedures and performance metrics for assessing compliance with program requirements, conducting risk assessments, assessing program controls, and monitoring quality. However, no one from the CBO, National Fee Program Office, VISN, or VHA's CBI Office, is routinely performing oversight activities for the Fee Program.

VHA Manual M-1 does not adequately address oversight authority and responsibilities, and it reflects an old organizational structure within the Fee Program. M-1 describes general oversight responsibilities of VAMC directors and other officials involved in the fee activities at the VAMCs. For example, M-1 states that VAMC directors may establish advisory groups and assign these groups the responsibility for “formal, periodic reviews to determine the effectiveness of control and appropriateness of utilization of their facility’s fee-basis authority.” However, VAMC officials we spoke with stated that they did not conduct periodic reviews of the Fee Program; instead, their focus is on meeting the national performance measure of paying 95 percent of received invoices within 30 days (in accordance with VHA Directive, 2007-010, “Timeliness Standards for Processing Non-VA Provider Claims”).

According to VHA's organizational chart, the CBO, which oversees the National Fee Program Office, has overall responsibility for the program. However, officials from the program office told us they did not conduct regular oversight reviews of the Fee Program because VAMC Directors are responsible for program oversight. Furthermore, program officials expressed their belief that although they developed program policy and provided technical guidance to VAMC fee activities, they did not have formal authority to oversee the Fee Program or enforce policy requirements.

We also spoke with CBI officials from the National CBI Program Office, six VISNs, and the sample VAMCs to determine what role, if any, they had in overseeing fee activities.

VHA's CBI Program advises the Under Secretary for Health on issues related to compliance, integrity, and accountability of VHA business operations. We found CBI officials are not involved in oversight of the Fee Program. According to National CBI Program officials, they primarily focus their attention on revenue-generating programs, such as third-party insurance billing. In addition, VAMC CBI officials did not have programs to monitor fee activities, nor did they include fee activities in their risk assessments.

The only office that has conducted any systematic review of the Fee Program is the VA Office of Business Oversight's Management Quality Assurance Service (MQAS), which is aligned under the Chief Financial Officer. In FY 2008, as part of its overall review of financial management operations, MQAS reviewed Fee Programs at selected VAMCs and made recommendations, such as avoiding duplicate payments of professional fees, to the VAMCs to improve compliance with VHA fee policies. Although officials at the National Fee Program Office were aware of the reviews, they viewed the results as issues that the individual VAMCs were responsible for addressing rather than systemic problems that VHA management needs to address at the national level.

Conclusion

The magnitude of the Fee Program's payment errors indicates VHA faces significant challenges to address these vulnerabilities and has an immediate need to improve controls over claims processing and the justification and authorization of fee services. Strong controls will help reduce payment errors and ensure fee care services are required and cost-effective. VHA needs to provide the fee staff with current and comprehensive written policies and procedures and access to quality training that they may use to correctly process claims. Additionally, VHA needs to strengthen Fee Program oversight at all levels of the organization.

Recommendations

1. We recommend the Acting Under Secretary for Health revise and publish fee policies that establish clear requirements for how VAMCs should justify and authorize outpatient fee care.
2. We recommend the Acting Under Secretary for Health develop and publish detailed fee claim processing procedures that provide specific instructions on how to prevent duplicate payments, review justifications and authorizations, and perform cost analyses.
3. We recommend the Acting Under Secretary for Health develop and publish detailed procedures to ensure fee staff have access to all contract rate information needed to accurately pay fee claims.

4. We recommend the Acting Under Secretary for Health identify core competencies for fee staff and supervisors and develop and implement mandatory initial and periodic training to address the required competencies.
5. We recommend the Acting Under Secretary for Health establish clear oversight responsibilities for the Fee Program and implement oversight procedures to regularly monitor program compliance and performance.
6. We recommend the Acting Under Secretary for Health instruct the eight sampled VAMCs to initiate recovery of overpayments and reimbursement of underpayments identified by our audit.

Management Comments and OIG Response

The Acting Under Secretary for Health agreed with the findings, recommendations, and monetary benefits in the report and provided acceptable implementation plans (see Appendix E for the full text of the comments). The Acting Under Secretary reported that VHA will update and publish fee policies and procedures that provide specific requirements on justifying and authorizing fee care and instructions on processing fee claims, to include access to all contract rate information needed to accurately pay fee claims. VHA will also identify core competencies for fee staff and supervisors and link these competencies to learning objectives, as well as develop a plan to identify mandatory training requirements and a tracking system to assure compliance.

Furthermore, the Acting Under Secretary acknowledged that additional oversight of the Fee Program is required and reported that the CBO and the CBI office will address program oversight and monitor compliance with program requirements. The CBI office will implement a compliance business oversight plan and has identified the Fee Program as a strategic goal in its Strategic Plan for FY 2010 and beyond. The CBO has established a Field Assistance Office to provide technical assistance to field facilities in development of structured business practices and has started a number of pilot initiatives intended to improve program effectiveness. Lastly, the Acting Under Secretary reported that the CBO will work with the eight sampled VAMCs to develop an action plan for initiating recovery of overpayments and reimbursement of underpayments identified by this audit.

In his response, the Acting Under Secretary expressed concern that some readers may misinterpret the OIG's discussion about improper justifications to mean that "VA was routinely purchasing unnecessary services," rather than not properly documenting justifications. He also stated his concern that the audit report did not identify information technology (IT) gaps as "key drivers in the erroneous payments" and reported the fee staff processes many claims manually and few upgrades have been made to the VistA Fee system in the past 10 years. He added that the CBO is working to address IT challenges and funding for these "technological needs is fundamental to the effective administration of the Fee Care Program."

We consider the Acting Under Secretary's planned actions acceptable, and we will follow up on their implementation. Based on our further discussions with National Fee Program Office officials and the Acting Under Secretary's comments, we made minor revisions to the final report to clarify that justifications were not properly documented, which increases the risk that resources will not be used appropriately. However, our audit did not assess the clinical necessity of services, and we did not draw any conclusions on that issue.

We also wish to address the Acting Under Secretary's concern about IT issues. Although the scope of the audit did not directly address IT issues, we recognize the shortcomings of VHA's current automated infrastructure, and we are aware of the challenges fee staff encounter using the current system. However, we would caution against any implication that the issues identified by this audit are wholly solvable with a better IT system.

The audit evidence we obtained from document reviews, statistical analyses, in-depth interviews with fee staff and program officials, and observations of fee processes at the eight sample sites supports our conclusion that VHA lacks clear, updated policies and procedures that reflect regulatory, organizational, and system changes that have occurred over the years. While we recognize the importance of technology and automation for the future success of the Fee Program, our audit recommendations focus on the *foundational* issues of establishing and defining policies, standardizing operational procedures and business practices, training and maintaining a competent professional staff, and developing a strong oversight program. Addressing these issues *prior* to any significant attempts to replace or upgrade an automated system will increase the likelihood of developing a successful automated infrastructure.

VHA Needs Regulatory Changes To Address Payment of Outpatient Facility Charges

VHA needs a regulation that addresses the payment of outpatient facility charges in the Fee Program. VHA Manual M-1 and the CBO Procedure Guide do not provide explicit guidance on how to pay for outpatient facility charges; consequently, we found wide variations in VAMC payment practices. According to National Fee Program Office officials, this is because the CFR does not address outpatient facility charges as part of the Fee Program; therefore, there is no regulatory authority to support internal policy and procedures. Specifically, the CFR does not authorize VA to use CMS payment methodologies for paying facility charges (although the CFR does provide this authority for professional charges). Without clear policies and procedures on how to pay for facility charges, VHA has no assurance that the amounts VAMCs pay for facility charges are consistent, reasonable, or proper.

VAMC Payment Practices for Outpatient Facility Charges Vary Widely

When paying for fee services, VAMCs may incur two types of costs—professional and facility charges. Facility charges generally include space, supplies, ancillary services,

and other overhead. Facility charges are typically incurred when a veteran receives treatment at a hospital-based outpatient clinic or ambulatory surgery center or receives dialysis treatments. Providers bill professional charges and facility charges separately. For instance, if a veteran undergoes an outpatient procedure at a hospital ambulatory surgery center, then the VA generally receives two bills—one to cover the professional charges of the physician and one to cover the facility charges of the surgery center.

VHA Fee Policies Do Not Address Facility Charges. VHA Manual M-1 and the CBO Procedure Guide do not address how VAMCs should pay for outpatient facility charges, which was evident from the wide variations in how VAMCs paid these charges. We found that when VAMCs received claims for facility charges, some VAMCs paid the full billed amount, some paid full rates from the CMS Physician Fee Schedule, while others could not explain the basis for the amounts paid. These wide variations in payment practices put the Fee Program at increased risk for fraud, waste, and abuse.

Officials at the National Fee Program Office are aware that determining correct payment amounts for outpatient facility charges has been problematic for VAMCs, and they described the following payment procedures that they advised VAMCs to use when paying facility charges.

- VAMCs should pay the lesser of the actual rate billed or the VA Fee Schedule rate. Each of the 137 fee offices develops its own VA Fee Schedule and bases payment rates on amounts billed in the prior fiscal year.
- If the claim is for a procedure that has both a technical and professional component, such as a radiology procedure, the VAMC should pay the technical component using the CMS Physician Fee Schedule.
- If the VAMC has a contract for the billed service, the contract rate will supersede other rates, even if it is higher.

However, National Fee Program Office officials could not explain the basis for their prescribed payment methodology, nor could they provide any written documentation that this methodology was clearly described or disseminated to VAMC fee staff. According to the program officials, they have discussed these payment procedures with VAMC fee staff during at least two national conference calls, briefly in formal training, and during technical consultation calls with individual VAMCs. However, many fee staff and supervisors were unclear on the procedures. We identified one national conference call in which the program office addressed its prescribed procedure. The call took place on September 7, 2006, and according to an audiotape of the call, the program office spent about only 2 minutes discussing this procedure before addressing other topics. Without written guidance, standardizing a prescribed payment methodology becomes a serious challenge in a decentralized environment such as VHA's Fee Program.

The National Fee Program Office's Prescribed Procedures for Paying Facility Charges May Significantly Increase Outpatient Fee Costs. Fee supervisors and other VAMC officials expressed serious concerns about the potential budget implications of

using the procedures prescribed by the National Fee Program Office. VAMC officials indicated that if they primarily use their VA Fee Schedules to pay facility charges, VA will see a dramatic increase in its outpatient fee costs. Officials explained that each VAMC develops its own VA Fee Schedule based on billed amounts from the previous fiscal year. The VAMCs do not perform any analyses to assess the reasonableness of these amounts, and they acknowledged there is a high potential for providers to inflate their bills. VAMC officials also expressed their opinion that VA's method for paying facility charges should be consistent with its method for paying professional charges; that is, both payment methodologies should follow CMS payment methodologies (the CMS Physician Fee Schedule for professional charges and the Outpatient Prospective Payment System for facility charges).

We agree with the concern about using the National Fee Program Office's prescribed procedures. In our sample of 800 claims, we identified 120 claims for facility charges where the VAMCs *did not* use the payment practices prescribed by the National Fee Program Office because the prescribed payment procedures were not clearly described or disseminated to VAMC fee staff. Instead, the VAMCs used other payment methods such as paying the full billed amount or full CMS Physician Fee Schedule rates. However, our analysis found that if the 8 VAMCs had used the prescribed payment procedures for the 120 claims, their fee costs would have increased about \$217,000. Nationwide, we estimate that the increased cost would have been about \$904.6 million, or about 56 percent of outpatient fee expenditures in FY 2008.

The following example shows how we applied the National Fee Program Office's prescribed payment procedures to estimate the budgetary impact.

Community Hospital Charges. A community hospital sent a claim for \$5,163 to the VAMC for facility charges related to a veteran's outpatient visit. The VAMC used the CMS Physician Fee Schedule and paid the community hospital \$1,508. However, since the bill was for facility charges, according to the National Fee Program Office, the VAMC should have paid the VA Fee Schedule rate of \$4,173. Therefore, the VAMC paid \$2,665 less than what they should have paid under the prescribed procedures.

National Fee Program Office officials acknowledged that they have not effectively communicated their payment methodology to the VAMCs. They also acknowledged that if all the VAMCs began using the payment methodology, costs would potentially increase resulting in significant budget implications for the Fee Program.

Regulatory Changes for the Outpatient Fee Program Will Help To Ensure Consistent Procedures and Limit Facility Costs

The wide variations in how VAMCs paid facility charges and the lack of clear policies and procedures occurred because the CFR does not address how VA should pay outpatient facility charges. Title 38 CFR §17.56, allows VA to use the CMS Physician

Fee Schedule to pay for non-VA physician and other health care professional charges, yet the CFR does not address how VA should pay for outpatient facility charges. In order to pay outpatient facility charges, the National Fee Program Office developed a payment methodology that was not based on any regulatory authority and was never established as a formal VHA policy.

Over the past 4 years, VHA has submitted to VA General Counsel three draft regulation changes to the CFR that give VA authority to use CMS payment methodologies that CMS implemented in August 2000 to pay outpatient facility charges. According to National Fee Program Office officials, their attempts have failed because VA General Counsel had concerns with the format, justification, and reasoning of the draft regulation. The program officials acknowledged that they did not have much experience drafting regulations, especially complex ones that address technical aspects of CMS payment methodologies. During our audit, the program office prepared another draft in consultation with a contractor who had experience writing regulation changes. Program officials believe that this draft, which they submitted to the CBO in April 2009, addresses the past concerns of VA General Counsel.

National Fee Program Office officials expect it will take 12–18 months to publish a new regulation due to VA's involved rulemaking process. While we recognize that the rulemaking process takes time, we believe that due to the potential budget implications of not addressing facility charges, this issue is economically significant and warrants high priority. Therefore, VHA must coordinate closely with VA General Counsel to expedite the rulemaking process. In addition, due to a potentially lengthy rulemaking process, VHA needs to implement interim guidance to provide VAMCs clear instructions on how to pay facility charges. In considering both long-term and interim guidance, VHA must carefully evaluate the cost impact and include this in their budget formulation and allocation decisions. Furthermore, VHA must provide clear written instructions and training to all VAMCs with fee activities.

Conclusion

VHA needs to obtain regulatory authority that supports internal policy and procedures for paying outpatient facility charges. We found wide variations in how VAMCs paid for outpatient facility charges. This occurred because the CFR does not address outpatient facility charges as part of the Fee Program; therefore, there is no regulatory authority to support internal policy and procedures on paying facility charges. Without clear policies and procedures on how to pay for facility charges, VHA has no assurance that the amounts VAMCs are paying for facility charges are consistent, reasonable, or proper. Furthermore, wide variations in payment practices put the Fee Program at increased risk for waste, fraud, and abuse. VHA needs to coordinate with VA General Counsel to expedite the rulemaking process to address outpatient facility charges and, due to the economic significance of this issue, develop and disseminate interim guidance for VAMCs to use until final regulatory authority is obtained.

Recommendations

7. We recommended that the Acting Under Secretary for Health coordinate with VA General Counsel to obtain regulatory authority that addresses the payment of outpatient facility charges.
8. We recommended that the Acting Under Secretary for Health develop and disseminate interim guidance to instruct VAMCs on how to pay outpatient facility charges.

Management Comments and OIG Response

The Acting Under Secretary for Health agreed with the recommendations and reported that VHA is obtaining regulatory authority that addresses the payment of outpatient facility charges. He stated that VHA has completed the rewrite of Title 38 CFR, §17.56 and the Office of General Counsel is currently reviewing the proposed CFR. In the interim, VHA will provide guidance to VAMCs on how to pay outpatient facility charges by development of a procedural guide that incorporates existing payment policy.

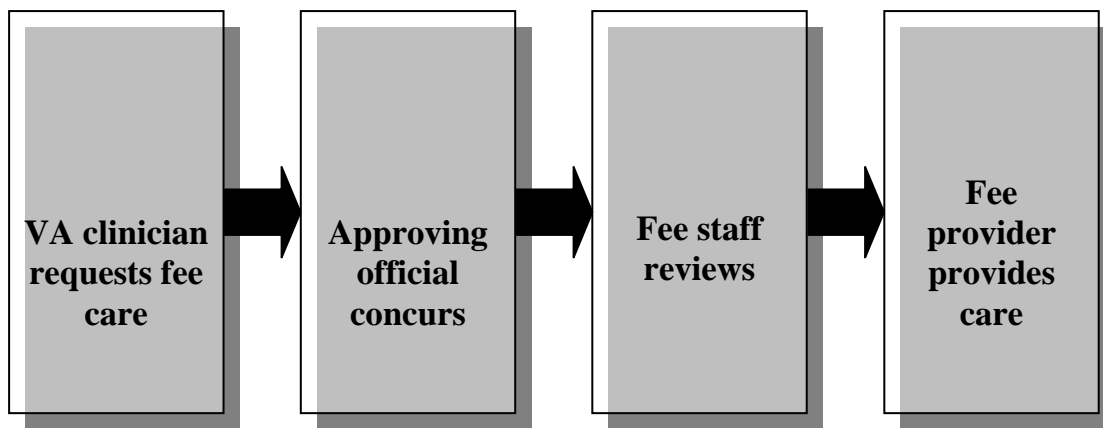
We consider the Acting Under Secretary's planned actions acceptable, and we will follow up on their implementation.

The Non-VA Outpatient Fee Care Process

From a process perspective, outpatient fee care involves two major phases—pre-authorizing outpatient fee care and processing outpatient fee claims. Each phase and the steps within those phases are described below.

Pre-Authorization Phase. With the exception of some emergencies, outpatient fee care must be authorized prior to veterans receiving services from non-VA providers. As depicted in Chart 3, the pre-authorization phase should include the following steps:

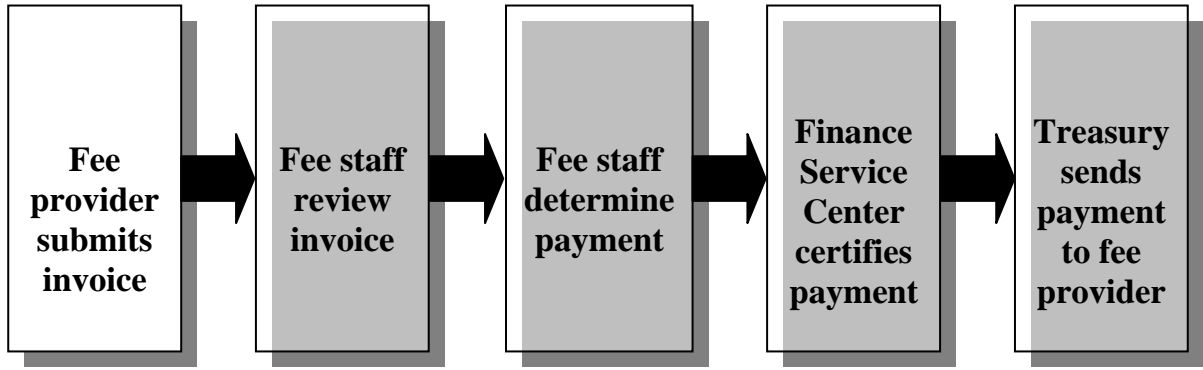
Chart 2. Necessary Steps in the Pre-Authorization Phase



- A VAMC clinician requests a specific service for a veteran and justifies the use of fee care based on the VAMC's lack of capability or capacity to provide services or the geographical inaccessibility of services.
- The Chief of Staff or designee reviews the request and authorizes fee care, if it is determined appropriate.
- Fee staff reviews the request for outpatient fee care and verifies that the veteran is eligible for the program, the appropriate justification is provided, and the Chief of Staff or appropriate designee has approved the request for fee care.
- The veteran selects a fee provider and receives services. (Although the veteran may select his or her own provider, the fee services must still be justified that VHA does not have the capability or capacity to provide the service or the service is geographically inaccessible for the veteran and authorized by appropriate VAMC officials.)

Processing Phase. As depicted in Chart 3, once the veteran receives the services from a non-VA provider and the provider submits an invoice to the fee office for payment, fee staff should complete the following steps to reimburse a fee provider:

Chart 3. Necessary Steps in the Processing Phase



- Fee staff performs an administrative review of the invoice to ensure it includes the required data elements and that the billed services match the services authorized.
- Fee staff determines the proper pricing methodology and payment rate based on the type and location of care provided. Fee staff processes payment through the VistA Fee system.
- Fee staff releases the claim to the Financial Service Center in Austin, TX to certify fee disbursements to the Department of Treasury.
- The fee provider receives an electronic payment from the Department of Treasury.

Scope and Methodology

Overview. To address the audit objective, we reviewed applicable laws, regulations, policies, procedures, and guidelines. We interviewed program officials from VHA's CBO and officials from VAMCs and VISNs to obtain information on the fee process, practices, and management controls. Additionally, we interviewed officials from VA's Office of Business Oversight's, VHA's CBI Office, and VISN and VAMC CBI offices to determine to what extent they had provided oversight of the Fee Program. We randomly selected eight VAMCs for our review, as shown in Table 2.

Table 2. VAMCs Randomly Selected for Onsite Review

Medical Center	Location	VISN
VA Roseburg Healthcare System (HCS)	Roseburg, OR	20
Overton Brooks VAMC	Shreveport, LA	16
Iowa City VAMC	Iowa City, IA	23
VA Southern Nevada HCS	Las Vegas, NV	22
VA North Texas HCS	Dallas, TX	17
VA Central California HCS	Fresno, CA	21
Minneapolis VAMC	Minneapolis, MN	23
Alexandria VAMC	Pineville, LA	16

Claims Review. To assess the accuracy of payments made for pre-authorized outpatient fee services, we reviewed a statistical sample of 100 paid claims from each of our eight sampled sites for a total of 800 claims valued at \$410,204. Our review included outpatient fee claims paid between March 1, 2008 and August 31, 2008. We excluded VAMCs in Alaska, Hawaii, Virgin Islands, and other territories of the United States because they fall under unique rules established by Title 38 CFR §17.52. (Appendix C provides more detail on our sample design and results.) For our review, we used the same payment criteria that the fee staff is required to use, as prescribed by the CFR and VHA policy. For professional services, we applied the payment methodology cited in Title 38 CFR §17.56. For home health and dental services, we referenced Handbooks 1140.3 and 1130.1, respectively.

To accomplish the audit objective, we used data from the VistA Fee system. VAMCs use this system to process claims and invoices for both fee and non-fee purchased care. To minimize the risk of including non-fee care claims in our sample, for each claim we checked with VAMC contract staff and reviewed supporting documentation to determine if a contract was in place. If there was no contract, we included the claim in our sample. If there was a contract, we determined which contract authority was used. If the authority was Title 38 USC §1703, the fee care authority, we included the claim in our sample. We did not include claims for services provided under other contracting authorities such as sharing agreements, Project HERO, and home health contracts executed under USC §1720.

Appendix B

To test the reliability of claims information in the VistA Fee system, we compared the VistA information with selected veteran and vendor data shown on the original invoices. We found no significant errors between the VistA Fee system data and the original invoice data. We concluded the data used from the VistA Fee system was sufficiently reliable to meet the audit objective.

Defining Improper Payments. Based on the IPIA of 2002 in conjunction with the implementing guidance and criteria from OMB Circular A-123, Appendix C, and the criteria shown in Table 3, we used the following conditions to determine whether outpatient Fee Program payments were in error:

Table 3. Conditions Used To Determine Erroneous Payments

Condition	Audit Verification Approach
The veteran was ineligible for the program.	Review of VistA Fee system eligibility screen and eligibility requirements in CFR §17.52.
The payment was the incorrect amount.	Application of payment hierarchy from CFR §17.56 and VHA Handbooks 1140.3 and 1130.1.
The payment was to an ineligible or incorrect vendor.	Reviewed HHS vendor exclusion list and VistA Fee vendor list.
The payment was for an ineligible service or service different than authorized.	Compared VistA Fee system authorization screen with services billed for and veteran medical records.
The payment was for a service not received	Reviewed veteran medical records and documentation submitted in support of invoices.
The payment was a duplicate payment.	Reviewed VistA Fee system payment history screen.
The payment lacks sufficient documentation.	Reviewed patient medical records and documentation submitted in support of invoices.

Defining Improper Justifications and Authorizations. Based on the CFR, VHA Manual M-1, and the CBO Procedure Guide, as shown in Table 4, we used the following conditions to determine whether fee care was properly authorized or justified:

Table 4. Conditions Used To Determine Erroneous Payments

Condition	Audit Verification Approach
The service was not adequately justified for the use of fee.	Review of veteran medical records and requirements outlined in CBO Procedure Guide 1601F and CFR §17.52.
The service was not properly authorized.	Review of VistA Fee system authorization screen and authorization requirements in VHA Manual M-1, Chapter 18.

We performed our audit work from September 2008 through March 2009. Our assessment of internal controls focused only on those controls related to our audit objectives. We did not review the appropriateness or the quality of the care provided. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Sampling Methodology

We selected a representative sample of outpatient fee invoice payments to review for attributes related to eligibility, pre-authorization, and claim amount using standardized review criteria. We reviewed each claim to ensure that each beneficiary was eligible for outpatient fee care, clinical staff approved the medical services, and payments were accurate.

Population. The population consisted of 1,592,099 (or about 1.6 million) outpatient fee invoices paid between March 1, 2008 and August 31, 2008. Before selecting our sample, we asked VHA officials if significant variations affected the number of claims processed monthly. VHA officials told us that our 6-month review period was representative of the other 6 months in the fiscal year.

Sampling Design. Our review of invoice information required that we go onsite to VAMCs where these records are stored. We chose to select a two-stage sample where the first stage consisted of eight VAMCs and the second stage consisted of a sample of invoices within each selected VAMC. The first-stage sample was determined using probability proportional to size methodology where facilities with more invoices had a proportionately higher probability of being selected into the sample.

We selected our second-stage sample by creating a list of all outpatient fee claims originating from each selected VAMC, sequentially numbering them, and using a random number generator to select outpatient fee claims for review. We selected 100 paid claims from each VAMC. Table 5 lists the first stage VAMCs and the sampling weights for each stage of selection.

Table 5. Sample Summary

Station No	Medical Center	2nd Stage Invoices	Base Weight	Weighted Invoices
653	VA Roseburg HCS	4,233	1,491.58	149,158
667	Overton Brooks VAMC	9,983	1,957.05	195,705
636A8	Iowa City VAMC	15,430	2,108.58	210,858
593	VA Southern Nevada HCS	17,347	2,012.59	201,259
549	VA North Texas HCS	7,356	1,243.19	124,319
570	VA Central California HCS	7,450	1,333.56	133,356
618	Minneapolis VAMC	20,012	1,473.78	147,378
502	Alexandria VAMC	9,533	2,013.22	201,322

Estimation Methodology. We weighted sample invoices by the inverse of their probability of selection. The sampling weights were post-stratified using simple ratio adjustments so that sample-based projections of known population totals equal those

totals. We estimated sample projections and associated margins of error using a jackknife replication approach.

Projections and Margins of Error. The following tables show population projections and their associated lower and upper boundaries of the 90 percent confidence interval.

Table 6 presents the estimated number of claims that VAMCs improperly paid, including the type of error, the associated upper and lower limits at the 90 percent confidence interval, and the number of errors in our sample.

**Table 6. Summary of Improper Payments—Number of Claims
(Total Claims Paid During 6-Month Period = 1,592,099)**

Description/Error Type	6-Month Estimated Error Rate*	6-Month Estimated Total Errors	6-Month Lower 90%	6-Month Upper 90%	Sample = 800
Duplicate Payments					
– Straight Duplicate Payments	4%	68,207	47,788	88,626	34
– Duplicated Professional Fees	7%	116,944	91,174	142,715	55
Total Duplicate Errors	12%*	185,151	154,820	215,482	89
Incorrect Rates					
– Incorrect Professional Rates	8%	126,052	101,235	150,869	65
– Exceeded Maximum Rates	4%	62,873	43,053	82,692	30
– Outdated Rates	14%	228,392	195,747	261,037	115
Total Incorrect Rate Errors	26%	417,317	378,698	455,936	210
Other Errors	2%	25,165	12,341	37,989	12
Total Errors		586,259*	544,569	627,949	290
Total Error Rate	37%**		34%	39%	290
* Note: The total does not equal the sum of the components due to rounding.					
**Note: Total estimated number of claims with errors and estimated error rates do not equal the sum of the estimated components (duplicate payments, incorrect rates, and other errors) because some claims contained multiple types of errors and were only counted once in calculating the overall error rate.					

Table 7 presents the estimated total overpayments resulting from improperly paid claims for each type of error and the associated upper and lower limits at the 90 percent confidence interval.

**Table 7. Summary of Improper Payments—Overpayment Projections
(Total 6-Month Value of Paid Claims = \$812,776,234)**

Description/Error Type	6-Month Estimated Overpayment	6-Month Lower 90%	6-Month Upper 90%	FY 2008 Estimated Overpayment
Duplicate Payments				
– Straight Duplicate Payments	\$66,864,747	\$25,296,849	\$108,432,646	\$133,729,494
– Duplicated Professional Fees	\$11,548,753	\$6,721,057	\$16,376,449	\$23,097,506
Total Duplicate Errors	\$78,413,500	\$36,843,086	\$119,983,915	\$156,827,000
Incorrect Rates				
– Incorrect Professional Rates	\$8,191,475	\$4,902,794	\$11,480,157	\$16,382,950
– Exceeded Maximum Rates	\$14,370,907	\$5,290,147	\$23,451,667	\$28,741,814
– Outdated Rates	\$1,339,764	\$589,570	\$2,089,957	\$2,679,528
Total Incorrect Rate Errors	\$23,902,146	\$13,656,734	\$34,147,558	\$47,804,292
Other Errors	\$10,249,617	\$1,217,790	\$19,281,443	\$20,499,234
ALL OVERPAYMENTS	\$112,565,263	\$69,993,362	\$155,137,163	\$225,130,526

Table 8 presents the estimated total underpayments resulting from improperly paid claims for each type of error and the associated upper and lower limits at the 90 percent confidence interval and underpayments.

**Table 8. Summary of Improper Payments—Underpayment Projections
(Total 6-Month Value of Paid Claims = \$812,776,234)**

Description/Error Type)	6-Month Estimated Underpayment	6-Month Lower 90%	6-Month Upper 90%	FY 2008 Estimated Underpayment
Duplicate Underpayments	\$0	\$0	\$0	\$0
Incorrect Rate Underpayments				
– Incorrect Professional Rates	\$24,612,619	\$5,628,121	\$43,597,116	\$49,225,238
– Exceeded Maximum Rates	\$0	\$0	\$0	\$0
– Outdated Rates	\$1,410,668	\$615,286	\$2,206,049	\$2,821,336
Total Incorrect Rate Underpayments	\$26,023,286	\$7,058,243	\$44,988,330	\$52,046,572
Other Underpayments	\$0	\$0	\$0	\$0
ALL UNDERPAYMENTS	\$26,023,286	\$7,058,243	\$44,988,330	\$52,046,572

Table 9 presents the estimated number of claims that were improperly justified and authorized, including the associated upper and lower limits at the 90 percent confidence interval, and the number of errors in our sample.

**Table 9. Summary of Improper Justifications and Authorizations
(Total Claims Paid During 6-Month Period = 1,592,099)**

Description/Error Type	6-Month Estimated Error Rate	6-Month Estimated Total Errors	6-Month Lower 90%	6-Month Upper 90%	Sample = 800
Justification	72%	1,142,147	1,104,279	1,180,015	564
Authorization	55%	881,976	838,420	925,532	458
Total Errors		1,277,879*	1,241,736	1,314,022	633
Total Rate	80%*		78%	83%	633

***Note:** Total estimated number of claims with errors and estimated error rates do not equal the sum of the estimated components (justifications and authorizations) because some claims contained both types of errors and were only counted once in calculating the overall error rate.

Monetary Benefits in Accordance with IG Act Amendments

<u>Recommendations</u>	<u>Explanation of Benefits</u>	<u>Questioned Costs</u>
1-6	Strengthening controls over outpatient fee care will help to reduce overpayments and underpayments to fee providers over 5 years.	\$1,125,652,629 (\$260,232,863)
	Total:	\$865,419,766

Acting Under Secretary for Health Comments

**Department of
Veterans Affairs**

Memorandum

Date: JUL 20 2009

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report: **Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program** (Project No. 2006-2902-R8-0178) (WebCIMS 432428)

To: Assistant Inspector General for Audit (52)

1. I appreciate the opportunity to respond to this report, which I have carefully reviewed. I concur with your findings as well as your statement of monetary benefits. The conclusions about Fee Program administrative inefficiencies, as well as the magnitude of the program's estimated payment errors, concern me very much. VHA acknowledges that the Fee Program has lacked needed organizational structure and oversight in the past, but is now fully committed to focusing on program improvements as a top national priority. As our attached plan of corrective actions for each recommendation details, strong measures have already been initiated and involved program offices are closely coordinating to strengthen controls.

2. Before highlighting planned or ongoing corrective actions, I think it is important to address a few concerns about the report that might lead to misinterpretation by an uninformed reader. These issues have been discussed with your auditors, and we appreciate your willingness to consider including of clarifying statements in the final report. One issue involves the findings related to improper justifications for payment. As currently written, the identified issues focus more on how justification is documented rather than the actual clinical necessity of the service. This could be misinterpreted to mean that VA was routinely purchasing unnecessary services, which is clearly not the case.

3. I also have concerns that information technology (IT) gaps were not identified as key drivers in the erroneous payments. While we agree that clear, concise and timely policy is an integral component for all programs of this massive scale, the most significant issue currently facing this program is antiquated technology support. Many of the claims are still manually processed by administrative clerks, and few upgrades have been made in the Veterans Health Information Systems Technology Architecture (VistA) Fee system in the past ten years. We are addressing these technology needs. The Chief Business Office (CBO) has a detailed plan in place that addresses the IT changes that are needed to support the program. This plan includes both an interim technical solution, as well as a long-term plan to resolve both business processes and technology changes. Funding for these technological needs is fundamental to the effective administration of the Fee Care Program, and VHA will continue to vigorously seek needed resource support.

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4. Apart from these observations, I believe that your conclusions and recommendations correctly target needed reforms that the CBO, in conjunction with other program offices, has already initiated. For example, the CBO is revising and updating fee policies and detailed procedural guides to initiate more standardized justification processes and authorizations for fee care at all facilities. At the same time, the CBO has partnered with the Austin Information Technology Center Central Fee Unit to develop new central fee reports that will better identify evidence of duplicate payment transactions.

5. In addition, the CBO and the VHA Chief Procurement and Logistics Office (CPLO) are preparing joint guidance to field facilities outlining claims processing requirements. The CBO has also developed a new IT Service Request to update and expand VistA Fee capability and will develop core competencies for fee staff and supervisors that will be linked to training objectives, as recommended.

6. An important part of establishing a strong organizational structure to administer the highly complex, decentralized Fee Program is the development and implementation of oversight procedures to ensure program compliance with established requirements. Both the CBO and the Office of Compliance and Business Integrity (CBI) have been working in close coordination to establish effective oversight mechanisms. For example, the CBO established a Field Assistance Office in April 2009 to oversee implementation of nationally-identified business operational procedures to ensure standardization and efficiency in the purchased care programs. Field Assistance staff will provide data analysis and field assistance visits to VA facilities experiencing backlogs in processing fee claims. One team, comprised of subject matter experts in this program area, has already made 22 site visits has conducted post visit conference calls to review performance and provide additional assistance. Additional teams will be established on an ongoing basis. The CBO is also exploring the effectiveness of multiple pilot initiatives intended to improve program performance. At the same time, the CBI has been provided with support to initiate and strategically roll out a multi-faceted compliance business oversight plan that will include Fee Basis/Purchased Care programs. Development of the compliance oversight plan is still in the early design phase. To facilitate progress, CBI has entered into a contract with an experienced private consulting firm, which will provide guidance and technical support in the development of this endeavor.

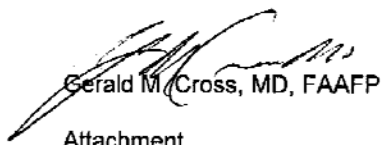
7. In summary, VHA acknowledges that major organizational intervention is required at all levels to restructure and oversee the VHA Outpatient Fee Care Program. VHA is committed to supporting this effort, with the understanding that the process will be lengthy and ongoing. I appreciate the cooperation of your auditors in working closely

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with VHA program managers, and I understand that they will continue to provide VHA with detailed claims review data so that appropriate follow-up assessments can be completed to better determine the reasons for improper payments.

8. Thank you again for the opportunity to respond to this report. If additional information is required, please contact Margaret M. Seleski, Director, Management Review Service (10B5), at 461-7245.



Gerald M. Cross, MD, FAAFP

Attachment

VETERANS HEALTH ADMINISTRATION
 Action Plan Response
 OIG Draft Report: **Audit of Veterans Health Administration's Non-VA Outpatient
 Fee Care Program (Project No. 2006-2902-R8-0178)**

Recommendations/ Actions	Status	Completion Date
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1. We recommend that the Acting Under Secretary for Health revise and publish fee policies that establish clear requirements for how VAMCs should justify and authorize outpatient fee care.

Concur

Although existing policies already establish authorization and justification processes for the purchases of non-VA care on a fee basis, VHA agrees that these policies should be updated, with clarifying direction that better reflects current organizational responsibilities. We reiterate, however, that the lack of an effective automated information technology (IT) infrastructure to support the fee program offices in conducting cost analyses is more of a contributing factor to the issues raised by this recommendation than the alleged absence or obscurity in policy.

The Chief Business Office (CBO) has already initiated plans to publish updated fee policies and anticipates that the revisions should be completed for field distribution by the end of October 2009.

In Process

October 31, 2009

2. We recommend that the Acting Under Secretary for Health develop and publish detailed fee claim processing procedures that provide specific instructions on how to prevent duplicate payments, review justifications and authorizations, and perform cost analyses.

Concur

The CBO, in conjunction with various clinical and administrative program offices, has begun to upgrade detailed procedural guides that will be issued to support more standardized justifications and authorizations for fee care, as well as to provide processes that should be utilized for the reduction of duplicate payments. This procedural guide is estimated to be completed by the end of October 2009.

For example, the CBO is working in conjunction with the Office of Dentistry to publish additional instructions to field facilities in processing fee dental claims. This guidance will be completed by the end of July 2009. In this regard, the CBO will also work jointly

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with the Office of Dentistry to augment specific dental modules. In addition, the CBO will ensure that a sample of dental claims will be included in future audits.

In coordination with the Office of Geriatrics and Extended Care, the CBO will also publish national guidance regarding payment of Home Health and other special services covered under Medicare's low utilization payment adjustment (LUPA) rates. This guidance should be available to the field by the end of October 2009.

At the same time, the CBO has partnered with the Austin Information Technology Center (AITC) Central Fee Unit to develop new central fee reports for fee sites that will identify possible duplicate payment transactions within one fee site and between fee sites. These reports should also be implemented by October 2009.

In Process

October 31, 2009

3. We recommend that the Acting Under Secretary for Health develop and publish detailed procedures to ensure fee staff have access to all contract rate information needed to accurately pay fee claims.

Concur

The Chief Business Office and the VHA Chief Procurement and Logistics Office (PCLO) will jointly develop guidance to the field facilities to include the following requirements: that the sites develop a plan for ensuring that all fee staff and other staff processing claims for health care services have a copy of contract requirements, which include pricing information, as well as a mandate to process any payments for health care services through the Veterans Health Information Systems Technology Architecture (VistA) Fee modality. This will ensure that all sites have workload credit entered and also allows VHA an opportunity at the national level to assess payment trends. The CBO will ensure that these claims are included in future audit plans. This guidance is expected to be completed by July 2009.

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VHA Action Plan/OIG Draft Report: **Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program** (Project No. 2006-2901-R8-0178)

The CBO has also developed a New IT Service Request (Update to VistA Fee) that will more readily identify those payment types to assist with providing more accessible information concerning payments made under these types of contracts and to allow for more robust oversight to ensure accuracy of payment processing.

In Process

December 31, 2009

4. We recommend that the Acting Under Secretary for Health identify core competencies for fee staff and supervisors and develop and implement mandatory initial and periodic training to address the required competencies.

Concur

The CBO currently has a significant number of training packages, and has developed new modalities during the current fiscal year that provide more options for field-based staff to participate, including use of Live Meeting and satellite broadcasts to enhance remote opportunities. One of the modules developed addresses the clinical review and oversight requirements of the program.

The CBO will develop a plan to identify core competencies for fee staff and supervisors and link these core competencies to learning objectives, as well as develop a plan to identify universally-applied mandatory training requirements and implement a systematic tracking system to ensure compliance with these mandatory trainings.

In Process

October 31, 2009 and Ongoing

5. We recommend that the Acting Under Secretary for Health establish clear oversight responsibilities for the Fee Program and implement oversight procedures to regularly monitor program compliance and performance.

Concur

The CBO and the Compliance and Business Integrity Office (CBI) have been working in close coordination to develop oversight and program compliance with requirements. While much progress is being made, we agree that additional long-term oversight is required. The CBO has established a Field Assistance Office to provide technical and training support to facilities with fee claim processing backlogs. CBO has established

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VHA Action Plan/OIG Draft Report: **Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program** (Project No. 2006-2901-R8-0178)

the first of multiple Field Assistance Teams, comprised of subject matter experts, and twenty-two site visits have been conducted to date. The teams provide a broad range of technical assistance to field facilities in the development of structured business practices. In addition, the CBO has been managing multiple pilot initiatives intended to improve program effectiveness, including the assessment of various technology improvements that might be implemented.

The CBI Office acknowledges the potential risk and material weaknesses that the VHA Fee Basis program poses and will play a key role in establishing and implementing a compliance business oversight plan. Toward that end, the CBI Strategic Plan for Fiscal Year (FY) 2010 and beyond clearly delineates this program as one of its strategic goals. In FY 2008, funding was requested and received in FY 2009 that will allow CBI to initiate and strategically roll out a comprehensive compliance business oversight plan that encompasses Fee Basis /Purchased Care programs.

The Under Secretary for Health approved a CBI reorganization in FY 2008, which included addition of a special section that focuses on the targeted oversight of purchased care. CBI established a field office in Secaucus, New Jersey to implement the reorganization. A program director was recently hired for the oversight sections for purchased care and consolidated care. Several additional staff have been hired and more personnel are being recruited to administer these sections.

CBI has also entered into a contract with a private consultant with broad and comprehensive experience in the area of health care compliance industry standards, established benchmarks, best practices and research-supported administrative processes that have proven effective in the purchased care arena. The consultant will provide guidance and technical support and expertise in the development of CBI's compliance business oversight plan for purchased care, as well as for the development of an implementation strategy, organizational oversight structure and educational and training materials to assist in the plan roll out. We anticipate that the preliminary design phase for the oversight plan should be completed by the third quarter of FY 2010.

The CBO and CBI have also collaborated with the VA Management Quality Assurance Service (MQAS) on review efforts related to Fee Basis care. MQAS has completed five expense reviews in FY 2009 and an additional four are either in progress or planned.

Although CBI has not yet provided concrete guidance on monitoring and auditing potential risks in the purchased care arena, the office has recently initiated guidance to

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provide consultation and some recommended monitoring tools to assist in initiating compliance oversight of this program. As already noted, both the CBI and the CBO will work in close coordination in the multi-phased development of the business oversight plan for purchased care.

In Process

March 2010 and Ongoing

6. We recommend that the Acting Under Secretary for Health instruct the eight sampled VAMCs to initiate recovery of overpayments and reimbursement of underpayments identified by our audit.

Concur

The CBO will work directly with the eight sites to develop an action plan for completing the necessary recoupments and reimbursements associated with the 800 cases reviewed by the OIG. Given the complex nature of the regulations and pricing activities guiding these programs, the CBO has requested a complete copy of these claims and payment histories from the OIG to determine exact amounts to be resolved.

In Process

September 30, 2009

7. We recommend that the Acting Under Secretary for Health coordinate with VA General Counsel to obtain regulatory authority that addresses the payment of outpatient facility charges.

Concur

This recommendation has been activated. The re-write of 38 CFR 17.56 was completed on June 11, 2009, in conjunction with the VA Office of Regulatory Affairs. The draft regulation is currently under review by the Office of General Counsel (OGC). VHA will continue to coordinate the required regulatory effort necessary to address the payment of outpatient facility charges with OGC.

In Process

September 30, 2009

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VHA Action Plan/OIG Draft Report: **Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program** (Project No. 2006-2901-R8-0178)

8. We recommend that the Acting Under Secretary for Health develop and disseminate interim guidance to instruct VAMCs on how to pay outpatient facility charges.

Concur

The CBO has begun the development of this procedural guide that incorporates existing guidance regarding payment of facility charges.

As already noted, the lack of an automated IT infrastructure to support fee office staff in paying facility charges is more of a contributing factor to this issue than the failure to follow existing or interim guidance. The CBO has submitted numerous technology change requests to improve the VistA Fee product supporting this program.

In Process

August 31, 2009

OIG Contact and Staff Acknowledgments

OIG Contact	Claire McDonald, 206-220-6651
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Acknowledgments	Gary Abe Barry Johnson Todd Groothuis Matthew Rutter Melinda Toom Orlando Velasquez Sherry Ware Lee Giesbrecht
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