

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



Department of Veterans Affairs

*Review of
Alleged Mismanagement
of Non-VA Fee Care Funds
at the Phoenix VA Health
Care System*

November 8, 2011
11-02280-23

ACRONYMS AND ABBREVIATIONS

CPRS	Computerized Patient Record System
HCS	Health Care System
LTAH	Long Term Acute Hospital
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Report Highlights: Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System

Why We Did This Review

The Office of Inspector General received an allegation of mismanagement of non-VA fee care funds at the Phoenix VA Health Care System (HCS). This review assessed the allegation that mismanagement of the Non-VA Fee Care Program at the Phoenix HCS resulted in a \$12 million budget shortfall at the end of FY 2010.

Since 2009, we have reported that the Veterans Health Administration faced significant challenges to address serious nationwide weaknesses in this program's controls. We also reported that this program needed immediate management attention given the magnitude of the payment errors.

What We Found

We substantiated that the Phoenix HCS experienced a budget shortfall and mismanaged fee care funds in FY 2010. We determined the shortfall to be \$11.4 million, 20 percent of the FY 2010 Non-VA Fee Care Program funds. The shortfall occurred because the HCS lacked effective pre-authorization procedures for Long Term Acute Hospital fee care. Additionally, HCS staff did not monitor inpatient fee care patients to determine if the patients could receive services in a VA facility.

Authorization procedures were so weak that the HCS processed about \$56 million of fee claims during FY 2010 without adequate review. Further, the HCS did not have

adequate procedures to obligate sufficient funds to ensure it could pay its commitments for these services. However, since the discovery of the budget shortfall, the HCS has initiated several corrective actions to reduce the risk of future shortfalls and strengthen the management of their Non-VA Fee Care Program.

What We Recommended

We recommended that the Interim Director of the Phoenix VA Health Care System establish monitoring procedures to ensure that the official designated to pre-authorize fee care thoroughly reviews fee care requests, clinical staff conduct necessary utilization and concurrent reviews, and fee staff obligate sufficient funds for approved fee care.

Director's Comments

The Phoenix HCS Interim Medical Center Director agreed with our finding and recommendations and plans to complete all corrective actions by December 2011. We consider these planned actions acceptable, and we will follow up on their implementation.

A handwritten signature in black ink that reads "Belinda J. Finn".

BELINDA J. FINN
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Objective	This review assessed an allegation submitted to the Office of Inspector General (OIG) that the Phoenix Health Care System (HCS) had a budget shortfall due to the mismanagement of their Non-VA Fee Care Program.
Hotline Complaint	On March 28, 2011, the OIG received an allegation that the Phoenix HCS mismanaged their Non-VA Fee Care Program, which resulted in a \$12 million budget shortfall at the end of FY 2010. The allegation pointed to a sharp increase in the use of Long Term Acute Hospital (LTAH) fee care due to a lack of pre-authorization procedures and alleged that the Phoenix HCS did not have adequate procedures in place to properly record obligations for fee care during FY 2010.
Phoenix VA Health Care System	The Phoenix HCS is part of Veterans Integrated Service Network (VISN) 18 and consists of a tertiary hospital located in Phoenix, AZ, and seven community based outpatient clinics. The Phoenix HCS provides medical services to about 81,000 unique veterans annually and had a total budget of about \$438 million in FY 2010, of which the facility budgeted \$56 million (13 percent) for their Non-VA Fee Care Program.
Description of the Non-VA Fee Care Program	The purpose of the Non-VA Fee Care Program is to assist veterans who cannot easily receive care at a VA medical facility. This program pays the medical care costs of eligible veterans who receive care from non-VA providers when VA is unable to provide specific treatments or provide treatment economically because of the veteran's geographical inaccessibility. Fee care may include dental services, outpatient care, inpatient care, emergency care, and medical transportation. Pre-authorization is required for non-emergency inpatient and outpatient care.
Prior OIG Audits	The OIG issued <i>Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program</i> (Report No. 08-02901-185, August 3, 2009) and <i>Alleged Mismanagement of the Fee Basis Program VA Connecticut Healthcare System West Haven, Connecticut</i> (Report No. 09-01219-141, June 3, 2009). OIG concluded in both of these reports that controls over pre-authorizing fee care services needed improvement. We also reported that the magnitude of the fee care program's payment errors indicated the Veterans Health Administration (VHA) faces significant challenges in addressing the healthcare and financial vulnerabilities associated with this program.

RESULTS AND RECOMMENDATIONS

Finding **Phoenix VA Health Care System Had a Budget Shortfall of \$11.4 Million in FY 2010**

We substantiated the allegation that the Phoenix HCS had a budget shortfall at the end of FY 2010. We determined the shortfall to be \$11.4 million (20 percent of the FY 2010 Non-VA Fee Care Program funds) rather than the alleged \$12 million. We found that the HCS did not have effective pre-authorization procedures for fee care and did not conduct utilization and concurrent reviews of patients receiving LTAH fee care. Additionally, the HCS did not ensure sufficient funds were obligated to pay fee care claims.

These problems occurred because HCS management did not have sufficient procedural and monitoring controls to ensure that: (1) the official designated to pre-authorize fee care thoroughly reviewed requests, (2) clinical staff conducted necessary utilization and concurrent reviews, and (3) fee staff obligated sufficient funds for fee care. As a result, the Phoenix HCS had to obtain additional funds from the National Fee Program and VISN 18 and cancel equipment purchases to cover the \$11.4 million shortfall.

Pre-Authorization Procedures Ineffective

The Phoenix HCS did not have effective pre-authorization procedures over the \$4.5 million they spent for LTAH fee care during FY 2010. Since the medical records of the veterans who received the LTAH care did not justify the use of this care, we attributed \$4.5 million (39 percent) of the \$11.4 million shortfall to uncontrolled and unsupported spending for LTAH care. VHA policy requires that the facility Chief of Staff or their formal designees pre-authorize non-VA fee care prior to a veteran receiving medical services. This is to ensure the request is appropriate and that medical facility management is aware of how they are utilizing fee services.

Part of the pre-authorization process is a requirement to conduct utilization reviews to evaluate the medical necessity, efficiency, or appropriateness of services and treatment plans for patients receiving inpatient fee care. A utilization review is an assessment of requests for fee care by nursing staff to ensure the requests are medically necessary and a VA facility cannot reasonably provide the care.

The Phoenix HCS sent 31 veterans to two non-VA long-term acute care providers for ventilator weaning during FY 2010. The medical records of the 31 veterans did not adequately justify the HCS's extended use of LTAH fee care. For example, the documentation for 6 (19 percent) of the 31 requests were for long-term care, such as a skilled nursing facility, rather than for the much more intensive and expensive long-term acute care. However, there

were no requests for clarification from the pre-authorizing official, such as asking requesting physicians about the medical necessity or requesting a utilization review to determine whether VHA could provide the services.

The Phoenix HCS did not have effective pre-authorization procedures for LTAH fee care because the Chief of Staff delegated the responsibility for reviewing and pre-authorizing virtually all of the fee care claims (budgeted at approximately \$56 million) to one physician in FY 2010. The physician told us that he pre-authorized hundreds of requests per week while also performing other clinical responsibilities.

He acknowledged routinely approving requests for LTAH care with no substantive questions or requests for additional information. In addition, the HCS did not have a utilization review team to ensure the HCS evaluated the medical necessity, efficiency, or appropriateness of services and treatment plans for patients receiving LTAH fee care. Authorization procedures were ineffective because HCS management did not adequately monitor the delegated physician to ensure the HCS only authorized appropriate fee care requests.

Opportunities for processing improper payments increase significantly in the absence of effective controls. The mismanagement of fee authorization procedures at the Phoenix HCS introduces risks to the Non-VA Fee Care Program, such as authorizing:

- Diagnostic tests or procedures that are not medically necessary.
- Services that are available at a VA medical facility.
- Unnecessary and often excessive numbers of therapy treatments.

Since October 2010, Phoenix HCS management has recognized these risks and has established a utilization review team. In January 2011, HCS management also delegated the responsibility for overseeing the pre-authorization of fee care to a different physician solely dedicated to managing the pre-authorization process.

**Concurrent
Reviews Not
Conducted**

The Phoenix HCS did not conduct concurrent reviews for patients sent to the two LTAH fee care providers for ventilator weaning. VHA requires a concurrent review, which is an assessment that determines medical necessity or appropriateness of services during a patient's hospital stay or course of treatment. This review assesses the need for continued inpatient care for hospitalized patients and includes continued-stay authorization and discharge review.

The Phoenix HCS paid for over 30 consecutive days of long-term acute care for 15 (48 percent) of 31 of these patients. The longest stay was 162 days

(over 5 months). The Chief of Staff and Chief of Intensive Care told us that 30 days was a reasonable limit to attempt ventilator weaning. If the veteran had not weaned in that time, then the HCS needed to re-evaluate the appropriateness of continued weaning and consider alternative medical options. Timely concurrent reviews would have assessed the need for continued ventilator weaning or a different course of treatment, thus reducing the cost of fee care.

The average cost paid for LTAH care by the HCS during FY 2010 exceeded \$2,600 per day. The Phoenix HCS did not conduct these reviews because the HCS management did not commit the attention and resources needed to provide the staffing necessary to have a concurrent review team. Since October 2010, Phoenix HCS management has recognized the need to monitor these veterans and has developed a utilization review team.

***Inadequate
Funds
Obligated***

The Phoenix HCS did not obligate sufficient funds for fee care. We attributed the remaining \$6.9 million (61 percent) of the \$11.4 million budget shortfall to fee staff obligating insufficient funds to pay for fee care services provided during FY 2010. VHA policy requires VA medical staff to submit requests for non-emergency fee care to the health care facility chief of staff or their formal designees for pre-authorization of fee care.

VA medical staff initiate their requests for fee care by entering the request in the Computerized Patient Record System (CPRS) and then sending it to the official designated to pre-authorize the type of fee care requested. CPRS notifies the fee staff when the fee care is pre-authorized. The fee staff enter the request into the fee payment system and obligate sufficient funds to pay for the specified care.¹ The medical facility then provides an approval letter to the patient to obtain the approved care from a non-VA provider.

The Phoenix HCS fee staff frequently paid claims for non-emergency fee care that was not pre-authorized. This occurred because HCS lacked adequate fee authorization processing controls. Although VA medical staff initiated their requests for fee care by entering the request in CPRS, they did not send it to the designated pre-authorization official. Instead, medical staff provided a copy of the request for fee care directly to veterans. The veterans presented the hardcopy fee request to their non-VA providers as authorization of care. Since the requested care was not pre-authorized, the fee staff were unaware of the care and did not obligate funds to cover costs of care. Later when fee staff received the invoice, they entered the request into the fee payment system and paid the invoice.

¹ VA pays Medicare rates for most inpatient and outpatient medical services. The Centers for Medicare and Medicaid services publishes these rates annually and were available to fee staff to create appropriate obligation amounts.

The fee staff did not obligate sufficient funds for all types of approved inpatient and outpatient fee care. For example, during FY 2010, fee staff obligated \$200 for six physical therapy sessions, but the cost of the six sessions was about \$1,000. They also obligated \$300 for a routine magnetic resonance imaging procedure, but the cost of the service was about \$800. This occurred because the fee staff did not take the time to calculate an estimated cost based upon appropriate pricing rates. The fee staff also did not obligate additional funds to cover higher than expected LTAH costs because HCS medical staff did not adequately monitor the patients' length of stay and inform the fee staff when a patient stayed longer than expected.

Due to the FY 2010 budget shortfall, the Phoenix HCS improved the controls over the fee authorization process in FY 2011. HCS management provided training to the HCS physicians regarding the importance of ensuring fee care is pre-authorized. They also added a statement to the fee request so that if the request is printed, it states that the request is not an authorization for payment. HCS fee management has also instituted a review process to update fee obligation amounts to reflect the expected payment amounts more accurately.

Effects of Shortfall

The Phoenix HCS made up the \$11.4 million shortfall by obtaining \$2.3 million in special funding from the National Fee Program, acquiring \$5.3 million in supplemental funding from VISN 18, and canceling \$3.8 million in equipment and other purchases. In addition, to emphasize the seriousness of the shortfall, the VISN reduced the Phoenix HCS's FY 2011 budget by \$2 million.

Conclusion

We substantiated that the Phoenix HCS experienced a budget shortfall of \$11.4 million and mismanaged fee care funds in FY 2010. Program management was ineffective because the HCS processed FY 2010 claims, budgeted at about \$56 million, without adequate review. The Phoenix HCS has substantially changed the control environment we audited. Its corrective actions, if implemented consistently and successfully, should improve the management of the Non-VA Fee Care Program. However, it will take HCS management's time and attention to monitor properly these corrective actions to ensure the actions become a permanent part of the management of this program.

Recommendations

1. We recommended that the Interim Director of the Phoenix VA Health Care System establish monitoring procedures to ensure that the delegated approving officials pre-authorize only fee care requests that are medically necessary or for services that a VA facility cannot provide.
2. We recommended that the Interim Director of the Phoenix VA Health Care System establish monitoring procedures to ensure that the utilization

review team reviews fee care requests to determine that requests are medically necessary or for services that a VA facility cannot provide.

3. We recommended that the Interim Director of the Phoenix VA Health Care System establish monitoring procedures to ensure that the concurrent review team ensures that hospitalized veterans need continued inpatient fee care.

4. We recommended that the Interim Director of the Phoenix VA Health Care System establish monitoring procedures to ensure that fee staff obligate sufficient funds to pay for approved fee care.

**Management
Comments
and OIG
Response**

The Phoenix HCS Interim Medical Center Director agreed with our finding and recommendations and provided responsive implementation plans to address our recommendations. The Phoenix HCS has designated a full-time Utilization Management Physician as the approving authority for fee consults and designated a utilization review team to review all fee consults and conduct concurrent reviews for all veterans while receiving inpatient fee care. The utilization review staff will review a minimum of 30 fee consults monthly to ensure that all authorized fee care requests are medically necessary or for services that a VA facility cannot provide. The HCS Office of Compliance will report the results of quarterly audits of this monitor to senior leadership quarterly.

In addition, the Phoenix HCS is establishing a process to appropriately estimate and track the funds needed to pay for requested services. The Manager Fee Basis will audit at least 30 newly created fee basis items monthly and the Office of Compliance will audit fee basis obligations quarterly. The HCS plans to complete all corrective actions by December 2011.

The implementation plan is acceptable, and we will follow up on the planned actions until they are completed. Appendix B contains the full text of the Interim Medical Center Director's comments.

Appendix A Scope and Methodology

We conducted site visits to the Phoenix HCS and reviewed all 31 claims the facility paid to LTAHs between October 1, 2009, and September 30, 2010. We reviewed the medical facility's fee authorization, utilization review, and budget processes. In addition, we interviewed the complainant, the HCS Interim Director, the Chief of Staff, and clinical and administrative staff. We also assessed the results of a financial review performed by VISN 18 officials and the preliminary results of an Administrative Investigation Board review of the facility, which included issues related to the Non-VA Fee Care Program.

Reliability of Computer- Processed Data

We used computer-processed data obtained from the Veterans Health Information Systems and Technology Architecture to determine fee billing and payment information during the period October 1, 2009, through September 30, 2010. To test the reliability of this data, we compared relevant computer-processed data with hardcopy documents, such as claims and medical records. We found no significant discrepancies and concluded the billing and payment data was sufficiently reliable for the review objective.

Government Inspection and Evaluation Standards

We conducted our work from March 2011 through September 2011. Our assessment of internal controls focused on those controls relating to our review objective. We conducted this review in accordance with the Council of Inspectors General on Integrity and Efficiency's Quality Standards for Inspection and Evaluation. We planned and performed the review to obtain sufficient, appropriate evidence to provide a reasonable basis for our finding and conclusions based on our review objective. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our review objectives.

Appendix B Phoenix VA Health Care System Interim Director Comments

Department of Veterans Affairs

Memorandum

Date: October 11, 2011

From: Interim Medical Center Director, Phoenix VA Health Care System (644/00)

Subj: Response to Draft Report: Review of Allegation of Mismanagement on Non-VA Care Funds at Phoenix VA Health Care System (Project No. 2011-02280-R8-0151)

To: Director, Seattle Audit Operations Division (52SE)

Thru: Director, VA Central Office (10N)
VISN 18 Network Director (10N18)

1. The following response is provided regarding the Office of the Inspector General's draft report of allegations regarding mismanagement of Non-VA Care Funds.
 - a. Recommendation 1. We recommend that the Interim Director of the Phoenix VA Health Care System establish monitoring procedures to ensure that the delegated approving officials pre-authorize only fee care requests that are medically necessary or for services that a VA facility cannot provide.

Concur

Target Completion Date: December 1, 2011

Action Taken: The Phoenix VA Health Care System (PVAHCS) has substantially changed the control environment for the fee care program. Corrective actions have been implemented to improve the management of the fee care program. The Phoenix VA HCS has established a clinical authorization process to carry out provisions of M-1, Part 1 Chapter 18, Change 3, July 20, 1995. The Chief of Staff has designated a full-time Utilization Management Physician as well as specialty care Service Chiefs as the approving authority for the clinical review of fee consults. A utilization review team has been designated for the administrative review of all fee consults. Delegation of Authority letters are in place. All fee consults are reviewed based on the guidance from the national fee office and Title 38 part 17: emergency request, administrative eligibility, consult accuracy, hierarchy of care, justification of service and service connection status. Utilization review staff will implement a monitor to review a minimum of 30 fee consults submitted each month to ensure that only fee care requests that are medically necessary for services that a VA facility cannot provide are pre-authorized. The Phoenix VA Health Care System Office of Compliance will perform quarterly audits of this monitor which will be reported to senior leadership.

- b. **Recommendation 2.** We recommend that the Interim Director of the Phoenix VA Health Care System establish monitoring procedures to ensure that the utilization review team reviews fee care requests to determine that requests are medically necessary or for services that a VA facility cannot provide.

Concur

Target Completion Date: December 1, 2011

Action Taken: The Phoenix VA Health Care System utilization review staff will implement a monitor to review a minimum of 30 of fee consults submitted each month to ensure that fee care requests are reviewed to determine that requests are medically necessary or for services that a VA facility cannot provide. The Phoenix VA Health Care System Office of Compliance will perform quarterly audits of this monitor which will be reported to senior leadership.

- c. **Recommendation 3.** We recommend that the Interim Director of the Phoenix VA Health Care System establish monitoring procedures to ensure that the concurrent review team ensures that hospitalized veterans need continued inpatient fee care.

Concur

Target Completion Date: December 1, 2011

Action Taken: The Phoenix VA Health Care System will establish a process for utilization review nurses to conduct continued stay concurrent reviews on 100% of veterans who are hospitalized under fee care to evaluate and ensure the clinical necessity of continued inpatient fee care utilizing InterQual criteria. Veterans who are identified as no longer meeting the intensity of service to justify continued hospitalization and are beyond the point of stability will be placed on a variance list. After identifying the variances, the utilization review nurses will notify the designated physician advisor or hospitalist on call of each instance to facilitate and expedite discharge or transfer of these veterans from inpatient fee care. The utilization review nurses identifying the variances will note the status on the authorization. The Phoenix VA Health Care System utilization review staff will implement a monitor to review a minimum of 30 fee veterans hospitalized under fee care each month to ensure that hospitalized veterans need continued inpatient fee care. The Phoenix VA Health Care System Office of Compliance will perform an annual audit of this monitor.

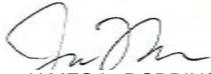
- d. **Recommendation 4.** We recommend that the Interim Director of the Phoenix VA Health Care System establish monitoring procedures to ensure that fee staff obligate sufficient funds to pay for approved fee care.

Concur

Target Completion Date: December 1, 2011

Action Taken: The Phoenix VA Health Care System is establishing a process wherein the Manager Fee Basis will ensure all authorized consultations for Fee Basis care is entered into the Fee Basis Claims System (FBCS) software and appropriate funds are obligated to each Fee Basis Authorization. The Fee Basis staff will utilize the reporting features of the Computerized Patient Record System (CPRS) to ensure all approved consults are identified and a matching Fee Basis Authorization is created for each authorized episode of care. All new Fee Basis Authorizations will record the consultation number. This process will ensure the creation of the authorization based on the consultation, the recording of the appropriate estimated obligated amount for the services requested, and the ability to track the expenditures of the estimated obligated amount. The tracking of these expenditures will allow for increasing/decreasing of funds, as required. The Manager Fee Basis will conduct an audit of at least 30 newly created Fee Basis Authorization cases on a monthly basis to ensure Fee Basis Authorizations are created and funded appropriately. This audit will be accomplished by utilizing the reporting capabilities of FBCS and VISTA. The Phoenix VA Health Care System Office of Compliance will perform quarterly audits of this monitor which will be reported to senior leadership.

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2. Please contact Kathy Sloan, Executive Assistant to the Director, PVAHCS at 602-277-5551, ext 2658, if you have any questions



JAMES L. ROBBINS, M.D.
Interim Medical Center Director



SUSAN P. BOWERS
Network Director, VISN 18

Appendix C **OIG Contact and Staff Acknowledgments**

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Acknowledgments	Gary Abe, Director Barry Johnson
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Appendix D Report Distribution

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