

**STATEMENT OF
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DEPARTMENT OF VETERANS AFFAIRS
BEFORE
THE UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
HEARING ON THE DEPARTMENT OF VETERANS AFFAIRS
PROGRESS IN ITS THIRD PARTY COLLECTIONS PROGRAM
JULY 21, 2004**

Mr. Chairman, and Members of the Subcommittee, I appreciate the opportunity to be here today and to report on our ongoing work concerning the Department of Veterans Affairs (VA) Medical Care Collections Fund (MCCF) Program. During the past several years, the Office of Inspector General (OIG) has dedicated significant resources to identify opportunities to improve MCCF collections and revenues and to find solutions for the financial and management challenges facing the Department's MCCF Program.

In February 2002, we issued an audit report on the Department's MCCF activities (*Audit of the Medical Care Collections Fund Program*, Report Number 01-00046-65, dated February 29, 2002) that identified opportunities to increase collections. We found that the Veterans Health Administration (VHA) could increase Fiscal Year (FY) 2000 collections by \$135.2 million after collections remained relatively stagnant for a 3 year period. Additionally, my auditors found that clearing the backlog of "unissued bills" totaling over \$1 billion would result in additional collections of \$368.4 million.

We made several recommendations to improve the collection process, increase revenue for VA, and to improve financial management practices. Recommendations were made to the Department to improve the quality of medical record documentation needed to bill for services, establish performance standards, and strengthen pre-registration efforts to identify insured patients, insurers, and insurance information.

We also reported on problems with the accuracy of coding on bills sent to insurers for collection in February 2002. Our report (*Evaluation of VHA's Coding Accuracy and Compliance Program*, Report Number 01-00026-68, dated February 25, 2002), showed that VA employees needed to focus their attention on reducing coding error rates for outpatient visits and to improve internal controls.

The review found that about 50 percent of the 570 outpatient visits reviewed contained coding errors. Recommendations were made to VHA to better educate clinicians on the necessary documentation requirements to accurately bill for services rendered, and to require managers to establish incremental goals to improve coding accuracy.

Similar issues were discussed with the Subcommittee at a hearing held in September 2001 where we reported that the effectiveness of billing reasonable charges relies upon accurate documentation of the medical care provided, use of consistent business processes, and compliance with policies and procedures. Although we reported collections were increasing in FY 2001, our audit results showed potential for significant additional collections. Many of these same conditions persist today, including missed billing opportunities, billing backlogs, accounts receivable management weaknesses, and procedures to identify and verify patient insurance coverage.

Since these reviews and the September 2001 hearing, VHA has aggressively worked to improve their collection efforts. As demonstrated in FY 2003, VHA increased revenues, met our reported projections, and collected about \$804 million. These results validated our findings and recommendations for enhancing monetary program recoveries through aggressive collection efforts.

While VHA has increased its collections, we continue to identify opportunities to increase MCCF revenues, and the need to improve internal controls to strengthen billing and monitoring practices. Our most recent work addressing MCCF collection activities has been conducted as part of our Combined Assessment Program (CAP) reviews. From March 31, 1999, through June 30, 2004, we issued about 50 CAP reports on VHA medical facilities that highlighted MCCF collection activities. During these reviews, we identified control deficiencies that have hindered VA's ability to maximize its revenues via collections from health insurers. Recent CAP reviews continue to show the need for VHA to improve processing and collections of accounts receivable in such areas as unbilled and delinquent accounts receivable, coding for medical services, and to ensure timely follow-up of accounts receivable.

For example, our CAP review performed at the VA Medical Center (VAMC) in Houston, TX (Report Number 03-01379-115, dated June 19, 2003), identified coding inconsistencies. During the review, we judgmentally sampled 25 accounts receivable valued at about \$1.2 million. Three of the bills valued at about \$197,000 contained coding errors that resulted in insurance carriers being under billed for almost \$96,400. VAMC staff needed to ensure that only bills with correct diagnostic and procedure codes were sent to insurers for collections. The erroneous bills have been amended and re-issued with correct information, and

plans have been developed by the VAMC to review and correct coding of other bills.

Our CAP review at the VA Medical Center in Togus, ME (Report Number 03-02729-120, dated April 2, 2004) identified almost 26,000 unbilled claims for episodes of care totaling approximately \$6.5 million for a 1 year period, September 26, 2002, through September 26, 2003. The facility's MCCF Coordinator estimated that approximately 30 percent of the unbilled episodes, valued at more than \$1.9 million, represented billable episodes of care. Applying the medical center's FY 2003 collection rate of 28 percent for billed care, we estimated that MCCF staff could have collected at least \$542,000 from third party insurers. We also examined a judgment sample of 10 receivables over 90 days old valued at about \$410,000, and found that MCCF staff had not aggressively followed up on 4 of the accounts valued at almost \$233,000 prior to referring them to a collection agency.

The CAP review at VA's Ann Arbor Healthcare System (Report Number 03-02729-140, dated May 6, 2004), identified about 13,000 unprocessed claims for episodes of care totaling approximately \$7.2 million listed in the "*Unbilled Amounts Report*" dated September 5, 2003. As mentioned in earlier recommendations made to the Department in 2002, actions were needed to timely bill for services.

Other bills were identified that were delayed nearly a year after the receivables were established before being entered into the VAMC's financial management system. Timely action is essential since no funds can be recovered until the insurance companies have been billed. In both the April and May 2004 CAP reviews described above, we recommended the Veterans Integrated Service Network (VISN) Directors ensure that MCCF Program employees bill third party insurers for outpatient episodes in a timely manner and take action to aggressively pursue MCCF accounts receivable. We will continue to follow-up on these recommendations until all issues are resolved.

We will soon issue the results of our CAP review on the VA Southern Nevada Healthcare System in Las Vegas, Nevada, where we identified coding and billing accuracy as an area needing improvement. As part of this review, we reviewed patient medical records corresponding to 20 unpaid bills valued at about \$234,200. We verified coding errors detected by the healthcare system staff on 13 of the 20 bills (65 percent) and found that 6 of the errors affected the billed amounts. Five bills were assigned diagnostic and procedure codes with higher reimbursement values than what was supported by medical record documentation. As a result, the bills were overstated by \$1,725. The remaining bill had been assigned codes with

a lower reimbursement value, resulting in the bill being understated by \$425. These coding errors caused the 6 bills to be overstated by a net amount of \$1,300.

At this same site, we also identified 40 outpatient care encounters that had missing or insufficient clinical documentation. If all 40 encounters had sufficient clinical documentation available for billing, the healthcare system could have potentially collected an additional \$13,000 in revenue. Better efforts were needed to ensure progress notes transcribed by physicians are attached to the patients' charts as required, and that attending physicians countersign the resident physician notes where appropriate. Complete medical record documentation and improved coding and billing processes would have resulted in increased reimbursements. We will follow-up on these recommendations until all actions have been completed.

Our CAP report on the VAMC in Chillicothe, Ohio (Combined Assessment Program Review of the VA Medical Center Chillicothe, Ohio, Report Number 04-00928, dated July 15, 2004) concluded that medical center management could further improve MCCF program results by strengthening billing procedures for fee-basis care, establishing procedures to ensure bills for outpatient and inpatient care provided prior to July 2003 are processed before insurance filing deadlines expire, billing for optometry services, and ensuring physicians adequately document care provided in the medical records. At this facility we identified additional billing opportunities totaling at least \$27,000, with estimated collections of about \$13,000.

To determine if fee-basis medical care was billed to patients' insurance carriers, we reviewed a judgment sample of 32 claims totaling about \$58,000. Of these 32 claims, 23 were not billable to the insurance carriers either because the fee-basis care was for service-connected conditions or the care was not billable under the terms of the insurance plans. MCCF staff at the VAMC had appropriately billed for five claims. However, we found additional billing opportunities totaling almost \$13,300 for four other claims. Follow-up reviews will be conducted until these issues are resolved.

Through the use of CAP reviews and periodic follow-ups with the Department, we continue to monitor efforts to improve the Department's MCCF Program. Currently, the Department is in the process of implementing a Revenue Action Plan resulting from our reviews and reviews conducted by the Government Accountability Office that includes 16 actions designated to increase collections by improving and standardizing collection processes.

The Department's Revenue Action Plan includes objectives to implement the Patient Financial Services System (PFSS). This system is a Department priority, Congressionally mandated business improvement effort designed to integrate a

commercially-off-the-shelf health care billing and accounts receivable system in the VHA with an initial objective of replacing legacy integrated billing and accounts receivable applications. According to VHA, the pilot project will create a comprehensive business solution for revenue improvement utilizing improved business practices, commercial software, and enhanced VA clinical applications.

As of June 2004, Department status reports showed that the analysis phase of the PFSS project was near completion and the project is about to enter the design phase. VA will use this design phase to obtain input from technical and business experts, and obtain user input throughout VA in order to gather requirements for building the dictionaries, screens, and edits that will complete the software design. The new timeline for delivery at the first test site in VISN 10 is October 2005.

While development of PFSS is ongoing, VHA has been exploring other opportunities to improve revenue cycle practices through standardization. VHA has designated Business Implementation Managers for each VISN to enhance accountability for patient care administration and revenue cycle matters.

VHA workgroups have also been formed to assess critical needs and to catalog best practices. For example, VISN 5 devised a best practice to enhance their insurance identification practices and potential collections. Pre-registration telephone calls are made 7 days in advance to remind patients of upcoming scheduled appointments and to update their demographics, including health insurance provider information. Collections have improved as a result of this best practice. For example, VHA management has reported that the Consolidated Pre-registration Unit in VISN 5 has increased overall collections from \$11.7 million in FY 2000 to \$27 million in FY 2002 by identifying additional billable cases. In fact, since VHA dedicated program staff responsible for verifying coverage and benefits of each new billable insurance case identified through pre-registration telephone calls in July 2000, VISN 5 staff has verified over 44,000 new insurance cases.

VISN 6 has implemented a centralized check-in process to improve the accuracy and timeliness of insurance information. Patients check in at one centralized area before going to clinical appointments. At the centralized area, intensive screening of demographics, insurance information, and future appointments are discussed with the patient. The patient does not have to go through the same procedures for the next 90 days unless he or she has a change in demographics or insurance. This enhanced process contributed to a 32 percent increase in collections valued at over \$20 million, as accurate insurance information allows for more efficient follow-up of accounts receivable. The centralized check-in best practice resulted in the identification of over 68,000 new insurance policies, resulting in an increase in over 154,000 bills processed when comparing FY 2002 results to FY 2003.

It is important that the Department implements its Revenue Action Plan and strengthens MCCF processing and collection practices. The plan identifies improvements needed to address weaknesses in coding and billing accuracy. We had received and reviewed allegations of improper or fraudulent MCCF billings to the American Association of Retired Persons (AARP).

In December 2003, we issued a report entitled, “*Evaluation of Medical Insurance Billing Practices at VAMCs Bedford and Northampton, Massachusetts*” (Report Number 03-00396-36, dated December 1, 2003). The AARP Health Care Options group, administered by the United Healthcare Insurance Company referred 35 potentially improper VA MCCF bills to the Insurance Fraud Bureau of Massachusetts. According to AARP’s allegation, VAMC’s Bedford and Northampton staff submitted claims for ineligible services. These included billings for outpatient visits to obtain drug refills, and physical therapy treatments for which there were no records of treatment plans. As reported in prior reviews, we also found outpatient visits that were billed for higher levels of care than that supported in the medical records.

While our review did not substantiate fraudulent activity, we substantiated AARP’s allegation of improper billings. Medical record documentation showed that although the patients in these cases received medical services on the dates billed, VAMC employees misinterpreted coding and billing guidelines and made poor billing decisions. Management implemented use of coding and billing scrubber software to ensure future bills were proper, improved education and communication among employees on what AARP covers, and began a constructive dialogue with AARP to address billing issues. VISN 1 also reviewed payments received on the bills and made refunds where appropriate.

The VA Under Secretary for Health agreed with our recommendations and provided acceptable implementation plans for all recommendations. In June 2004, VHA provided an update on follow-up actions from meetings with AARP. We are currently assessing the adequacy of the actions taken in response to our recommendations. This includes VHA’s efforts to monitor follow-up actions from the meeting with AARP and to ensure all billing concerns are resolved. We also are reviewing actions taken to provide appropriate guidance to facility staff to ensure that solutions to current billing issues (e.g., billings for outpatient visits for prescriptions, annual examinations, and physical therapy visits) are effectively implemented nationwide.

In conclusion, the Department increased collection revenues, but more needs to be done. While VA has addressed many of the concerns we reported over the last several years, our most recent work continues to identify major challenges where

VA could improve collection activities. This completes my statement, Mr. Chairman. I would be pleased to answer any questions you and the Subcommittee members may have today.