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BY THE U.S. GENERAL ACCOUNTING OFFICE

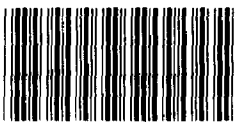
Report To The Administrator Of Veterans Affairs

VA Needs Better Control Over Its Payments To Private Health Care Providers

In fiscal year 1984 the Veterans Administration's (VA's) Department of Medicine and Surgery (DM&S) paid about $93 million to private physicians and other health care providers for care provided to eligible veterans. GAO evaluated DM&S' system for determining how much it pays these providers for medical services.

DM&S policy provides that clinics are to establish an appropriate fee for each procedure performed by private providers. The maximum allowable fee is to be at or above the middle of the range of fees charged the general public but is not to approach the top of the range (90th percentile). At the five clinics GAO reviewed, 74 percent of the maximum allowable fees examined fell outside the intended range. As a result, these clinics, which accounted for about 15 percent of all claims processed by 79 VA clinics in fiscal year 1983, often paid health care providers either more or less than they should. This problem exists because DM&S' system for developing and applying fee schedules is not adequately maintained or updated and is difficult to administer. Since all clinics use this system, GAO believes that the problems identified at the five clinics would be found at other clinics.

GAO is recommending that, rather than updating its existing fee schedule system, DM&S use fee schedules from other federal programs to pay private health care providers.



GAO/HRD-85-49
AUGUST 28, 1985

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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-219885

The Honorable Harry N. Walters
Administrator of Veterans Affairs

Dear Mr. Walters:

This report summarizes the results of our review of VA's payments to private health care providers. The report recommends that VA use data available from other federal agencies to determine how much it should pay for medical care provided to eligible veterans. We undertook this review because we had indications from other work that VA's internal controls over its payments were not adequate.

This report contains recommendations to you on page 24. As you know, 31 U.S.C. 720 requires you to submit a written statement on actions taken on our recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Operations not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with VA's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this report to the Director, Office of Management and Budget, and the Chairmen and Ranking Minority Members of the four above-mentioned Committees and the House and Senate Committees on Veterans' Affairs.

Sincerely yours,

Edward A Densmore

for Richard L. Fogel
Director

GENERAL ACCOUNTING OFFICE
REPORT TO THE ADMINISTRATOR
OF VETERANS AFFAIRS

VA NEEDS BETTER CONTROL OVER ITS PAYMENTS TO PRIVATE HEALTH CARE PROVIDERS

D I G E S T

The Veterans Administration's (VA's) Department of Medicine and Surgery (DM&S) provides medical care to most veterans at its own facilities. However, when certain veterans cannot travel to a VA facility because of illness, debility, or distance or when its own facilities cannot provide the needed medical service, DM&S can use community medical services, including private physicians, to provide care. DM&S pays health care providers a fee for the services provided.

The fee-for-service medical program is administered by 79 VA medical centers designated as "clinics of jurisdiction." Each clinic is responsible for authorizing care, establishing a schedule of maximum fees, and processing claims for services provided to eligible veterans. During fiscal year 1984, these clinics processed about 1 million bills for medical services provided by private physicians and other health care providers and paid $93 million for this care.

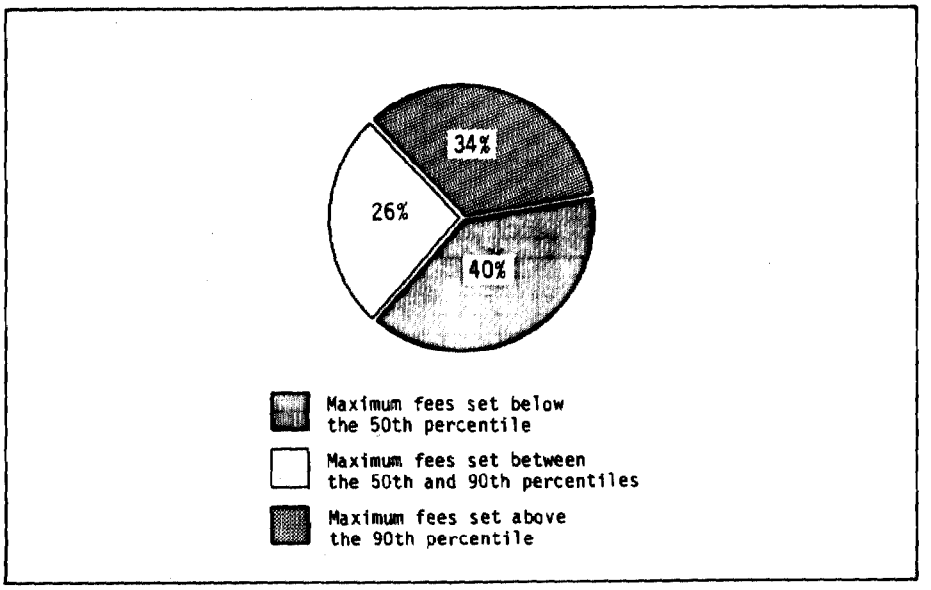
GAO visited five clinics of jurisdiction to evaluate DM&S' system for determining how much it pays for services provided by private physicians and other health care providers. GAO selected these clinics to provide a cross-section of clinics by geographic location, volume of claims, and varying claims reimbursement practices. At each clinic, GAO analyzed a judgmental sample of claims to determine if payments were within DM&S' reimbursement criteria. Since DM&S requires all clinics to use the same system for developing fees, GAO believes that the problems identified at the five clinics would be found at the other clinics.

Tear Sheet

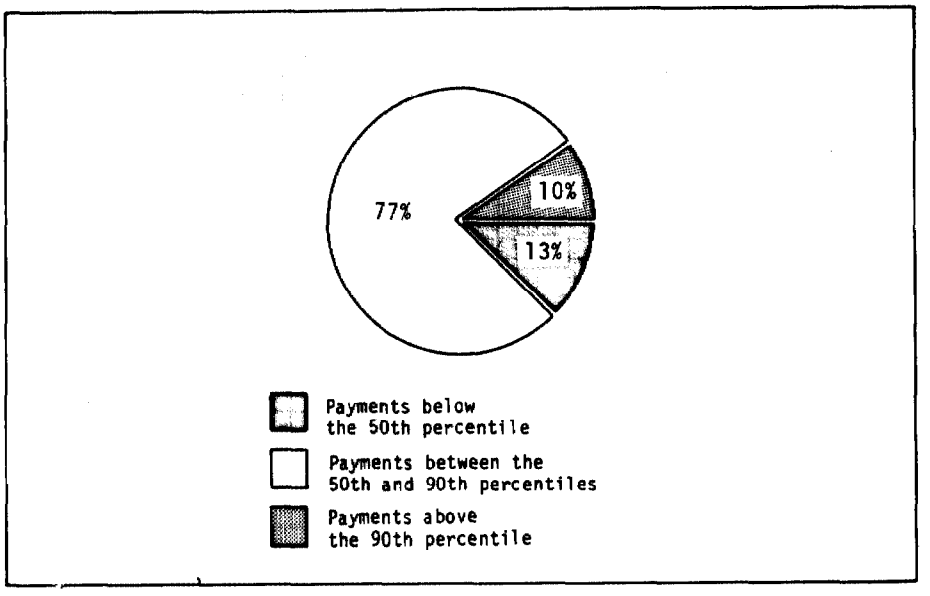
GAO/HRD-85-49
AUGUST 28, 1985

DM&S MAXIMUM ALLOWABLE FEES FOR PRIVATE HEALTH CARE ARE OFTEN OUTSIDE INTENDED RANGE

Under DM&S reimbursement criteria, the maximum allowable fee for any medical procedure should be at or above the middle of the range of fees normally charged the general public, but should not approach the top of the range. DM&S manuals are not specific as to what constitutes a fee at the middle or a fee approaching the top of the range. However, DM&S officials agreed that the 50th percentile of charges to the general public constitutes the middle and the 90th percentile of such charges constitutes approaching the top of the range. At the five clinics GAO examined, however, the maximum fees were above or below the range in 327 of the 440 maximum fees examined. (See p. 5.)



When DM&S pays providers, a clinic pays the maximum allowable fee or the provider's actual charge, whichever is less. To determine the effect of having so many maximum allowable fees above or below the range, GAO analyzed payments on a judgmental sample of bills involving 1 or more of these 440 maximum allowable fees. In all, GAO analyzed 1,328 payments and found that 23 percent were outside the range. (See p. 7.)



The reason that only 23 percent of the payments were outside the range when 74 percent of the maximum allowable fees were outside the range is that providers often bill at less than the maximum rates. (See p. 9.)

GAO did not determine what the total dollar effect would be if all payments met DM&S' reimbursement criteria. GAO's review sought instead to determine whether DM&S' system of internal controls was adequate to assure compliance with these criteria. The results show that, under the present system, none of the clinics visited fully complied with DM&S reimbursement criteria. (See p. 10.)

DM&S' SYSTEM FOR DEVELOPING FEES IS OUTDATED AND INADEQUATE

DM&S uses a 1964 study as its basis for developing fees for medical procedures. The study, published by the California Medical Association, contained "unit values" for medical procedures that were intended to represent the relationship or relative value of one medical procedure to another at that time. Clinics are supposed to develop maximum allowable fees for their area by multiplying these unit values by a locally established dollar conversion factor. (See p. 10.)

The system has become outdated and inadequate because DM&S has not:

--Updated its list of unit values to include values for the thousands of new medical procedures added since the list was originally published in 1964, causing clinics to determine charges by contacting private physicians in the area or paying the full amount of the bill. (See p. 11.)

--Recognized changes in unit values due to the use of improved medical techniques or equipment. (See p. 12.)

--Converted to the system currently used by health care providers to code medical procedures. (See p. 12.)

--Established a system to accumulate the data needed to develop conversion factors that result in appropriate fees. (See p. 13.)

DM&S COULD IMPROVE ITS CONTROL OVER PAYMENTS TO PRIVATE HEALTH CARE PROVIDERS BY USING FEE SCHEDULES FROM OTHER FEDERAL PROGRAMS

DM&S officials agreed that their present fee schedule system does not assure that clinics pay private health care providers within DM&S' reimbursement criteria. They further agreed that changes are needed, but as of April 1985 they had not reached a decision on what these changes should be. Rather than improving its present system, however, GAO believes that DM&S should use existing fee schedules being developed under other federal health programs. (See p. 15.)

The Medicare program offers one set of options. Each year, government contractors develop fee schedules based on actual physician and other provider charges in the prior calendar year. Previous GAO work has indicated that the Medicare fee schedules are based on physician charges which are representative of charges to the general public. To recognize urban and rural

differences in fees, Medicare provides separate fee schedules for about 250 localities in the country. In some localities Medicare contractors develop separate fees for specialists and general practitioners. (See p. 17.)

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is another source of fee schedules. This program helps pay for civilian medical care provided to dependents of active duty members of the armed services, military retirees and their dependents, and dependents of deceased members of the uniformed services. Under CHAMPUS, contractors develop fee schedules each year based on actual charges during a 12-month period. CHAMPUS fee schedules are developed for each state and contain one fee for each medical procedure based on the combined charges from physicians in different kinds of specialty practice. (See p. 21.)

Both the CHAMPUS and Medicare systems for establishing schedules have advantages over VA's. The CHAMPUS and Medicare systems

--include fees for many medical procedures not in DM&S' current system,

--more accurately reflect provider charges to the general public,

--use the medical procedure coding system commonly used by health care providers in the community, and

--are updated annually.

The Medicare fee schedules are more detailed--and, as a result, more precise--than the CHAMPUS schedules. However, the Medicare system is also fully automated and may not be readily adaptable to DM&S' program because clinics now hand-process all claims. Medicare fee schedules are quite voluminous and require several steps to use manually. By comparison, the CHAMPUS fee schedules are readily adaptable to DM&S' current manual claims processing system. (See p. 23.)

DM&S officials said they plan to automate the claims processing systems as part of DM&S' Decentralized Hospital Computer program. In commenting on a draft of this report, the Administrator of Veterans Affairs stated that automation of the fee system is proceeding and VA's goal is full implementation by the end of fiscal year 1986, depending on the availability of resources.

RECOMMENDATIONS

GAO recommends that the Administrator of Veterans Affairs, through the Chief Medical Director:

--Use the CHAMPUS fee schedules as the temporary basis for reimbursing health care providers until DM&S develops the automated capability needed for the more precise Medicare fee schedules.

--Use the Medicare fee schedules once DM&S automates its claims processing system. (See p. 24.)

AGENCY COMMENTS AND GAO'S EVALUATION

In an August 1, 1985, letter, the Administrator of Veterans Affairs stated that VA was testing the CHAMPUS fee schedules at two medical centers to determine if it is appropriate to use them throughout the VA system. GAO believes that its work has shown that VA's current system needs to be replaced and that either the CHAMPUS or Medicare schedules could be used to assess the reasonableness of fees charged VA by private health care providers. GAO also believes that VA's current and planned studies of these fee schedules should focus on how, rather than whether, VA can use them. (See p. 24.)

Contents

Page

ILLUSTRATIONS

ABBREVIATIONS

AMA	American Medical Association
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DM&S	Department of Medicine and Surgery
GAO	General Accounting Office
VA	Veterans Administration

CHAPTER 1

INTRODUCTION

The Department of Medicine and Surgery (DM&S) administers the Veterans Administration (VA) health care programs. Although DM&S treats most veterans at its own facilities, it also pays for treating others through private health care providers under its fee basis medical program. DM&S is authorized to use private health care providers for certain eligible veterans who cannot travel to a VA facility because of illness, debility, or geographic inaccessibility. DM&S can also use private health care providers when its own facilities are not able to furnish the needed medical service. During fiscal year 1984, DM&S reported that it spent about $554 million on such private health care as medical, dental, pharmacy, hospital, and nursing home services. This report deals with that portion of private health care obtained from private physicians and other health care providers.[1] During fiscal year 1984, DM&S paid about 1 million invoices for provider services. These payments totaled about $93 million.

The fee basis medical program is administered by 79 VA medical centers designated as "clinics of jurisdiction." Each clinic is responsible for authorizing care for veterans living within its designated geographical area. Each clinic is also responsible for reviewing and processing claims for services provided to those veterans by private providers. The clinic issues eligible veterans an identification card listing the disability approved for treatment. The veteran can then obtain medical services from a licensed physician of his/her choice.

As a means of controlling costs, clinic directors are responsible for establishing maximum fees for each medical service provided in their area of jurisdiction by physicians and other health care providers. If the provider's bill for the service is more than the maximum set by the clinic, VA will not pay the additional amount. If the provider's bill is less than the clinic's maximum amount, VA will pay the provider for the full amount billed. Upon agreeing to treat a veteran under the fee basis medical program, health care providers also agree not to accept payment from the veteran, or from another party, over and above the amount VA will pay. As part of VA's internal control system, personnel at each clinic of jurisdiction review

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[1]Physicians and other health care providers, hereafter referred to as providers, include, but are not limited to, private physicians, psychologists, podiatrists, nurses, optometrists, and laboratory technicians.

all bills for medical care to determine if fees are in line with those charged the general public and are not in excess of the clinic's fee schedule.

OBJECTIVE, SCOPE, AND METHODOLOGY

Our objective was to evaluate DM&S' system for determining how much it will pay for medical services provided by private physicians and other health care providers under the fee basis medical program.

To meet that objective, we:

--Reviewed the law, legislative history, and agency policies and procedures for the program.

--Contacted all clinics of jurisdiction except those in Puerto Rico and the Philippines by questionnaire and follow-up telephone conversations to determine how they developed and applied their fee schedule.

--Interviewed agency officials to identify current policies and procedures and planned changes in the program.

--Contacted Health Care Financing Administration, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and Indian Health Service officials to determine how they establish fees and process medical claims.

To examine procedures in more detail, we visited five clinics of jurisdiction:

--Bay Pines, Florida.

--Fargo, North Dakota.

--Los Angeles, California.

--Seattle, Washington.

--Syracuse, New York.

We selected these clinics to provide a cross-section of clinics by geographic location, volume of claims, and varying claim reimbursement practices. Together, the five clinics accounted for about 15 percent of all claims processed by VA's 79 clinics of jurisdiction in fiscal year 1983.

At each of the five clinics, we

--examined all claims processed by the clinic during periods ranging from 3 to 10 days before our visits, for a total of 2,010 claims;

--selected all claims that identified the services provided by a medical procedure code and could thus be analyzed against Medicare pricing data, for a total of 777 claims, containing 1,328 procedure codes;

--analyzed payments on all claims with medical procedure codes to determine if the fees applied were within DM&S' reimbursement criteria, for a total of 777 claims containing 1,328 medical procedures; and

--compared the fees each clinic established for the different classifications of medical procedures on our sampled claims with rates charged the general public in the area based on Medicare pricing data, for a total of 440 different fees for the 1,328 medical procedures.

We conducted most of our fieldwork between May 1983 and October 1984. We performed the review in accordance with generally accepted governmental auditing standards. The results of our analysis to determine if VA payments met DM&S' reimbursement criteria are not projectable beyond the sampled claims because we did not (1) take a statistically valid sample of claims processed by each clinic during a specified period because of incomplete clinic records and (2) sample claims from enough clinics.

CHAPTER 2

DM&S MAXIMUM ALLOWABLE FEES FOR PRIVATE HEALTH CARE ARE OFTEN OUTSIDE INTENDED RANGE

Clinics of jurisdiction are supposed to pay providers the lower of two amounts--the actual charges or a maximum allowable fee the clinics establish. At the five clinics we visited, the maximum fees for 74 percent of the services that we examined did not meet the DM&S criteria. As a result, VA often paid providers more or less than it should have. This problem exists because DM&S' system for developing and applying fee schedules was not adequately maintained or updated and was difficult to administer.

DM&S' REIMBURSEMENT CRITERIA CALL FOR MAXIMUM FEES BASED ON CHARGES TO THE GENERAL PUBLIC

VA's legislative and statutory authority to use private health care providers does not mandate a ceiling for payments to providers. However, DM&S' manual M-1, part 1, chapter 18, provides that the maximum allowable fee for any one medical procedure should be at or above the median of the range of fees normally charged the general public, but should not approach the top of the range. The manual and the other program instructions are not specific as to what constitutes a fee at the median or a fee approaching the top of the range. However, DM&S officials agreed with our definition that the 50th percentile of charges to the general public constitutes the median and the 90th percentile of such charges constitutes fees approaching the top of the range.

To determine whether clinics were operating within this definition, we obtained data on the amounts that providers were charging the general public in each clinic's area of jurisdiction. There are several sources available for such data, including private health insurance companies, the Medicare program, CHAMPUS, the Federal Employees Health Benefits program, and studies conducted by state or local medical societies or public agencies. For our study we used the data on provider charges being accumulated under the Medicare program because the data were readily available for all the locations we visited.

Evidence indicates that the provider charges under the Medicare program are representative of charges to the general public in an area. Medicare's coverage for physician services is administered by private insurance organizations, referred to as "carriers." The Social Security Act (42 U.S.C. 1395)

provides that the reasonable charges for services under Medicare may not exceed the charges applicable for a comparable service to policyholders and subscribers under the carrier's private insurance plan. In September 1979,[1] we reported that a comparison of samples of physician charges at six Medicare carriers showed that physicians usually charge Medicare patients the same as their private health insurance plan patients. In January 1983,[2] a study sponsored by the Health Care Financing Administration found that in Pennsylvania there were only slight differences in physician charges between the Medicare and Blue Shield programs.

MOST MAXIMUM FEES WE ANALYZED DID NOT MEET DM&S' REIMBURSEMENT CRITERIA

To determine the extent to which the maximum fees established by the clinics met DM&S' reimbursement criteria, we compared the fees that the five clinics were using at the time of our visit with provider charges under Medicare at the 50th and 90th percentiles. For our comparison, we selected the fees that each clinic had applied to the medical procedures on our sampled claims. Since some medical procedures appeared more than once, there were fewer maximum fees to compare at each clinic than there were medical procedures on our sampled claims. In total, there were 440 different maximum fees established by the clinics for the 1,328 medical procedures on the sampled claims. We found that maximum fees were above or below that range in 327 cases, or 74 percent of all the cases reviewed. More specifically,

--177 (or 40 percent) of the maximum fees were below the 50th percentile;

--113 (or 26 percent) of the maximum fees were equal to or above the 50th percentile, but not above the 90th percentile; and

--150 (or 34 percent) of the maximum fees were above the 90th percentile.

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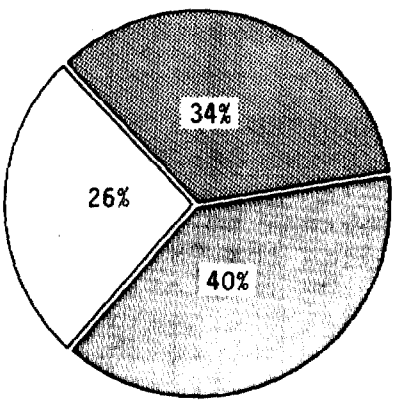
[1]"Comparison of Physician Charges and Allowances Under Private Health Insurance Plans and Medicare" (HRD-79-111, Sept. 6, 1979).

[2]"A Study of the Physicians' Services Market in Pennsylvania," Pennsylvania Blue Shield Research Division, January 1983.

Chart 1 shows combined results for the five clinics.

CHART 1
MAXIMUM FEE LEVELS INSIDE AND OUTSIDE
THE INTENDED RANGE



Maximum fees set below the 50th percentile

Maximum fees set between the 50th and 90th percentiles

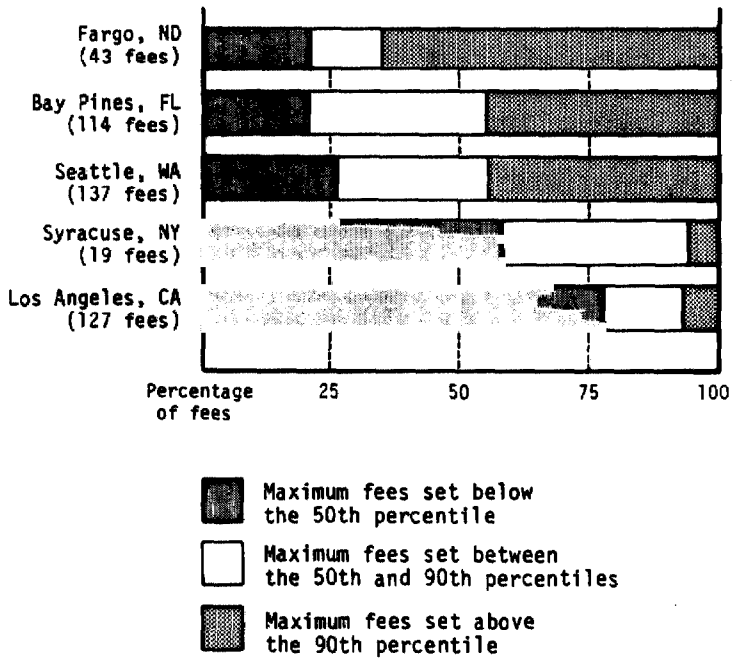
Maximum fees set above the 90th percentile

GAO analyzed a total of 440 different maximum fees established by VA clinics and found that 74 percent of them were outside the intended range.

The 177 maximum fees set below the 50th percentile ranged from 2 to 94 percent below the charge at the 50th percentile. The 150 fees above the 90th percentile ranged from 2 to 300 percent above the charge at the 90th percentile.

In examining each clinic separately, two clinics--Syracuse and Los Angeles--established maximum fees for sampled procedures that were predominantly below the 50th percentile. The three other clinics--Fargo, Bay Pines, and Seattle--tended to establish many of their maximum fees above the 90th percentile. Chart 2 shows the results for each clinic.

CHART 2
MAXIMUM FEE LEVELS BY CLINIC



At the five clinics GAO examined, there were considerable differences in the degree to which maximum fees were at, below, or above the intended range.

PAYMENTS OUTSIDE DM&S' REIMBURSEMENT CRITERIA RESULT WHEN CLINICS APPLY MAXIMUM FEES TO BILLS

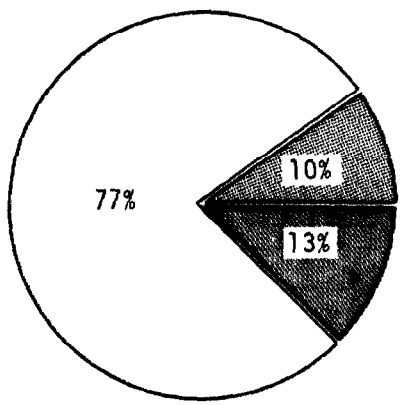
To determine the effect of having so many maximum fees set above or below the range, we analyzed the payments made by the five clinics on actual bills. We examined payments on 1,328 medical procedures appearing on claims processed just before our visits. We found that the payments on 23 percent of the medical procedures did not fall within the range established under DM&S' reimbursement criteria. Specifically, we found the following regarding these procedures:

--On 907 of the 1,328 medical procedures, provider charges were equal to or above the 50th percentile. However, on 177 of these 907 procedures, the clinic's maximum allowable fee was below the 50th percentile. Therefore, the clinic paid below the 50th percentile.

--On 259 of the 1,328 medical procedures, provider charges were above the 90th percentile. On 128 of the 259 procedures, the clinic's maximum allowable fee was also above the 90th percentile. Therefore, the clinic's payment was above the 90th percentile.

Chart 3 shows the combined results for the five clinics.

CHART 3
PAYMENTS INSIDE AND OUTSIDE THE INTENDED RANGE



Payments below the 50th percentile

Payments between the 50th and 90th percentiles

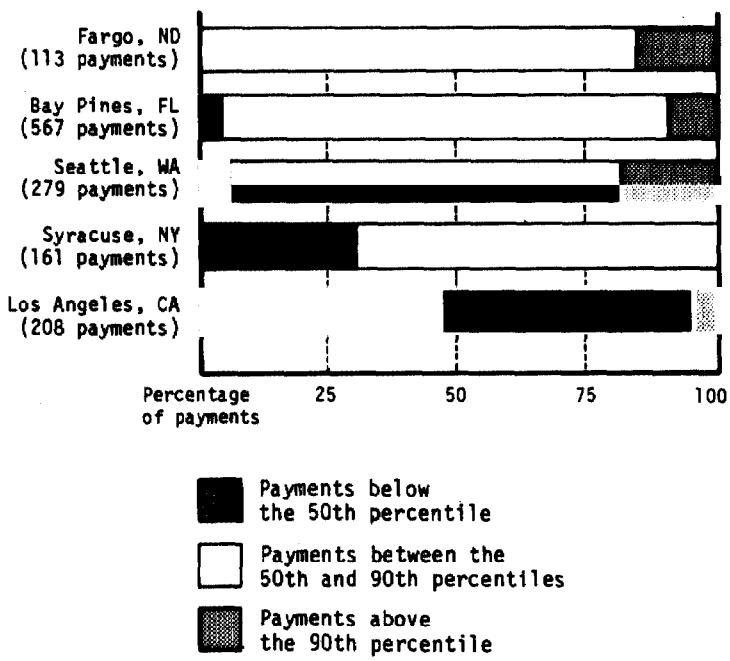
Payments above the 90th percentile

GAO analyzed actual payments on a total of 1,328 medical procedures and found that 23 percent were outside the intended range.

The reason that only 23 percent of the payments were outside the range when 74 percent of the maximum allowable fees were outside is that providers often bill at less than the maximum rates. DM&S' reimbursement policy provides for payment to providers based on a maximum allowable fee or the provider's actual charge, whichever is less. For the 177 medical procedures for which VA paid providers below the 50th percentile of charges to the general public, VA's payment ranged from 2 to 57 percent below the charge at the 50th percentile. On the 128 procedures paid above the 90th percentile, VA's payment ranged from 1 to 260 percent above the charge at the 90th percentile.

Most of the payments below the median were made by the same two clinics (Syracuse and Los Angeles) that established maximum rates predominantly below the 50th percentile because they used outdated information. (See p. 14.) The payments above the range were made primarily by the three clinics (Bay Pines, Fargo, and Seattle) that established more rates near the top of the range. Our findings are shown in chart 4.

CHART 4
PAYMENTS BY CLINIC



The five clinics examined by GAO differed greatly in the percentage of payments above or below the intended range.

Our results are not projectable either to all claims processed by the five clinics visited or to the VA system as a whole. Therefore, we do not know what the total dollar effect would be if all payments by clinics met DM&S' reimbursement criteria. Rather than to develop an overall dollar effect, the purpose of our sampling approach was to determine whether DM&S' system of internal controls was adequate to assure compliance with its reimbursement criteria. The results show that, under the present system, none of the clinics visited fully complied with these criteria. As described in the following section, the clinics' inability to comply with DM&S' reimbursement criteria is the result of deficiencies in VA's system for developing fees.

DM&S' SYSTEM FOR DEVELOPING FEES IS OUTDATED AND INADEQUATE

Deficiencies in VA's reimbursement system resulted in these overpayments and underpayments. In brief, this system works as follows:

1. For each claim, VA clerks must identify an appropriate procedure code and accompanying unit value for the service provided. Procedure codes, which are published in VA's manual, identify the specific services provided. Unit values, which are also published in VA's manual, represent the relative value of the service compared to other kinds of services. Unit values are based on such factors as the complexity of the procedure, the time required to perform it, and the equipment needed.

2. After determining the unit value, VA clerks must multiply it by a conversion factor. This factor, which is developed by each clinic, allows the clinic to take into account the rates normally charged the general public in its area. For example, a medical procedure with a unit value of 1.5 would have a maximum allowable fee of $15 if the conversion factor had a value of 10. If the conversion factor had a value of 20, the same procedure would have a maximum allowable fee of $30.

Our examination showed that this system was not adequately maintained or updated and was difficult to administer. We found that:

--DM&S' published list of medical procedures and related unit values is outdated and incomplete.

--DM&S' published list of procedure codes uses an outdated coding system.

--Efforts to maintain an appropriate conversion factor have been ineffective.

DM&S' published list of medical procedures and related unit values is outdated and incomplete

The medical procedures and related unit values published in DM&S' manual, which all clinics must use in developing fees, are based on a 1964 study[3] by the California Medical Association. Since publishing its manual in 1965, DM&S has not updated it to include unit values for the thousands of medical procedures added since 1965. The California Medical Association, on the other hand, has substantially expanded its list of medical procedures since then. In 1969, the Association issued a revised edition of its relative value study. This edition included about 3,600 medical procedures, or about 1,200 more than the 1964 edition, reflecting both the addition of new procedures and subdivisions of previous procedure lists. In 1974 the Association issued another edition. This edition lists about 4,600 medical procedures, or about 30 percent more than the 1969 edition.

DM&S' incomplete list of procedure codes caused problems for several of the clinics we visited. DM&S' manual instructs clinic directors to give an unlisted service a value comparable to the most similar listed procedure, but the amount is not to be greater than the usual and customary charge to the general public for similar services. Contrary to these instructions, two of the five clinics we visited (Seattle and Fargo) did not determine what constitutes a usual and customary charge for unlisted procedures. Instead, they paid the full amount of the bill. Officials at these clinics said that they pay the full amount because DM&S' policy is so difficult and time consuming to implement.

At the Bay Pines clinic, unlisted services also created administrative problems, but the clinic was able to work around them. Officials at the clinic said that for all unlisted procedures, they determine what the customary charges are by contacting private physicians or other providers in the area. At the Los Angeles and Syracuse clinics, unlisted claims were not as much of a problem. In Los Angeles, the clinic had a fee

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[3]"1964 California Relative Value Studies," California Medical Association, 1964.

for most procedures because it used the 1974 edition of the California Relative Value Studies rather than the earlier study incorporated in the DM&S manual. At the Syracuse clinic, over 80 percent of the claims we sampled were for psychiatric services. All these services are listed in DM&S' manual, which the clinics use to develop maximum allowable fees.

A second problem with using an outdated list of unit values is that it does not reflect changes in the relative value of services as a result of improved techniques or equipment. By the time it issued its 1974 edition of relative value studies, the California Medical Association had changed some of these relative rankings. For example, in the 1964 edition the relative value of a total protein test was 300 percent greater than that for a hematocrit (blood test). By the time the 1974 edition was published, the difference between these two procedures had changed substantially. The relative value of the total protein test was listed as being only 40 percent greater than the hematocrit test.

DM&S' published list of procedure codes uses an outdated coding system

In the 1964 edition of its relative value studies, the California Medical Association used a four-digit coding system for medical procedures which DM&S adopted. DM&S has continued to use the four-digit codes, while the Association changed to a five-digit coding system in 1969. The purpose of this change was to have procedure codes correspond to those of the American Medical Association (AMA). This AMA coding system is the most comprehensive list of medical procedures. It is familiar to many physicians.

VA clinic officials often have a difficult and time-consuming task identifying the appropriate maximum allowable fee to apply to billed medical procedures. One reason is that DM&S does not require physicians to identify billed services by DM&S procedure codes or any other medical coding system. As a result, many bills are submitted with only a narrative description of the services provided. Of the 2,010 bills we examined, providers used only a narrative description on 1,233; we were able to analyze VA's payment on only the 777 bills with codes.

The narrative descriptions on these 1,233 bills were not always in sufficient detail to enable clinics to identify the appropriate maximum allowable fee to apply to the procedure. To illustrate, on 19 of the 114 bills we reviewed at the Fargo clinic, physicians billed VA for office visits and described the service provided with such terms as "OC," "office exam," and

"office call." DM&S' fee schedule includes as many as nine different fees for office visits, depending on the type of service provided, the physician's specialty, and the type of patient (new or established).

The lack of a code is not the only problem. Officials at three of the clinics also said they have difficulty in deciding which procedure code and related fee to apply even when physicians use medical procedure codes to describe services. They attributed this in part to DM&S' coding system. DM&S has not developed a schedule showing which four-digit code, if any, best describes the services identified under the AMA coding system. Clinic officials must therefore review the narrative descriptions from the VA and AMA coding systems in deciding which DM&S procedure code and related fee to apply to a billed service.

Because the AMA coding system reports services more precisely, it is difficult to decide from narrative descriptions which DM&S procedure code to apply to a service. To illustrate, under the DM&S coding system, office visits are described as brief, routine, or over and above routine. Under the AMA coding system, office visits are described as minimal, brief, limited, intermediate, extended, and comprehensive, with a separate procedure code for each description.

Efforts to maintain conversion factors have been ineffective

DM&S' manual places the responsibility for developing and maintaining conversion factors on the clinics of jurisdiction. This is an important function because these factors, when multiplied by unit values, establish the maximum allowable fee that clinics will pay for individual medical procedures. Clinics are instructed to use fees that providers normally charge the general public as the basis for establishing an appropriate conversion factor. Clinics have difficulty in performing this function because they do not have a system for (1) routinely accumulating the data needed to establish appropriate conversion factors and (2) periodically updating these conversion factors to reflect changes in charges to the general public.

Lack of a system to routinely accumulate data

To develop and maintain an appropriate conversion factor, clinics must periodically compare their maximum allowable fees with those that providers normally charge the general public in their area of jurisdiction. Several sources for data on

normal provider charges are available from private insurance programs and other federal programs, such as Medicare or CHAMPUS. The five clinics we reviewed did not use any of these sources.

Officials at the Bay Pines and Syracuse clinics said that they occasionally sampled a limited number of their invoices to determine if their conversion factors needed to be changed. To illustrate, in 1980 the Bay Pines clinic conducted a 1-month survey of incoming bills. The survey included an analysis of 315 charges on bills for 15 medical procedures. The clinic used the survey results to justify an increase in its conversion factor from 12 to 16 for all procedures. On the other hand, the Los Angeles and Fargo clinics relied on samples taken by other clinics. To illustrate, an official at the Fargo clinic said the clinic obtained headquarters approval to increase its conversion factor from 15 to 20 on the basis of a study of bills received by the Minneapolis clinic--outside of its area of jurisdiction.

Medicare and CHAMPUS also use bills that they receive to update their fee schedules. These programs, however, systematically accumulate data on provider charges from all bills and therefore use a substantially larger number of bills and medical procedures to establish their fee schedules. For example, Medicare contractors use provider charges on all bills they received in the prior calendar year. Under this process, the Medicare contractor for Washington State used 119,552 physician charges to establish a reimbursement rate for a limited service office visit provided by general practitioners in one area of the state.

Lack of a system for updating conversion factors

In addition to lacking a system for accumulating accurate data for conversion factors, the clinics we visited lacked a system for updating the conversion factors. DM&S manuals do not establish a specific time frame that clinics must meet in updating their conversion factors and related fees. Forty-three of the 67 clinics responding to our May 1983 questionnaire said they had not updated their conversion factor since 1980 or earlier. Officials at three of the five clinics we visited said they relied primarily on physicians' complaints about DM&S' maximum allowable fees before taking any action to update their conversion factors. In contrast, Medicare and CHAMPUS regulations require that program officials update their fee schedules at least annually.

If a clinic does not periodically adjust its conversion factor, providers may be reimbursed below DM&S' established criteria. This was the case at the Los Angeles and Syracuse clinics. The Los Angeles clinic continued to use conversion factors that were last updated in 1980. The Syracuse clinic, before adjusting its conversion factor in September 1983, used the same conversion factor for about 8 years.

However, the lack of a periodic adjustment in the conversion factor does not necessarily result in paying providers based on fees below DM&S' reimbursement criteria. To illustrate, the Bay Pines clinic had not updated its conversion factor since November 1980, yet about 45 percent of its fees we sampled in 1984 were above the 90th percentile of charges to the general public. In 1980, the clinic requested an increase in its conversion factor from 12 to 16 based on a 1-month study of incoming bills. DM&S approved the request although the study showed that if granted, the increased maximum allowable fees for at least 6 of the 15 medical procedures would be above the 90th percentile of provider charges.

One clinic attempted to compensate for an outdated conversion factor by using inflated unit values. The Seattle clinic last updated its conversion factor in 1977, and its use of this factor would result in fees below the 50th percentile for many medical procedures. To reimburse providers with fees that more closely represent what providers charge, the clinic used many unit values that were for more complicated medical procedures than the services actually billed. In all, the Seattle clinic "upgraded" unit values for 106 of the 279 medical procedures we examined. To illustrate, on 42 occasions in which a physician billed VA for a limited service follow-up office visit, the clinic applied a unit value for an office visit involving a complete general routine history and physical examination. The clinic's maximum allowable fee was $25 for the more complicated office visit compared with $15 for the follow-up office visit. A clinic official said the clinic had not had the time or staff to update conversion factors.

DM&S' COMMENTS ON OUR FINDINGS

On October 2, 1984, we briefed DM&S officials responsible for policy formulation and oversight of this program. They agreed that the existing system did not provide reasonable assurance that clinics were reimbursing providers based on fees within DM&S' criteria. They also agreed that improvements are needed in their method of establishing fee schedules.

CONCLUSIONS

The payment systems used in the five clinics we reviewed have not provided reasonable assurance that payments to providers were within DM&S' reimbursement criteria. As a result of the deficiencies we identified in DM&S' reimbursement system and our discussions with DM&S and other clinic officials, we believe that the findings developed at the five clinics exist at all clinics.

If DM&S were to use its present fee schedule system to improve internal controls over payments, we believe it would have to

--add procedure codes and unit values for the medical procedures established since 1964,

--develop and maintain accurate and reliable data on provider charges to the general public,

--require providers to use a common coding system when they submit claims, and

--establish a system that all clinics would follow for revising their conversion factors.

As an alternative to improving its present fee schedule system, DM&S could use existing systems from other federal programs. Medicare or CHAMPUS could provide DM&S clinics with fee schedules based on actual provider charges and thereby improve its control over the fees used by clinics to reimburse providers. These alternatives are discussed in chapter 3.

CHAPTER 3

CHANGES IN DM&S' METHOD OF ESTABLISHING FEE SCHEDULES COULD IMPROVE CONTROL OVER PAYMENTS TO PRIVATE HEALTH CARE PROVIDERS

DM&S could improve its control over payments to private health care providers by changing the method its clinics use to establish fee schedules. If DM&S were to use Medical or CHAMPUS fee schedules, it would have reasonable assurance that clinics throughout the country adhere to its criteria. These systems are more sophisticated than DM&S', and DM&S' ability to use them is hampered by its system of processing bills by hand. Of the two, the CHAMPUS system appears better suited at this time to DM&S' current operations, but the Medicare system appears to have advantages once DM&S' operations are automated.

SEVERAL OPTIONS ARE AVAILABLE FOR USING THE MEDICARE SYSTEM, BUT DM&S' CURRENT PROCEDURES POSE SOME DIFFICULTIES FOR USING THEM

The Medicare Part B medical insurance program provides physician services and other medical services to eligible beneficiaries. Medicare reimburses providers on a "reasonable charge" concept. The reasonable charge is the lowest of (1) the individual provider's customary charge for the service, (2) the prevailing charge for similar services in the locality, or (3) the provider's actual charge. The customary charge refers to the fee that a provider charges most of the time for a specific medical procedure. The prevailing charge takes other providers' charges for the same service into account. Medicare's prevailing charge is set at the 75th percentile of all charges for the service--that is, at the level below which 75 percent of the providers have set their rates. Since 1975 an economic index has also been applied to limit the rate of increase in Medicare prevailing charges.

The Medicare Part B program is administered by about 50 contractors. Every year these contractors update the customary and prevailing charge schedules used to calculate reasonable charges. These schedules are based on billed charges from the previous calendar year. To recognize urban-rural differences in fees, contractors have divided the country into about 250 reimbursement localities, ranging in size from subcounty to statewide areas. In addition, contractors may develop different prevailing charges in a locality for physicians in different kinds of specialty practice. This entire system is automated.

Recommendations to use the Medicare fee system are not new to VA. In its 1983 report, a task force of the President's Private Sector Survey on Cost Control (the Grace Commission) recommended that VA adopt the Medicare reimbursement rates.[1] Also, in a June 1982 report by the VA Inspector General's Advisory Council on Fee Basis Medical Programs,[2] the Council reported that VA often pays on the basis of fees that are very different from those allowed by Medicare and the Department of Defense. The Council recommended that a maximum allowable fee schedule be adopted and used by all federal health care programs. It suggested that the Medicare fee schedule would be the simplest for VA to implement. The Chief Medical Director did not concur with the Council's recommendation and reported that setting national uniform fees could create inequitable situations where some providers are underpaid, while others are overpaid. As we discussed in chapter 2, this is the situation under VA's current system. Further, we believe this situation would not result if VA adopted the Medicare system because there would be separate fee schedules for different parts of the country based on actual physicians' charges in each area.

We identified three options for using the Medicare system to establish DM&S fee schedules:

--Using the Medicare system and related fee schedules as the basis for reimbursing providers.

--Using only the Medicare prevailing charge fee schedules as the basis for reimbursing providers.

--Using the Medicare data to establish a fee schedule, but setting the maximum allowable fees at a level that is different from Medicare's.

Under each option, a clinic would have fee schedules that are based on actual provider charges in its area of jurisdiction. It would also have schedules that are updated annually. Each of these options, however, has limitations because DM&S' current procedures are manual, not automated, and the Medicare system would be difficult to administer under a manual system. These options are discussed below.

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[1]"Task Force Report on Federal Hospital Management," President's Private Sector Survey on Cost Control, 1983.

[2]"Report of the Inspector General's Advisory Council on Fee Basis Medical Programs," Veterans Administration, June 10, 1982.

Option 1: Using the Medicare system and related fee schedules as the basis for reimbursing providers

Under this approach, DM&S would abandon its present method of developing fee schedules and adopt the Medicare "reasonable charge" concept and related fee schedules. In using the Medicare system, DM&S would be tapping into a nationwide system for establishing maximum allowable fees based on provider charges. Under this system, DM&S could be reasonably assured that fees would be within its current maximum allowable reimbursement criteria.

Under this approach, clinics would no longer need to develop and maintain fee schedules. Instead, each clinic would obtain the applicable fee schedules from Medicare contractors. Because DM&S uses a manual claims processing system, the clinics would have to obtain copies of the fee schedules rather than computerized files that contractors use in their automated claims processing systems. DM&S' costs to obtain the Medicare fee schedules should not be significant. To illustrate, the Medicare contractor for Washington State said printing the four prevailing charge schedules for that state would cost about $160 annually. In total, the Medicare contractors would have to provide DM&S' 79 clinics of jurisdiction with about 250 different prevailing charge fee schedules. They would also have to provide each clinic with schedules on physicians' customary charges.

The fee schedules obtained from Medicare carriers should accurately reflect charges to the general public in each area because they are based on thousands of provider charges during the previous year. The fee schedules would also be more precise because the Medicare reimbursement system recognizes differences in costs between urban and rural areas as well as between physicians in different kinds of specialty practice in most localities.

This approach, however, would be difficult to administer under DM&S' manual system because of the many voluminous fee schedules it would entail and the many steps that a clinic would have to follow in processing each bill manually. To illustrate, the VA clinics in California would have to use 28 different Medicare prevailing charge fee schedules. They would also have 28 different schedules on provider customary charges. These schedules could be voluminous because they would include a median or customary charge for each service a provider used in the previous year. To determine the maximum allowable fee on each bill processed, clinic personnel would have to look up the provider's specialty, select the appropriate fee schedule to

use, determine the provider's customary charge for each billed service, and determine the prevailing charge in the area. Under Medicare, these steps are performed by computer.

DM&S' clinics of jurisdiction hand-process all claims. In its 1982 report, the VA Inspector General's Advisory Council on Fee Basis Medical Programs characterized DM&S' processing system as cumbersome, slow, and frequently inaccurate. The Council recommended that DM&S automate claims processing at all clinics immediately. The Chief Medical Director concurred with this recommendation, and VA was designing a partially automated system at the time of our review. However, a DM&S official said it could be several years before the system is fully automated.

Option 2: Using only the Medicare prevailing charge fee schedules as the basis for reimbursing providers

Like the first option, this one involves abandoning DM&S' present fee schedules. It differs from the first alternative in that it excludes the Medicare screen for the provider's customary charge. Instead, DM&S payment would be based on the actual charge or the prevailing charge, whichever is lower.

Under this approach, the clinics would need to obtain prevailing charge fee schedules from Medicare contractors. VA's cost to obtain these schedules would be less than the first alternative because only about 250 fee schedules are involved.

As with the first alternative, this approach would provide the clinics with more precise fee schedules; that is, the prevailing charge fee schedules recognize the cost differences between urban and rural areas. Also, in some locations these fee schedules recognize cost differences between physicians in different kinds of specialty practice. The fees would be within DM&S' current maximum reimbursement criteria because they would be equal to or below the 75th percentile of charges to the general public.

Under VA's manual claims processing system, this approach would be somewhat easier to administer than the first option because it eliminates the screen involving provider customary charges. It would still be somewhat difficult to administer, however, because clinics would have to use several fee schedules and take several steps to process each claim. For each claim processed, VA personnel would have to look up the provider's specialty, select the appropriate fee schedule, and identify the appropriate fee.

Option 3: Using the Medicare data to establish separate fee schedules

This alternative involves developing new fee schedules each year based on the array of provider charges under the Medicare program. This alternative differs from the other two in that DM&S would decide the percentile level at which to set the reimbursement fees rather than adopting the Medicare fees. This would give DM&S the flexibility to set its own maximum allowable fees.

Under this approach, clinics could arrange for Medicare contractors to furnish fee schedules calculated at a set percentile of provider charges--for example, at the 70th or 80th percentile. This should not be difficult because these contractors now use the array of provider charges to calculate fees at the 50th and the 75th percentiles. Under this approach, DM&S would be reasonably assured that the fees clinics use to reimburse providers would be based on an established uniform percentile of charges to the general public in their areas.

This option would be as complicated to administer as the previous option. Fee schedules would need to be developed for each of about 250 reimbursement localities, and different fees would need to be applied in some localities for physicians in different kinds of specialty practice. For each bill processed, clinic personnel would have to look up the provider's specialty, select the appropriate fee schedule, and identify the appropriate maximum allowable fee for the billed service.

CHAMPUS FEE SCHEDULES CAN BE MORE READILY ADAPTED TO DM&S' MANUAL PROCESSING SYSTEM

CHAMPUS helps pay for medical care provided by civilian health care providers to dependents of active duty members of the uniformed services, military retirees and their dependents, and dependents of deceased members of the uniformed services. The program is administered by the Office of the Civilian Health and Medical Program of the Uniformed Services. This office uses contractors to process CHAMPUS bills. In fiscal year 1984, these contractors processed about 3 million bills. Government payments for these bills totaled about $1.3 billion.

CHAMPUS payments for medical services are limited to the 80th percentile of all actual provider bills in each state. The 80th percentile is determined based on bills during a 12-month period and must be adjusted at least once a year. As part of their responsibilities, CHAMPUS contractors establish a fee schedule for each state based on actual bills received during a

12-month period. The fee schedule identifies the maximum allowable fee that CHAMPUS will pay for billed medical procedures in a particular state.

The CHAMPUS fee schedules are relatively simple compared with Medicare fee schedules. For example, the CHAMPUS contractors do not establish separate fee schedules for urban and rural areas; instead, they prepare one fee schedule for each state. They also do not establish separate fees for physicians in different kinds of specialty practice. Also, the CHAMPUS fee schedules are based on a much smaller volume of physician charges than those developed under the Medicare program.

The CHAMPUS fee schedules would be an improvement over DM&S' present fee schedules because they are based on actual physician charges and updated annually. Although the CHAMPUS schedules are not as precise as those developed under the Medicare program, they would provide DM&S with maximum allowable fees for medical procedures based on actual physician charges in each state.

Under DM&S' manual claims processing system, it would be easier for clinics to use the CHAMPUS fee schedules rather than either the present DM&S or the Medicare fee schedules. In contrast to DM&S' current system, clinic personnel would not have to make any calculations to determine the maximum allowable fee for each billed medical procedure. Instead, the personnel would only have to refer to a schedule to identify the maximum allowable fee.

DM&S could obtain updated CHAMPUS fee schedules each year. It could arrange with CHAMPUS officials to obtain the fee schedules for each state from the six CHAMPUS contractors responsible for developing the schedules. An official from the contractor for 15 western states said that the contractor would provide DM&S with copies of its fee schedules at no cost.

DM&S' COMMENTS ON ALTERNATIVES FOR IMPROVING FEE SCHEDULES

On February 6, 1984, the Chief Medical Director wrote us with DM&S' response to our questions on the possible use of Medicare allowed rates to reimburse providers. The Chief Medical Director said VA was considering various methods for changing its fee schedule, including using Medicare outpatient fee schedules. He stated, however, that before committing VA to using the Medicare fee schedules, DM&S will need to examine these schedules more closely and had requested information on the schedules from Medicare.

In our October 2, 1984, briefing of DM&S officials, we discussed alternative ways for using the Medicare fee system. The DM&S officials said that after examining the Medicare fee schedules, they were concerned about what it would cost, as well as the difficulty in using these schedules under DM&S' manual processing system. DM&S officials also said that they had just recently contacted CHAMPUS officials to obtain information on that program's fee schedules. However, the Director of Medical Administration Services said that because of other higher priority work, he did not have the staff available to make any changes in VA's present fee schedule system.

On April 15, 1985, we again contacted a DM&S official to determine whether the agency had taken any action to change its fee schedule or automate claims processing since our October 1984 meeting. This official said DM&S has made no final decision as to what these changes should be. However, he said DM&S is considering using the CHAMPUS fee schedule and has a test project underway at two locations evaluating its potential impact on payments to providers.

In regard to automating claims processing, this official said DM&S plans to accomplish this as an extension of the agency's Decentralized Hospital Computer Program. In commenting on a draft of this report, the Administrator of Veterans Affairs stated that automation of the system is proceeding and VA's goal is full implementation by the end of fiscal year 1986, depending on the availability of resources.

CONCLUSIONS

The Medicare and CHAMPUS systems for establishing fee schedules both appear to have advantages over DM&S' current system. The fee schedules created by these systems

- --include fees for many medical procedures not included in DM&S' current system,
- --more accurately reflect charges to the general public,
- --use the coding system commonly used by physicians and other health care providers in the area, and
- --are updated annually.

If used by DM&S, these schedules would provide greater assurance that the maximum allowable fees used by clinics meet DM&S' reimbursement criteria.

The Medicare reimbursement system would provide DM&S with more precise fee schedules than the CHAMPUS system. DM&S could adopt any of the three Medicare alternatives we discussed. The alternative selected depends on the amount of flexibility DM&S wants to retain when setting maximum allowable fees. However, the Medicare reimbursement system is fully automated and may not be readily adaptable until DM&S automates its system. By comparison, the CHAMPUS fee schedules are readily adaptable to DM&S' manual system. They could be used immediately.

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator of Veterans Affairs direct the Chief Medical Director to use the CHAMPUS fee schedules as the temporary basis for paying private physicians and other health care providers for care provided to eligible veterans. We also recommend that the Chief Medical Director be directed to use the more precise Medicare fee schedules once the automated claims processing system is fully developed.

AGENCY COMMENTS AND OUR EVALUATION

In an August 1, 1985, letter, the Administrator of Veterans Affairs told us that VA was testing the CHAMPUS fee schedules at two medical centers to determine if it is appropriate to use them throughout the VA system. VA said it expects to have its fee system fully automated by the end of fiscal year 1986, if needed resources are available, and would further study whether it is appropriate for VA to use the Medicare fee schedules.

We believe that our work has shown that VA's current system needs to be replaced and that either the CHAMPUS or Medicare schedules could be used to assess the reasonableness of fees charged VA by private health care providers. We also believe that VA's current and planned studies of these fee schedules should focus on how, rather than whether, VA can use them.

APPENDIX I

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

AUG 1 1985

Mr. Richard L. Fogel
Director, Human Resources Division
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Fogel:

Your June 25, 1985 draft report "VA Needs Better Control Over Its Payments to Private Health Care Providers" has been reviewed.

GAO recommends that I direct the Chief Medical Director to

--use the CHAMPUS fee schedules as the temporary basis for paying private physicians and other health care providers for care provided to eligible veterans.

The VA is currently testing the CHAMPUS fee schedules at two VA medical centers. Once the test results are analyzed, we will be in a better position to decide if use of the CHAMPUS fee schedules is appropriate.

GAO also recommends that the Chief Medical Director be directed to

--establish a timeframe for fully automating its claims processing system, and

--use the more precise Medicare fee schedules once the claims processing system is fully automated.

Automation of the fee system is proceeding and our goal is full implementation by the end of Fiscal Year 1986. However, completion of the project within this specified time is dependent upon the availability of resources.

It is necessary to conduct further studies of the Medicare fee schedules to determine if adoption of these schedules is appropriate. This determination will be made when the studies are completed and the results are analyzed.

Thank you for the opportunity to review this report.

Sincerely,

Harry N. Walters

HARRY N. WALTERS
Administrator

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