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Report to Max Cleland, Administrator, Veterans Administration; by Gregory J. Ahart, Director, Human Resources Div.

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A study was conducted of the Veteran's Administration (VA) fee-basis program at selected VA hospitals to evaluate the management of selected fee-basis medical services and to determine if any of the services provided on a fee basis could be performed by the VA. Veterans who are eligible for outpatient fee-basis treatment are issued a VA Outpatient Medical Treatment Information (ID) card. The VA's monitoring of the ID card program is inadequate, and as a result, staff of VA hospitals and outpatient clinics do not routinely know whether patients who were issued ID cards remain eligible for private medical treatment at VA expense. Fee-basis dental costs could be reduced if VA hospitals performed more dental work in-house. Some VA hospitals' methods of recording the costs of fee-basis services are incorrect and inconsistent, and providers are often overpaid for the fee-basis services they render. There is a need for cost limitations for certain automobile adaptive equipment, including citizens' band radios. The Administrator of the VA should: establish a system for monitoring the initial authorization and continued need for ID cards which would include, as a minimum, requiring periodic medical reports from private practitioners and cyclical redeterminations of fee-basis eligibility; evaluate dental services available in VA hospitals and those needed based on workload demands; develop a standardized fee-basis guide for charging specific inpatient fee-basis procedures; direct a study to determine the extent of fee-basis overpayments and take appropriate corrective action; and establish limitations for reimbursing disabled veterans for citizens' band radios installed in automobiles. (RRS)

6422

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

HUMAN RESOURCES
DIVISION

B-133044 June 6, 1978

The Honorable Max Cleland
Administrator of Veterans Affairs

Dear Mr. Cleland:

We have completed a study of the Veterans Administration (VA) fee-basis program at selected VA hospitals. Our objectives were to (1) evaluate the management of selected fee-basis medical services and (2) determine if any of the services provided on a fee basis could be performed by VA.

Enclosure I describes in detail the results of our review. Among other things, we found

--inadequate monitoring of veterans' medical condition to determine their continued need and eligibility for fee-basis services,

--more dental services could be performed by VA,

--incorrect and/or inconsistent methods used among VA hospitals and clinics in reporting fee-basis costs,

--overpayments by VA for fee-basis services, and

--a need for cost limitations on certain automobile adaptive equipment.

We are recommending that you

--establish a system for monitoring the initial authorization and the continued need for ID cards in the fee-basis outpatient program which would include, as a minimum, requiring periodic medical reports from private practitioners and cyclical redeterminations of fee-basis eligibility,

--evaluate dental services available and those needed in VA hospitals, based on workload demands,

--develop a standardized fee-basis guide listing the specific account and subaccount to which each specific inpatient fee-basis procedure should be charged,

--direct a study to determine the extent of fee-basis overpayments and take the appropriate actions to correct this problem, and

--establish national limitations for reimbursing disabled veterans for the cost of CB radios installed in automobiles and consider establishing reimbursement limitations for other adaptive equipment.

As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency'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 Chairmen, House Committees on Appropriations, Government Operations, and Veterans' Affairs; the Chairmen, Senate Committees on Appropriations, Governmental Affairs, and Veterans' Affairs; and the Director, Office of Management and Budget.

We would appreciate being informed on any actions taken or planned on the matters discussed in this report.

Sincerely yours,

Gregory J. Ahart
Director

Enclosures - 2

ENCLOSURE I

STUDY OF THE VETERANS ADMINISTRATION FEE-BASIS PROGRAM

BACKGROUND

The Veterans Administration operates hospitals or outpatient clinics in most major cities. Since its establishment more than 50 years ago, the VA health care system's primary mission has been to provide care to veterans with service-connected disabilities. Its secondary mission has been to provide care to veterans with non-service-connected disabilities, but only to the extent that facilities and staff are available.

Veterans are usually treated in VA hospitals or outpatient clinics. However, those who do not live near a VA hospital or clinic or who need specialized treatment, unavailable at a nearby VA facility, may obtain the needed services from private providers who are paid by VA. Chapter 17 of title 38 of the U.S. Code authorizes treatment for veteran beneficiaries in VA hospitals and outpatient facilities and also authorizes non-VA medical services for certain beneficiaries. Services authorized include (1) outpatient care, dental care, prescriptions and prosthetics, provided on a "fee basis" at VA expense, and (2) hospital care and community nursing home care provided by facilities under contract with VA. For these services, VA spent $289 million in fiscal year 1976 (see enc. II) and about $241 million in fiscal year 1975.

SCOPE OF REVIEW

Our work was performed at VA central office in Washington, D.C.; at VA hospitals in Cincinnati, Ohio; Martinez and San Francisco, California; and Reno, Nevada; and at the independent outpatient clinic in Brooklyn, New York. We reviewed records pertaining to services classified as medicine, surgery, radiology, nuclear medicine, prosthetics, outpatient medical and dental treatment, and contract hospitalization.

We interviewed VA officials and staff, reviewed program policies and guidelines, and reviewed files and reports on selected patients.

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INADEQUATE MONITORING
OF ID CARD PROGRAM

Veterans who are eligible for outpatient fee-basis treatment and who require medical and/or nursing services for an extended or indefinite period of time are issued a VA Outpatient Medical Treatment Information (ID) card. Approving outpatient fee-basis status is the responsibility of the clinic director at the VA health care facility which has an authorized fee-basis activity. An ID card may be issued if the veteran is (1) housebound, (2) needs medical care which is unavailable at the VA facility, or (3) lives outside a locally determined mileage radius of a VA facility.

This card may be used by the veteran to obtain outpatient medical services from a licensed physician of his choice for the approved disability recorded on the card. Normally, an issued ID card has no expiration date and is not terminated unless it becomes known by VA that the need for medical or nursing services no longer exists.

At VA hospitals we reviewed, we found that VA does not have an effective procedure for periodic reevaluation of veterans issued ID cards. Therefore, questionable cases are not always found and presented to the VA clinic director, who is supposed to assure himself that the type and amount of treatment by a fee-basis provider is appropriate for the condition for which the veteran is authorized fee-basis care by VA. The need, frequency, and means of evaluation are considered a matter of professional determination. We believe VA should establish requirements for periodic reevaluation of whether veterans need to continue receiving fee-basis care.

We selected a sample of 205 veterans who had been issued ID cards and who received fee-basis outpatient treatment during fiscal years 1976 and/or 1977. We examined records of 182 veterans but could not locate medical records for the 23 remaining veterans. Our examination showed the following:

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VA Facilities Reviewed

	Cincinnati VA Hospital	San Francisco VA Hospital	Reno VA Hospital	New York Outpatient Clinic	Total
Properly authorized ID cards	71	19	39	15	144
Questionably authorized ID cards	4	4	1	1	10
ID cards should be recalled	0	a/25	0	3	28
Unavailable medical records	0	2	0	21	23
Total ID cards sampled	75	50	40	40	205

a/Twenty-two of these veterans live within the service area of the Palo Alto VA Hospital, which recently began treating outpatients; the veterans could now use the VA hospital instead of obtaining services from private providers on a fee basis.

The following examples illustrate the need for VA to monitor the ID card program more closely.

--Two veterans were issued ID cards for podiatry care even though both veterans lived within a 50-mile criterion established by the Cincinnati VA Hospital. The hospital has had a consulting podiatrist since 1973. Still, in fiscal year 1976, VA paid a total of $325 for outpatient fee-basis services rendered these two veterans.

--A veteran was issued an ID card by the Cincinnati VA Hospital to obtain private treatment of a diabetic condition even though he lived within the 50-mile criterion established by the Cincinnati VA Hospital.

--A veteran was authorized fee-basis psychiatric treatment by the Brooklyn VA Outpatient Clinic in 1949 because he was employed and could not take time off to travel to a VA hospital. His medical record was last reviewed in 1967. At the time of our review in 1977 he was being seen by a private psychiatrist twice a month at a cost of $20 per visit.

--A veteran was authorized an ID card by the Brooklyn VA Outpatient Clinic in 1946 for treatment of a nervous condition. Employment status was given as the reason for approval because the veteran was unable to take time off from work and travel to a VA hospital. Although he retired in 1973, he was treated on a fee basis in 1975.

We presented questionable cases to VA hospital officials, who generally concurred with our finding that VA does not adequately monitor fee-basis cases. The VA officials we interviewed believed that, although there is an apparent need to monitor fee-basis cases, VA regulations do not require it.

We believe VA should require periodic monitoring and evaluation of patients with fee-basis ID cards to determine if initial authorizations were proper and if patients have improved medically or, in fact, are still eligible for private medical treatment.

MORE DENTAL SERVICES SHOULD BE PROVIDED IN-HOUSE

The San Francisco VA Hospital normally performs unusual or complicated dental procedures and refers other cases to private dentists for treatment on a fee basis. We believe the hospital could perform more of the general dental work in-house and reduce the amount of fee-basis work. We also believe that dentists, when not working on speciality cases, should work on general type cases.

The number of fee-basis dental outpatient visits paid for by the San Francisco VA Hospital increased from 5,467 in fiscal year 1975 to 6,686 in fiscal year 1976. The fee-basis outpatient dental costs at the hospital were $3,566,972 for fiscal year 1976, a $628,805 increase from fiscal year 1975. Veterans living within 25 miles of San Francisco are required to go to the San Francisco VA Hospital for any required dental examination. Prior to April 1977, the hospital used a 50-mile radius

Dental work indicated by examinations is screened, and the unusual or complicated cases having training value for dental residents are done in-house. General practice type dentistry is usually performed by private dentists on a fee basis.

The reasons cited by San Francisco VA Hospital officials for not doing more outpatient dental work included the following:

--Emphasis is placed on training--only one of the seven VA dentists and two of the five dental residents at the hospital are generalists.

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--Productivity is low, due in part to training programs and lack of demand for the speciality capabilities (each VA dentist is averaging four patients a day--two examinations and two treatments).

We noted that VA's Internal Audit Service (IAS) reviewed the San Francisco VA Hospital's Dental Service in 1977. In its March 1977 report, IAS recommended that:

> "Mission priorities within the service should be evaluated in terms of the type of dental services available and those needed based upon workload demands. The service is organized and staffed to stress specialization and teaching activities. As a result, some general practice type dentistry must be performed on a fee basis and there is less than adequate utilization of staff dentists. Additional emphasis is also needed to increase the number of initial oral dental examinations and to strengthen the preventive dentistry program."

In contrast to the San Francisco VA Hospital's policy of referring general practice type dentistry to private dentists, the Reno VA Hospital, which has three general dentists, refers only its dental speciality cases. We were told that this procedure frees the VA dentists to treat more patients. The number of fee-basis outpatient visits paid for by the Reno VA Hospital decreased from 571 in fiscal year 1975 to 235 in fiscal year 1976. The fee-basis dental costs for fiscal year 1976, including those of the Henderson VA Outpatient Clinic located 15 miles from Las Vegas, Nevada, were $138,309, a decrease of 45 percent over the previous year. The decreases continued into the first quarter of fiscal year 1977. Reno VA Hospital officials attributed the decrease in fee-basis costs to a combination of better control over the program and fewer veterans leaving the military. By law, veterans leaving the military are allowed 1 year to apply to VA for any service-connected dental treatment considered necessary.

In light of our findings at San Francisco and Reno VA Hospitals, we concur with the recommendation in the IAS report that VA should evaluate the dental services available in its hospitals and those services needed based on workload demands.

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METHODS OF RECORDING CERTAIN FEE-BASIS COSTS ARE INCORRECT AND INCONSISTENT

Some VA hospitals' methods of recording costs of services for patients in VA hospitals by non-VA providers are incorrect and inconsistent. This can distort the data which the hospitals report to VA central office for use in making management decisions relating to budgeting, planning, and other aspects of the fee-basis programs.

At the Reno VA Hospital, fee-basis program costs were being reported based on the wards of the VA hospital to which patients were assigned rather than on the type of medical procedures performed. For example, a medical procedure such as an electroencephalogram (EEG) was charged to a surgery account if the patient was on the surgery ward. If the same procedure involved a patient on a psychiatric ward, it would be charged to the psychiatry account. The EEG is a medical cost and should be charged to the medical account. We brought this matter to the attention of Reno VA Hospital officials, and, effective April 15, 1977, the hospital began charging these costs by type of procedure performed.

At the San Francisco VA Hospital, we found some inconsistencies and inaccuracies in the methods of reporting these costs--the same procedures were charged to different accounts. For example, over a 12-month period mammograms were charged either to the inpatient medical, radiology, or nursing service accounts. Until fiscal year 1977, many specialized tests, such as computerized tomographic scans, were charged to the nursing service account, and radiation therapy services were charged to the medical account instead of the radiology account. To correct some of these problems, the hospital's accounting section prepared a memorandum on August 30, 1977, which listed the accounts to which some of these tests should be charged.

As a result of such incorrect and inconsistent methods in reporting, fee-basis cost data reported to VA central office does not always provide an accurate presentation. For example, at the San Francisco VA Hospital, most of the fiscal year 1976 radiation therapy costs of about $208,000 were charged to the outpatient medical account, and $101,000 of the computerized tomographic scan costs were charged to the nursing service account. This problem was corrected at the hospital, and, now, radiation therapy and scans are charged to the radiology account.

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The guidance which VA central office has provided to its hospitals and clinics for reporting fee-basis costs is a numerical chart of accounts and subaccounts. This chart lists what services can be charged to a specific account but provides no guidance to the hospitals and clinics for charging special medical procedures to specific accounts. For example, there is no guidance as to where fee-basis radiation costs should be charged. As a result, each VA hospital or clinic makes its own decision as to which account each medical procedure should be charged. Left to their own determinations, Martinez, Reno, and San Francisco VA Hospitals reported some fee-basis costs inconsistently.

We believe VA central office should develop a nationwide standardized fee-basis guide, listing the specific account and subaccount to which each fee-basis medical procedure should be charged by the hospital or clinic. This would result in more consistent, accurate, and reliable data being reported to VA central office.

OVERPAYMENTS FOR FEE-BASIS SERVICES

Many veterans who receive fee-basis services are covered under other Federal health programs such as Medicare. When another Federal program pays for services authorized by VA under the fee-basis program, VA regulations require the authorizing VA station to pay only the unpaid portion of the bill, including any deductibles and coinsurance, up to the amount that would be paid if the entire bill had been submitted only to VA.

Our review of bills paid by the San Francisco VA Hospital revealed two problems. We found instances where Medicare and VA were paying for the same service, each unaware that the other had already paid the bill. We also found that the San Francisco VA Hospital overpaid providers of fee-basis services who billed VA for balances of unpaid portions of their fees. Our initial review disclosed 15 fee-basis claims which were overpaid by $595 because VA regulations were not followed.

To determine the extent of this latter problem at the San Francisco VA Hospital, we reviewed all fee-basis payments made by the hospital in January 1977. Of the 2,069 bills reviewed, 39 showed prior payment by another Federal program. VA incorrectly paid 9, or 24 percent, of the 39 bills, resulting in overpayments totaling $434. If the hospital's overpayment experience in January 1977 can be considered representative, annual overpayments could total about $5,200 at the San Francisco VA Hospital.

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San Francisco VA Hospital officials said the overpayments were caused by two problems. First, some voucher examiners in Medical Administration Services did not understand the medical explanation of the benefit coverage and payments from other Federal health programs which physicians included with their bills to VA. This resulted in the voucher examiner approving payment in the same amount that the other Federal program had already paid.

Second, some voucher examiners erroneously approved payment of the full differences between what the physicians billed and what the other Federal programs had paid. Only the maximum VA allowable amounts for the particular services rendered should have been paid. For example, a physician billed Medicare $25 for an office visit, of which Medicare paid $13.60. The physician then billed VA for the difference of $11.40. The maximum VA allowable payment for the consultation was $22.75. The VA voucher examiner should have approved payment of only $9.15--$22.75 minus $13.60--but instead approved for payment the full difference of $11.40 resulting in an overpayment of $2.25.

Although we looked into these problems only at the San Francisco VA Hospital, they could be more widespread. Therefore, we believe VA central office should study the extent of similar overpayment problems at other VA hospitals and clinics. Payment determinations made by hospital voucher examiners should be periodically audited to insure their accuracy, and voucher examiners should be properly instructed as to the maximum allowable payments for fee-basis service under VA regulations.

NEED FOR COST LIMITATION FOR CERTAIN AUTOMOBILE ADAPTIVE EQUIPMENT

During our review, we noted a problem concerning automobile adaptive equipment paid for by VA. (We did not evaluate the need for adaptive equipment.)

Effective February 1, 1975, Public Law 93-538 (38 U.S.C. 1902) extended eligibility for automobile allowances and adaptive equipment to all veterans and active duty personnel who have lost, or lost use of, a hand or foot resulting from service during World War II or thereafter. The costs of all adaptive equipment necessary to safely operate a motor vehicle are eligible for reimbursement. In May 1975, VA central office informed its stations that such items as air-conditioning

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equipment and citizen band (CB) radios may be furnished upon local authority without regard to cost under existing criteria for furnishing such items. A disabled veteran needs only to send a paid invoice, along with a letter explaining his or her use of the equipment, to the local VA authority and, upon approval, will be reimbursed for the full cost without limitation.

While we did not review payments for all automobile adaptive equipment, we noted that many veterans in the Cincinnati, Ohio, area were buying expensive CB radios for their automobiles when less expensive CB radios might meet their requirements. During calendar year 1976, the Cincinnati VA Hospital reimbursed 43 veterans for CB radios at prices ranging from $126 to $486. The average cost was $270. The hospital's reimbursement totaled $11,628.

If the Cincinnati VA Hospital could have limited its reimbursements for CB radios to the lowest price of $126, it could have reduced its fee-basis costs for this item to about $5,418, resulting in a savings of about $6,210.

We believe VA should adopt reasonable national reimbursement limitations for CB radios and other adaptive equipment.

CONCLUSIONS

Based on our review at selected hospitals, we believe that certain improvements are needed in VA's management of the fee-basis program. Specifically, we found that:

--VA's monitoring of the ID card program is inadequate. As a result, staff of VA hospitals and outpatient clinics do not routinely know whether patients who were issued ID cards remain eligible for private medical treatment at VA expense.

--Fee-basis dental costs could be reduced if VA hospitals performed more dental work in-house.

--Some VA hospitals' methods of recording costs of fee-basis services are incorrect and inconsistent.

--Providers are often overpaid for fee-basis services rendered.

--Limitations are needed on the amount VA will pay for certain automobile adaptive equipment.

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RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator:

--Establish a system for monitoring the initial authorization and the continued need for ID cards in the fee-basis outpatient program which would include, as a minimum, requiring periodic medical reports from private practitioners and cyclical redeterminations of fee-basis eligibility.

--Evaluate dental services available in VA hospitals and those needed based on workload demands.

--Develop a standardized fee-basis guide listing the specific account and subaccount to which each specific inpatient fee-basis procedure should be charged.

--Direct a study to determine the extent of fee-basis overpayments at VA's clinics of jurisdiction and take the appropriate actions to correct this problem.

--Establish national limitations for reimbursing disabled veterans for the cost of CB radios installed in automobiles and consider establishing reimbursement limitations for other adaptive equipment.

ENCLOSURE II

FISCAL YEAR 1970 DIRECT PATIENT CARE COST OF FEE-BASIS MEDICAL ASSISTANCE

Department	Consultants & Attendings (note a) Medical & Nursing	Consultants & Attendings (note a) Dental	Fee Basis Medical & Nursing	Fee Basis Dental	Personal Services Contracts With Individuals (note b)	Contract Hospital & Outpatient Treatment	Fee Prescriptions	Miscellaneous Contractual Services	Grand Total
Medical	$140,211		$ 8,557,274		$ 8,556,654			$ 10,363,056	$ 27,617,195
Surgical	310,364		1,909,258		6,623,397			3,729,032	12,572,051
Psychiatry	75,119		501,143		2,276,621			559,342	3,412,225
Social Work					68,621			10,559	79,180
Radiology	83,448		2,852,970		2,519,817			5,013,853	10,470,088
Laboratory	57,114		2,337,151		1,288,151			2,481,328	6,163,744
Pharmacy			829		32,650			75,949	109,428
Medical Illustration					13,000			101,744	114,744
Libraries					1,019			228,260	229,279
Psychology			2,362		264,348			28,391	295,101
Audiology & Speech Path.			4,517		84,093			9,987	98,597
Nuclear Medicine			253,923		299,285			517,258	1,070,466
Nursing			207,063		182,465			92,164	481,692
Rehabilitation Medicine	607		60,238		365,771			82,153	508,769
Dietetic					6,402			65,620	72,022
Chaplains					312,600			39,686	352,286
Blind Rehab. Centers			89		21,379			9,758	31,226
Dental Clinics		$8,087	585	$ 4,191	746,265			23,881	783,009
Central Dental Laboratories					9,375				9,375
Dental Training Center					1,677			12,719	14,396
Outpatient Fee--Medical, Dental, & Pharmacy (note c)			36,996,522	55,154,010			$9,354,048		103,504,580
Federal Employee Health Program					16,064			15,689	31,753
Prosthetic Activities			1,126,724		58,046			1,392,236	2,577,006
Contract Hospitalization						$16,146,661		25,870,509	42,017,170
Nursing Home Care - Community						1,303,542		53,607,511	54,911,053
CHAMPVA						3,517,108		16,553,323	22,070,431
Total	$666,863	$8,087	$56,810,648	$55,158,201	$23,747,700	$22,967,311	$9,354,048	$120,884,008	$289,596,866

a/Payroll Consultants and Attendings.

b/Includes Nonpayroll Consultants and Attendings.

c/Cost of Hometown Physicians, Dentists, and Pharmacies.

ENCLOSURE II