DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

VHA Risks Overpaying Community Care Providers for Evaluation and Management Services

REVIEW | REPORT #21-01807-251 | DECEMBER 8, 2021

MISSION

The mission of the Office of Inspector General is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

www.va.gov/oig/hotline

1-800-488-8244

Executive Summary

Veterans increasingly obtain medical care from community providers because of legislative initiatives such as the VA MISSION Act of 2018.[1] The VA Office of Inspector General (OIG) conducted this review to identify and evaluate the Veterans Health Administration's (VHA) risk of improperly paying community care providers for evaluation and management services not supported by medical documentation. An earlier OIG audit revealed the high risk associated with missing and insufficient medical documentation for evaluation and management services billed by non-VA acupuncturists and chiropractors.[2] This review builds on the findings of that report and assesses the risks of billing for such services by care providers of all specialties.

In fiscal year (FY) 2020, VHA paid community providers about $303.6 million for evaluation and management services, which include evaluating a patient's history or examining a patient and making a medical decision. Payments have increased by about 350 percent from about $67.5 million in FY 2017. These services are billed according to their complexity, and providers are paid more for more complex visits. VHA's vulnerability to overbilling for these services warranted this review.

What the Review Found

VHA's lack of internal controls puts it at risk of improperly paying for non-VA evaluation and management services in two significant areas.

First, the OIG's data analysis results showed some providers are billing for a significantly higher rate of high-level evaluation and management services than their peers in the same specialty, indicating the need to look more deeply to ensure providers are not improperly upcoding, either intentionally or not. Upcoding is the practice of assigning an inaccurate billing code to a medical procedure that results in higher compensation. The OIG determined that in FY 2020, more than 37,900 non-VA providers billed and were paid for significantly more high-level evaluation and management codes than were all providers in that specialty on average.[3] For these high-level evaluation and management services, the community providers received about $39.1 million (13 percent) of the about $303.6 million that VHA paid for all non-VA evaluation and management services. Appendix A defines the levels of codes that providers can use to charge

[1] John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182.
[2] VA OIG, *VHA Improperly Paid and Reauthorized Non-VA Acupuncture and Chiropractic Services*, Report No. 20-01099-249, December 8, 2021.
[3] These providers were paid for high-level evaluation and management services proportionally more than one standard deviation above the mean for all providers within their specialty. This included about 17 percent of all providers.

for evaluation and management services; appendix B describes the review scope and methodology.

Second, the team's data analysis results also showed some providers billed separately for evaluation and management services while the global surgery package, which generally encompasses all charges related to a surgery, was in effect.[4] If the evaluation and management service is separate and identifiable—for example, charged by an orthopedist for a shoulder problem the patient experiences after a hip surgery—it may be reasonable. However, the global surgery package is supposed to cover all services related to the surgery for a set period before, during, and after surgery. Therefore, separately billed evaluation and management services during this period are more apt to be improper. The review team identified more than 45,600 providers who were paid about $37.8 million in FY 2020 for these evaluation and management services while the global surgery package was in effect.[5]

Improper payments are not easily detected because the OIG found VHA staff at medical facilities did not retrospectively audit medical documentation to determine whether the evaluation and management service was billed at an appropriate level, even though retrospective reviews are required by VA guidance.[6] VHA requires provider documentation to support what was billed in accordance with the American Medical Association's Current Procedural Terminology (CPT) code guidelines. However, VHA staff did not conduct these reviews because few VA medical facilities had access to the claims information needed. VHA was in the process of trying to direct these data and reporting tools to facilities but had not completed the task by May 2021.

The MISSION Act requires VA to teach employees and contractors how to administer non-VA programs, evaluate the effectiveness of this program at least annually, and assess medical service care quality.[7] Further, the MISSION Act requires VA to educate providers who participate in community care programs and provide the same "continuing medical education material" to non-VA providers that is available to VA providers to "ensure that all medical professionals treating veterans have access to the same materials."[8] However, VHA relied on third-party contractors that assist in administering community care programs to train providers. The OIG

[4] The Centers for Medicare & Medicaid Services (CMS) Global Surgery Booklet states that the global surgical package "includes all the necessary services normally furnished by a surgeon before, during, and after a procedure." Medicare Learning Network, *Global Surgery Booklet*, accessed May 25, 2021, https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/globallsurgery-icn907166.pdf.

[5] About 6,700 providers were responsible for billing both an estimated $4.8 million of global surgery charges and high-level evaluation and management significantly more than their peers.

[6] VHA Guidebook, *HIM Clinical Coding Program Guide*, ver. 1.4, chap. 5, sec. m, September 7, 2018.

[7] MISSION Act of 2018, § 102, 122, 123.

[8] MISSION Act of 2018, § 123. "The Secretary of Veterans Affairs shall establish a program to provide continuing medical education material to non-Department medical professionals."

found no evidence that these contractors or VHA provided training to non-VA providers that was similar to training for VA providers on how to document evaluation and management services.

As a result, VHA risks overpaying for evaluation and management services amounting to about $19.9 million in FY 2020 based on a conservative estimate. The OIG arrived at this estimate based on the Centers for Medicare & Medicaid Services (CMS) improper payment rate for like services from non-VA providers. As noted in appendix C, this amount was estimated for the following two fiscal years (the time during which monetary benefits would not yet be realized due to the need for corrective actions to yield results). That amount is about $59.6 million in questioned payments made for non-VA evaluation and management services from FY 2020 to FY 2022.[9]

What the OIG Recommended

The OIG recommended the under secretary for health ensure the review of medical documentation for evaluation and management services billed by community providers, develop processes to act on the results, and ensure non-VA providers receive continuing education materials on proper medical documentation for evaluation and management services.

Management Comments

The acting under secretary for health concurred with the recommendations and provided responsive corrective action plans. The acting under secretary for health said program offices and facility chiefs of staff would create a plan to conduct retrospective audits of billed outpatient services and to take corrective actions based on non-VA provider billing issues and will give community providers appropriate educational materials. The OIG will monitor implementation of all planned actions and will close the recommendations when it receives sufficient evidence demonstrating progress in addressing the recommendations and the risk areas identified in this report.

The acting under secretary for health also made a technical comment stating that the OIG inappropriately applied VHA Handbook 1907.01 because the handbook only provided specific guidance on the inclusion of non-VA medical care documentation and not that community providers are required to meet the American Medical Association and CMS guidelines.

The OIG acknowledges VHA's position but does not interpret VHA Handbook 1907.01 to limit the requirement for the American Medical Association's CPT code use to VA providers alone; rather, it seems broadly to require that the American Medical Association's CPT codes and code

[9] To estimate monetary benefits for FY 2020, the review team multiplied CMS's average improper payment rate by all non-VA evaluation and management services except for those on acupuncture and chiropractic claims (which were questioned in an earlier OIG report). This $59.6 million in questioned costs is separate and distinct from the questioned costs in the VA OIG report, *VHA Improperly Paid and Reauthorized Non-VA Acupuncture and Chiropractic Services*. The total questioned costs do not sum exactly due to rounding.

assignment in accordance with CMS guidelines be used when documenting care in veterans' health records. Appendix D includes the full text of the acting under secretary for health's comments.

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

Contents

Abbreviations

CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
FY	fiscal year
HIM	Health Information Management
OCC	Office of Community Care
OIG	Office of Inspector General
VHA	Veterans Health Administration

Introduction

The VA Office of Inspector General (OIG) conducted this review to identify and evaluate the risks of VA improperly paying for community care providers' evaluation and management services that are not supported by medical documentation. These services include reviewing a patient's history, conducting examinations, and making a medical decision. Another OIG audit of non-VA acupuncture and chiropractic care revealed that the Veterans Health Administration (VHA) reimbursed non-VA acupuncture and chiropractic providers for claims that were not supported by medical documentation. Specifically, the vast majority of evaluation and management service treatment codes included in acupuncture and chiropractic claims were not supported.[10] This review builds on the findings of that report and assesses the risks of billing for such services by care providers of all specialties.

VHA Medical Documentation Standards

VHA's Health Information Management (HIM) office is responsible for ensuring health records are accurate and for developing VHA coding procedures. VHA policy required non-VA providers' medical documentation to meet American Medical Association and Centers for Medicare & Medicaid Services (CMS) guidelines.[11] The American Medical Association's Current Procedural Terminology (CPT) coding guidelines describe terms and identify codes for reporting medical services and procedures performed by physicians. The CMS also requires practitioners to use treatment codes in accordance with these guidelines.[12]

Office of Community Care

VHA's Office of Community Care (OCC) manages VA programs allowing veterans to receive medical care from local, non-VA providers. This review covers evaluation and management services delivered by non-VA providers under the authority of the VA MISSION Act of 2018,

[10] VA OIG, *VHA Improperly Paid and Reauthorized Non-VA Acupuncture and Chiropractic Services*, Report No. 20-01099-249, December 8, 2021. Specifically, the OIG found that about 97 percent of the billed evaluation and management services reviewed on acupuncture claims and about 78 percent of the billed evaluation and management services on chiropractic claims were not fully supported by medical documentation.

[11] VHA Handbook 1907.01, Health Information Management and Health Records, March 19, 2015. According to the handbook, "The medical facility Director, or designee, is responsible for establishing policies and processes in compliance with this Handbook, to include ensuring … Non-VA medical care is documented," and "the latest United States editions of the American Medical Association's CPT … must be used to provide uniform disease and operation terminology." VHA Guidebook, *HIM Clinical Coding Program Guide,* ver. 1.4, chap. 5, sect. m, September 7, 2018. For billing purposes, a treatment is represented by a CPT code.

[12] "CPT Purpose & Mission," American Medical Association, accessed May 19, 2021, https://www.ama-assn.org/about/cpt-editorial-panel/cpt-purpose-mission.

which were administered by third-party contractors.[13] Under their contracts, the third-party administrators pay the non-VA healthcare providers, and VA reimburses the third-party administrators. The MISSION Act requires VHA to authorize care before it is delivered.[14]

Evaluation and Management Services

VHA payments for non-VA evaluation and management services increased by about 350 percent from about $67.5 million in fiscal year (FY) 2017 to about $303.6 million in FY 2020. Payments for all non-VA care increased by more than 500 percent during this time.

To deliver an evaluation and management service, a care provider generally evaluates a patient's history or examines a patient to make a medical decision. There are five levels of evaluation and management service codes, from level 1 to level 5. Level 1 codes are for medical encounters that contain the least complex patient visit and documentation requirements. A provider may use a level 1 code for evaluating a cold, for example. Each subsequent level requires a more complex visit and requires more in-depth documentation. Level 5, which could be the evaluation of a chronic illness such as progressive severe rheumatoid arthritis, requires the most complex visit and documentation. The documentation must satisfy all requirements for the billed code(s). Appendix A contains a precise definition of each service level and code.

The CMS changed the evaluation and management services standards on January 1, 2021, to reduce the amount of time it takes providers to document these services.[15] Some of the revisions included eliminating medical history and physical examination as elements for code selection, allowing code selection based on modified criteria for medical decision-making or time, and eliminating the lowest level code for the evaluation and management of a new patient.[16] HIM officials told the review team that the updates might actually make determining whether a code supports the procedure performed more difficult.

[13] John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182.

[14] VA MISSION Act of 2018. The "covered veteran may only receive care or services under this section upon the authorization of such care or services by the Secretary."

[15] The updated standards took effect after the scope of this review period, which was FY 2020.

[16] Lori Baker, "2021 Changes for Evaluation and Management Services," *The National Law Review*, vol. XI, no. 99 (February 26, 2020), accessed April 9, 2021, https://www.natlawreview.com/article/2021-changes-evaluation-and-management-services.

Results and Recommendations

Finding: VHA Risks Improperly Paying for Non-VA Evaluation and Management Services

VHA faces a high likelihood of paying for non-VA evaluation and management services that are not supported by documentation. Through data analyses, the OIG identified two areas of risk: (1) some community care providers billing significantly more high-level evaluation and management services than their non-VA peers (those within their specialty group), and (2) providers billing evaluation and management services during periods when the global surgery package was in effect when all related surgery costs are not billed separately.[17] VHA is susceptible to such overpayments because its staff did not perform oversight reviews to ensure medical documentation supports billed services. By not conducting the required reviews, VHA misses the opportunity to establish a process for using any resulting information to improve medical documentation for non-VA evaluation and management services. The OIG conservatively estimated questioned costs of about $59.6 million in non-VA evaluation and management services payments from FY 2020 to FY 2022.[18]

This finding takes into consideration the following five determinations:

1. Some non-VA community care providers billed high-level evaluation and management services significantly more than their peers, which may be an indicator of upcoding.
2. Some non-VA care providers billed evaluation and management services that potentially should not have been separately charged during periods when the global surgery package was in effect.[19]
3. VHA staff did not retrospectively audit medical documentation for billed services as part of their oversight responsibility.
4. VHA did not make continuing education materials related to evaluation and management services available to community providers.

[17] CMS, *Global Surgery Booklet*, September 2018. The global surgery package covers related services for a fixed period before and after a surgery. Medicare payment for a surgical procedure includes all services routinely performed by the surgeon or by members of the same group with the same specialty related to the surgery.
[18] The $59.6 million in questioned costs is separate and distinct from the questioned costs in the VA OIG, *VHA Improperly Paid and Reauthorized Non-VA Acupuncture and Chiropractic Services*.
[19] CMS, *Global Surgery Booklet*. The global surgery package covers related services for a fixed period before and after a surgery. "Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician."

5. Unaddressed risks could lead to millions of dollars in payments for non-VA evaluation and management services without assurance of proper billing.

What the OIG Did

The team reviewed payment data for non-VA evaluation and management services by

- conducting trend analyses to substantiate that payments for non-VA evaluation and management services were increasing, along with payments for all non-VA care;
- analyzing data to isolate high-level evaluation and management service codes in the FY 2020 population and evaluate how often providers were billing for these different levels;
- using data to identify evaluation and management services billed during global surgery periods in FY 2020;
- determining how many non-VA providers were also eligible to render Medicare services to corroborate the similarity in the providers who perform services under VA community care and CMS healthcare; and
- calculating a conservative estimate of questioned costs for VA payments to community care providers for evaluation and management services.

The review team also interviewed officials from VHA's OCC and HIM program offices to ask about risk-mitigation efforts.

Some Non-VA Community Providers Billed High-Level Evaluation and Management Services Significantly More Than Their Peers

High-level evaluation and management services (levels 4–5) are significantly more expensive than low-level services (levels 1–3). In FY 2020, at least 37,900 providers of about 218,000 community care providers billed level 4 and level 5 evaluation and management services significantly more often than all other providers in their specialty—a potential flag for upcoding that warrants additional examination.[20] Upcoding describes the improper practice of assigning an inaccurate billing code to a medical procedure to increase reimbursement. For example, a provider bills a level 4 evaluation and management code but only satisfies the elements for level 3. Therefore, level 4 and 5 codes are higher risk because they are more profitable.

[20] The review team examined the data of 3.2 million community care claims. The providers in question billed high-level evaluation and management services proportionally more than one standard deviation above the mean for all non-VA providers in their specialty. The 37,900 providers identified from October 1, 2019, through September 30, 2020 (FY 2020), represent about 17 percent of all non-VA care providers.

These 37,900 providers collectively received payments of around $39.1 million specifically for these high-level evaluation and management services or about 13 percent of the roughly $303.6 million VHA paid for all non-VA evaluation and management services during that period. For example, the data indicated that a dermatologist billed and was paid for level 4 and 5 codes for more than 90 percent of submitted evaluation and management service claims.[21] In comparison, the average rate of level 4 and 5 codes billed and paid for all dermatologists was 15 percent during the same period. There may be a reasonable explanation for this non-VA dermatologist's billing patterns. However, this example as well as other outliers warrant further inquiry by VA. Figure 1 highlights the magnitude of payments by non-VA providers who billed significantly more high-level 4 and 5 evaluation and management services than other non-VA providers in their same specialty.

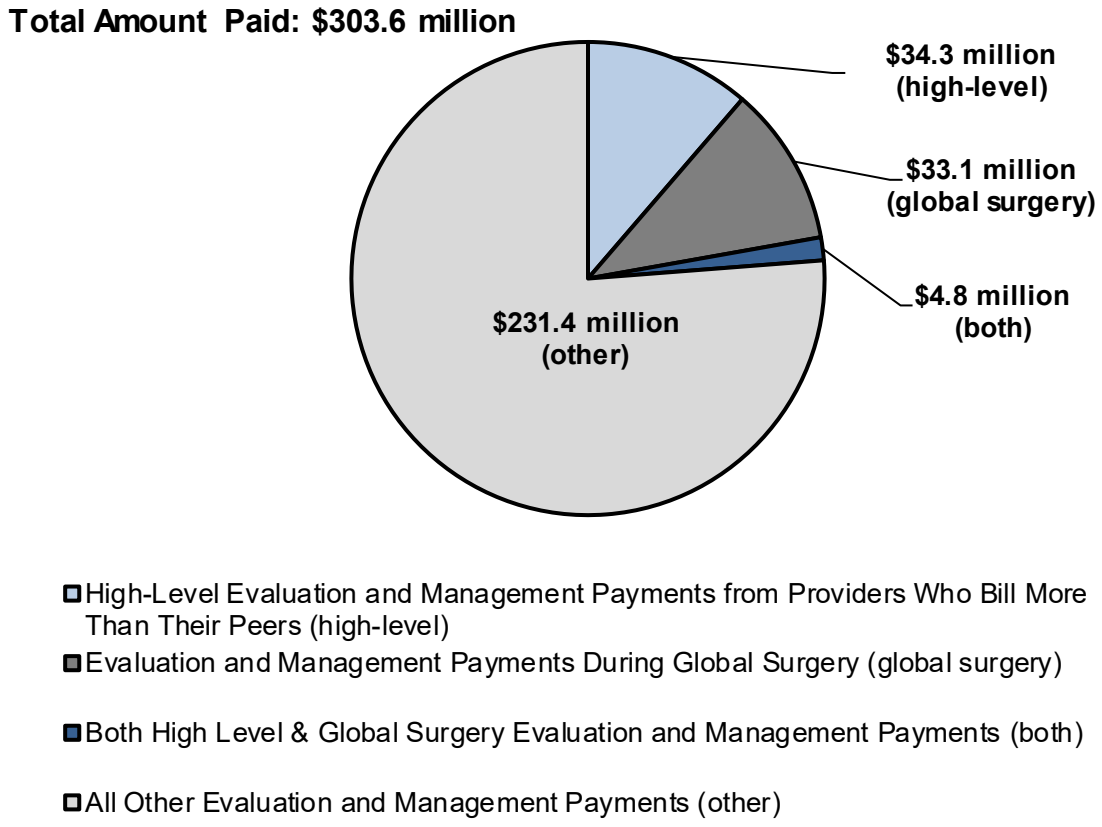

Figure 1. *Distribution of FY 2020 evaluation and management charges emphasizing higher risk payments. Source: VA OIG analysis of claims data from the Community Care Reimbursement System and Plexis Claims Manager. Numbers are rounded and may not sum to totals within the report text.*

[21] This amounted to about $111,000 for high-level evaluation and management services out of $121,000 for all evaluation and management services for which the dermatologist was paid.

Note: "Other" includes payments for level 1, level 2, and level 3 evaluation and management codes made any time not during global surgery as well as payments for level 4 and level 5 evaluation and management codes made to non-VA providers not determined to be high risk.

Some Non-VA Care Providers Billed Evaluation and Management Services during Periods That Potentially Should Not Have Been Separately Charged When the Global Surgery Package Was in Effect

Through data analysis, the OIG identified at least 45,600 providers of about 218,000 community care providers who were paid about $37.8 million more than costs that are generally included in the services provided within periods when the global surgery package is in effect during FY 2020.[22] The CMS states,

> The global surgical package … includes all the necessary services normally furnished by a surgeon before, during, and after a procedure. Medicare payment for a surgical procedure includes the pre-operative, intra-operative, and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty. Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.[23]

Although a provider can bill an evaluation and management treatment code during the global surgery period if it is a separate and identifiable service—for example, charged by an orthopedist for a shoulder problem the patient experiences after hip surgery—there is a higher risk that these charges are improper. Refer to figure 1 for the magnitude of evaluation and management payments during global surgery.

VHA Staff Did Not Review Medical Documentation for Billed Services as Required

VHA guidance requires that medical facility coding supervisors oversee retrospective sample reviews of community care claims at each medical facility.[24] However, HIM national staff interviewed reported they believed medical facility staff were generally not conducting these types of reviews and said only two facilities had access in FY 2019 to the claims information needed to conduct retrospective reviews. HIM staff went on to say that about 25 facilities had the information they needed to conduct audits by September 2020 and that they were working to provide all facilities with the needed information. In May 2021, HIM said that developing a

[22] About 6,700 providers were responsible for about $4.8 million of both global surgery charges and higher-than-peers' evaluation and management billing (see figure 1).

[23] CMS, *Global Surgery Booklet*.

[24] VHA Guidebook, *HIM Clinical Coding Program Guide*.

report to conduct reviews of non-VA provider medical documentation was still a work in progress. In addition, VHA did not have a process for how to act on information from such reviews. In November 2020, HIM and OCC officials stated they began discussing steps they could take, but these conversations had not produced results as of May 2021.

The OIG's first recommendation addresses the need for VHA to conduct postpayment audits to verify that non-VA providers are documenting evaluation and management services to support claims, including riskier high-level and global surgery evaluation and management services, and to develop processes for corrective actions based on audit results.

VHA Did Not Make Continuing Education Materials Related to Evaluation and Management Services Available to Community Providers

The MISSION Act requires VA to develop and implement a program to teach VA employees and contractors how to administer non-VA programs, establish a method to evaluate the effectiveness of this program at least annually, create a system to assess the quality of medical services provided by non-VA providers, and institute a program to provide continuing medical education material to non-VA providers.[25] Specifically, the MISSION Act requires VA to provide the same "continuing medical education material" to non-VA providers that is available to VA providers to "ensure that all medical professionals treating veterans have access to the same materials."[26]

HIM established training for VA providers regarding the application of evaluation and management standards that were implemented in 2021, but they did not make this training available to non-VA providers. According to both OCC and HIM officials, the responsibility for educating and communicating with non-VA providers falls on third-party administrators. In May 2021, HIM officials said their role in providing education would be limited to relaying results of non-VA care claims reviews to OCC for action. In June 2021, HIM national program staff said they were not responsible for non-VA provider behavior and can only tell them to follow industry standards. Further, according to HIM, non-VA providers are required to follow industry documentation and billing standards and non-VA providers, as a routine part of their scope of practice, should know these standards. However, these non-VA providers are still acting on behalf of VA.

The OIG's second recommendation addresses the need for VHA to ensure non-VA providers receive current and future continuing education materials on evaluation and management services to improve non-VA provider medical documentation of these services.

[25] MISSION Act of 2018, § 102, 122, 123.
[26] MISSION Act of 2018, § 123.

Unaddressed Risks Could Lead to Millions of Dollars in Payments for Non-VA Evaluation and Management Services without Assurance of Proper Billing

VHA risks overpaying for evaluation and management services. The OIG conservatively questioned about $59.6 million in payments made for such services from FY 2020 through FY 2022 using a prior three-year (FY 2018 through FY 2020) average improper payment rate from the CMS for outpatient or office visit evaluation and management services (7 percent).[27] The team multiplied that rate by all FY 2020 non-VA evaluation and management services, except for those on acupuncture and chiropractic claims.[28] The CMS rate is fitting because the provider population is similar: about 90 percent of VHA's evaluation and management services payments were to non-VA providers who were also registered to deliver care for the CMS. Table 1 presents the review team's estimate of FY 2020 questioned costs paid by VA.

Table 1. Estimated Questioned Costs for Non-VA Evaluation and Management Services (FY 2020)

Description	Paid (in millions)	Percent	Questioned costs (in millions)
FY 2020 evaluation and management services	$282.4	7	$19.9

Source: VA OIG estimates of potential monetary benefits based on CMS improper payment rates.
Note: Numbers are rounded and may not sum exactly.

The review team considered 7 percent a conservative estimate for the following reasons:

- The OIG's other audit found 97 percent and 78 percent error rates for evaluation and management services for acupuncture and chiropractic claims, respectively.[29]
- The CMS's payment process is more mature as the program was established in 1965, whereas non-VA care was not expanded legislatively until 2014.[30]

[27] "2020 Medicare Fee-For-Service Supplemental Improper Payment Data," Department of Health and Human Services, accessed February 4, 2021, https://www.cms.gov/files/document/2020-medicare-fee-service-supplemental-improper-payment-data.pdf. The CMS found improper payments for outpatient or office visit evaluation and management services in 2020, totaling about $1.1 billion. Generally, the CMS considered payments for evaluation and management services improper if the medical documentation was not sufficient or the coding was incorrect.

[28] The OIG did not include $21.2 of $303.6 million in FY 2020 payments for evaluation and management services in this calculation because they were on acupuncture and chiropractic claims, and those costs were questioned in a prior OIG audit (VA OIG, *VHA Improperly Paid and Reauthorized Non-VA Acupuncture and Chiropractic Services*).

[29] VA OIG, *VHA Improperly Paid and Reauthorized Non-VA Acupuncture and Chiropractic Services*.

[30] The Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

- VHA does not audit evaluation and management payments for community care as the CMS does.
- The review team identified additional risks among high-level evaluation and management services being billed by certain providers significantly more than their counterparts and among evaluation and management services being charged during global surgery periods.

Based on the FY 2020 questioned costs, the risk of overpayments would total an estimated $59.6 million over a three-year period, which could be reduced with corrective actions.

Conclusion

VHA faces a significant risk of overpaying non-VA providers for evaluation and management services when their claims are not supported. Through the end of FY 2022, these potential overpayments could total $59.6 million, based on a conservative estimate. The OIG found some providers billed more expensive evaluation and management services significantly more often than their peers, and some providers billed these services during periods when the global surgery package was in effect when most procedures should be covered under the original billing. Furthermore, evaluation and management charges continue to mount as payments for non-VA care grow. Because payments for evaluation and management services increased by about 350 percent from about $67.5 million in FY 2017 to about $303.6 million in FY 2020, there is an intensifying need for VHA to develop more effective controls, consistent provider education, and oversight.

Recommendations 1–2

The OIG made two recommendations to the under secretary for health:

1. Direct the Health Information Management program office, in coordination with the Office of Community Care and facility chiefs of staff, to ensure facilities are conducting postpayment audits of billed evaluation and management services to verify non-VA providers are properly supporting their claims, including a focus on providers who frequently bill high-level evaluation and management services and/or submit charges during periods when global surgery packages are in effect, and develop processes for corrective actions based on audit results.
2. Ensure the Office of Community Care and the Health Information Management program office make any current and future continuing education material related to documenting evaluation and management services available to non-VA providers.

Management Comments

The acting under secretary for health concurred with recommendations 1 and 2. To address recommendation 1, the acting under secretary for health reported VHA's HIM and OCC program offices and facility chiefs of staff would develop a plan to conduct retrospective audits, such as for evaluation and management services. In addition, the plan is to include taking corrective actions based on non-VA provider billing issues. Regarding recommendation 2, the acting under secretary for health said the HIM and OCC program offices will ensure educational material is made available to non-VA providers.

The acting under secretary for health also provided technical comments, which the OIG addressed below. VHA comments may be found in full in appendix D.

OIG Response

The corrective action plans are responsive to the intent of the recommendations. The OIG will monitor implementation of all planned actions and will close the recommendations when it receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and the specific risk areas identified in this report.

In its technical comments, VHA takes the position that the OIG inappropriately applied the reference to VHA Handbook 1907.01 regarding the use of the American Medical Association's CPT codes by non-VA care providers because the handbook only provided specific guidance on the inclusion of non-VA medical care documentation and does not require that community providers meet the American Medical Association standards and CMS guidelines. VHA further states that the use of the CPT codes is for VA facilities, not non-VA care.

VHA Handbook 1907.01, Health Information Management and Health Records, March 19, 2015, states that "the medical facility Director, or designee, is responsible for establishing policies and processes in compliance with this Handbook, to include ensuring … Non-VA medical care is documented" (p. 8–9). It also states that "the latest United States editions of the American Medical Association's CPT … must be used to provide uniform disease and operation terminology … [and code] assignment must be in accordance with … CMS … guidelines" (p. 63). The OIG does not interpret this reference to limit the requirement for the American Medical Association's CPT code use to VA providers alone; rather, it seems broadly to require that the American Medical Association's CPT codes and code assignment in accordance with CMS guidelines be used when documenting care in veterans' health records. Further, VHA's *HIM Clinical Coding Program Guide*, which provides procedures to be used in conjunction with VHA Handbook 1907.01, requires that the facility HIM manager or coding supervisor conduct retrospective reviews for codes submitted for payment under the Care in the Community program and "ensure that the clinical services identified in the clinical documentation were

performed."[31] The guide states that VHA uses CPT codes and explains that one of the purposes of coding is for reimbursement. The OIG has added VHA's *HIM Clinical Coding Program Guide* to footnote 11.

[31] VHA Guidebook, *HIM Clinical Coding Program Guide*.

Appendix A: Definitions of Evaluation and Management Service Codes

Code and level	Definition
99201 (Level 1)	Office or other outpatient visit for the evaluation and management of a new patient. (As of January 2, 2021, this code was retired.)
99211 (Level 1)	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
99202 (Level 2)	Office or other outpatient visit for the evaluation and management of a new patient that requires a medically appropriate history or examination and straightforward medical decision-making. When using time for code selection, 15–29 minutes of total time is spent on the date of the encounter.
99212 (Level 2)	Office or other outpatient visit for the evaluation and management of an established patient that requires a medically appropriate history or examination and straightforward medical decision-making. When using time for code selection, 10–19 minutes of total time is spent on the date of the encounter.
99203 (Level 3)	Office or other outpatient visit for the evaluation and management of a new patient that requires a medically appropriate history or examination and low level of medical decision-making. When using time for code selection, 30–44 minutes of total time is spent on the date of the encounter.
99213 (Level 3)	Office or other outpatient visit for the evaluation and management of an established patient that requires a medically appropriate history or examination and low level of medical decision-making. When using time for code selection, 20–29 minutes of total time is spent on the date of the encounter.
99204 (Level 4)	Office or other outpatient visit for the evaluation and management of a new patient that requires a medically appropriate history or examination and moderate level of medical decision-making. When using time for code selection, 45–59 minutes of total time is spent on the date of the encounter.
99214 (Level 4)	Office or other outpatient visit for the evaluation and management of an established patient that requires a medically appropriate history or examination and moderate level of medical decision-making. When using time for code selection, 30–39 minutes of total time is spent on the date of the encounter.
99205 (Level 5)	Office or other outpatient visit for the evaluation and management of a new patient that requires a medically appropriate history or examination and high level of medical decision-making. When using time for code selection, 60–74 minutes of total time is spent on the date of the encounter.
99215 (Level 5)	Office or other outpatient visit for the evaluation and management of an established patient that requires a medically appropriate history or examination and high level of medical decision-making. When using time for code selection, 40–54 minutes of total time is spent on the date of the encounter.

Source: EncoderPro.

Appendix B: Scope and Methodology

Scope

The review team performed its work from May 2021 to August 2021 to identify and evaluate the risks of improper community care payments for evaluation and management services. The review included a universe of approximately 3,200,000 claims from FY 2020 representing about $303.6 million paid to community care providers for evaluation and management services.

Methodology

To achieve the review objective, the OIG team extracted payment data for non-VA evaluation and management services from the Corporate Data Warehouse and analyzed the data for questionable billing practices. For the purposes of this review, the non-VA payment data universe was obtained from the VA Plexis Claims Management System and the VA Community Care Reimbursement System.

The OIG team reviewed the MISSION Act, third-party administrator contracts, medical documentation requirements, and other applicable VHA policies and guidelines. Finally, the team reviewed CMS improper payment reports.

To understand why managers did not address identified risks, the review team interviewed officials from OCC and the HIM program office. The team also evaluated VHA's non-VA provider education programs and the status of its medical documentation reviews.

Identifying and Evaluating Risks

To identify the risks, the OIG team analyzed the population of non-VA evaluation and management FY 2020 payments and identified a subsection of providers who were billing for high-level evaluation and management services significantly more often than their peers. These services are also reimbursed at higher levels.

In addition, the team reviewed criteria from the CMS regarding global surgery periods and concluded that evaluation and management services billed during these periods carried more risk than evaluation and management services not billed during global surgery periods.

Calculating Questioned Costs

To calculate questioned costs, the review team applied CMS improper payment rates for the same services to all non-VA evaluation and management services in FY 2020. The review team extrapolated the FY 2020 questioned costs three years through the end of FY 2022 because that is the earliest VHA would realize the benefits of corrective actions.

Fraud Assessment

The review team assessed the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant in the context of the review objective, could occur during this review. The team exercised due diligence in staying alert to any fraud indicators by

- soliciting the OIG's Office of Investigations for indicators and
- reviewing hotline complaints for allegations of inappropriate non-VA evaluation and management payments.

The OIG did not identify any instances of fraud during this review.

Data Reliability

The OIG Data Analytics Division provided the review team with Plexis Claims Manager and Community Care Reimbursement System evaluation and management service claims data. The review team and the analytics division assessed the reliability of how the non-VA claims with evaluation and management services were aggregated and categorized.

In addition, the review team assessed the completeness and accuracy of the payment data fields for a sample of 60 claims by reconciling the payment data in the Plexis Claims Manager or the Community Care Reimbursement System to payment data retrieved from the Financial Management System. The review team evaluated each sampled claim's categorization to determine that it was properly categorized in the subtotals the OIG reported as risks and the subtotals reported for the questioned costs calculation.

For the CMS data, the review team determined that a data reliability assessment was not necessary because the CMS data are used for a widely accepted purpose and obtained from sources generally accepted as appropriate, and it was not practical to conduct the assessment. In addition, the use of CMS data was contextual in this report.

Government Standards

The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

Appendix C: Monetary Benefits in Accordance with Inspector General Act Amendments

Recommendations	Explanation of Benefits	Better Use of Funds	Questioned Costs
1–2	VHA is at risk of overpaying an estimated $19.9 million in unsupported claims for non-VA evaluation and management services during FY 2020. The OIG further estimated unsupported evaluation and management claims could result in $59.6 million in overpayments from FY 2020 through FY 2022.[32]	Not applicable	$59.6 million
	Total		**$59.6 million**

Note: The OIG extrapolated the questioned costs from FY 2020 through FY 2022 based on when effective actions could address the problems identified in this audit. Although the corrective actions to address the OIG recommendations may be implemented by the end of FY 2022, it is likely VHA may not realize benefits from these corrective actions until then. Numbers are rounded and may not sum exactly.

[32] To estimate monetary benefits for FY 2020, the review team multiplied the CMS's average improper payment rate by all non-VA evaluation and management services except for those attached to acupuncture and chiropractic claims (which were questioned in an earlier OIG report). This $59.6 million in questioned costs is separate and distinct from the questioned costs in the VA OIG, *VHA Improperly Paid and Reauthorized Non-VA Acupuncture and Chiropractic Services*. The total questioned costs do not sum exactly due to rounding.

Appendix D: Management Comments

Department of Veterans Affairs Memorandum

Date: September 8, 2021

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report, VHA Risks Overpaying Community Care Providers for Evaluation and Management Services (2021-01807-AE-0083) (VIEWS # 5587103)

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report VHA Risks Overpaying Community Care Providers for Evaluation and Management Services. I concur with the recommendations and provide an action plan in the attachment to address the findings. VHA provides technical comments below to improve the accuracy and completeness of the report.

2. Page 1, paragraph 2, lines 2-4: For purposes of accuracy and to prevent any potential misunderstanding or unintended confusion, VHA recommends removing the reference to VHA Handbook 1907.01. The interpretation and reference to VHA Handbook 1907.01 has been applied inappropriately because the handbook only provided specific guidance on the inclusion of Non-VA medical care documentation and not that Non-VA providers are required to meet American Medical Association (AMA) and Centers for Medicare & Medicaid Services (CMS) guidelines. Additionally, the reference to VHA Handbook 1907.01 regarding use of AMA Current Procedural Terminology codes is referencing the codes and terminology utilized by the facility, not services from Non-VA care providers.

The OIG removed point of contact information prior to publication.

(Original signed by)

Stephen L. Lieberman, M.D.

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

Review of Evaluation and Management Non-VA Care Payments

(OIG 2021-01807-AE-0083)

Recommendation 1. The Under Secretary for Health should direct the Health Information Management program office in coordination with the Office of Community Care and facility chiefs of staff to ensure facilities are conducting post-payment audits of billed evaluation and management services to verify non-VA providers are properly supporting their claims, including a focus on providers who frequently bill high-level evaluation and management services and/or submit charges during periods when global surgery packages are in effect, and develop processes for corrective actions based on audit results.

VHA Comments: Concur.

VHA understands the importance of conducting post-payment audits of community care providers' records for services rendered to Veterans. These audits are a fundamental way to monitor the billing, coding and documentation practices of non-VA health care providers in order to prevent fraud and abuse within the VHA payment system. The Health Information Management (HIM) program office in coordination with the Office of Community Care (OCC) and facility chiefs of staff will develop an approach and plan for regularly conducting post-payment audits of billed outpatient services, such as for evaluation and management services. The plan will address the resourcing needed for conducting audits, which may include coordination with additional program offices. The plan will also outline approaches for scoping, sampling and taking corrective actions inclusive of non-VA provider-specific billing and documentation issues.

Status: In progress Target Completion Date: March 2022

Recommendation 2. The Under Secretary for Health should ensure the Office of Community Care and the Health Information Management program office make any current and future continuing education material related to documenting evaluation and management services available to non-VA providers.

VHA Comments: Concur.

HIM Program Office will ensure any current and future provider education material developed by the HIM Program Office for VA providers relating to documenting evaluation and management services are made available to OCC for dissemination to non-VA providers. OCC will make the education material available to these providers via the VA OCC public facing website and will ensure that providers are made aware of the availability of these education materials.

Status: In progress Target Completion Date: November 2021

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Review Team	Daniel Morris, Director Joseph Benham Geoffrey Ferguson Eric Sanford Grisbell Soto Johan Thatil
Other Contributors	Kate Feingold Charles Hoskinson Victor Rhee Nelvy Viguera Butler Allison Tarmann

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget

OIG reports are available at www.va.gov/oig